NHS
Central East
Integrated Care Board

Agenda
Board Meeting of NHS Central East ICB held in Public

Date: Friday 25 September 2026
Time: 12:30 – 16:00
Venue: Davis Suite, The Rufus Centre, Steppingley Road, Flitwick, Beds MK45 1AH

No.	Agenda Item	Purpose	Lead	Paper	Timings
1.	Welcome, Introductions and Apologies	Note	Chair		12:30
2.	Relevant Persons Disclosure of Interests	Note	Chair	✓	
	Annual General Meeting				
3.	Annual Review of 2025/26: • Bedfordshire, Luton and Milton Keynes ICB • Cambridgeshire and Peterborough ICB • Hertfordshire and West Essex ICB	Note	Chair	Verbal Appendices Available	12:35
4.	Annual Report and Accounts 2025/26: • Bedfordshire, Luton and Milton Keynes ICB • Cambridgeshire and Peterborough ICB • Hertfordshire and West Essex ICB		Deputy Chief Executives and Executive Director of Finance, Resources and Contracts	✓ Appendices Available	
	Business of the Board of the ICB				
5.	Minutes from the previous Board Meeting on 26 June 2026 and Matters Arising	Approve	Chair	✓	13:00
6.	Review of Action Tracker	Note	Chair	No formal actions	
7.	Questions from the Public		Chair	Verbal	13:05
8.	Residents Stories Theme: Care Coordination for Advanced Illness		Executive Clinical Director Total Quality Management and Elaine Tolliday, Deputy CEO and Clinical Director Keech Hospice	Presentation on the day	13:15
9.	Our Way Priority Programmes: Delivery Progress	Note	Executive Director of Corporate Services and ICB Development	✓	14:00

No.	Agenda Item	Purpose	Lead	Paper	Timings
10.	People Update - Culture	Note	Director of People and Culture	✓	14:25
11.	Central East ICB Winter Plan	Discussion and Note	Executive Director for Neighbourhood Health, Place and Partnerships	✓	14:40
12.	Chairs Report	Note	Chair	Verbal	15:00
13.	Chief Executive Report	Note	Chief Executive Officer and Deputy Chief Executives	✓	15:10
	Governance and Assurance				
14.	Risk Management Update	Assurance	Executive Director of Corporate Services and ICB Development	✓	15:20
15.	Audit and Risk Committee Chair's Report	Note	Chair of the Audit and Risk Committee	✓	
16.	Finance Planning and Payer Function Committee Chair's Report	Note	Chair of the Finance Planning and Payer Function Committee	✓	
17.	Neighbourhood Health Delivery Committees Chair's Reports • Bedfordshire, Luton and Milton Keynes Neighbourhood Health Delivery Committee • Cambridgeshire and Peterborough Neighbourhood Health Delivery Committee • Hertfordshire Neighbourhood Health Delivery Committee	Note	Chairs of the Neighbourhood Health Delivery Committees	✓	
18.	Utilisation Management and Quality Improvement Committee	Note	Chair of Utilisation Management and Quality Improvement Committee	✓	
19.	Any Other Business		Chair		15:45

NHS Central East Integrated Care Board
Register of Interests 2026/27 - Board Members

NHS Central East Integrated Care Board

Surname	Forename	Position (within or relationship with the Integrated Care Board)	Interest to Declare? (Y/N)	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect Interest	Details of Interest	Date From	Date To	Action
Allen	Sharon	Ordinary Member - VCFSE Alliance	Yes	✓				CEO of Arthur Rank Hospice Charity which provides contracted services for the ICB (Company number 03059033)	01/04/2019	Current date	Declare in accordance with Conflicts of Interest Policy
Allen	Sharon	Ordinary Member - VCFSE Alliance	Yes		✓			Member of the Voluntary Sector Network Cambridgeshire and Peterborough	Since it began	Current date	Declare in accordance with Conflicts of Interest Policy
Allen	Sharon	Ordinary Member - VCFSE Alliance	Yes				✓	Trustee - Age UK (Company number 06825798)	Sep-17	Sep-26	Declare in accordance with Conflicts of Interest Policy
Allen	Sharon	Ordinary Member - VCFSE Alliance	Yes				✓	Trustee - Hospice UK (Company number 02751549)	2021	Current	Declare in accordance with Conflicts of Interest Policy
Allen	Sharon	Ordinary Member - VCFSE Alliance	Yes				✓	Cambridgeshire Care Providers Alliance Patron	2021	Current	Declare in accordance with Conflicts of Interest Policy
Allen	Sharon	Ordinary Member - VCFSE Alliance	Yes				✓	Fellow Chartered Institute of City and Guilds	2021	Current	Declare in accordance with Conflicts of Interest Policy
Allen	Sharon	Ordinary Member - VCFSE Alliance	Yes				✓	Social Work England, Registrant	2019	Current	Declare in accordance with Conflicts of Interest Policy
Allen	Sharon	Ordinary Member - VCFSE Alliance	Yes				✓	Association of Coaching, Member	2017	Current	Declare in accordance with Conflicts of Interest Policy
Barker	Karen	Transition Director and Executive Director of Corporate Services	No					N/A			
Borrett	Alison	Non-Executive Member	Yes	✓				Director, 2Billys Ltd, Company no 14038119.	11/04/2022	Ongoing	Business has not been involved with any NHS organisations, if relevant will declare in accordance with Conflicts of Interest Policy

Surname	Forename	Position (within or relationship with the Integrated Care Board)	Interest to Declare? (Y/N)	Financial Interest	Non-Financial Professional	Non-Financial Personal	Indirect Interest	Details of Interest	Date From	Date To	Action
Bracey	Michael	Chief Executive, Milton Keynes City Council – ICB Partner Member (Local Authority)	Yes		✓			Employee of Milton Keynes City Council	01/09/2009	Present	Declare in accordance with Conflicts of Interest Policy
Bracey	Michael	Chief Executive, Milton Keynes City Council – ICB Partner Member (Local Authority)	Yes		✓			Director, Home & Futures Cawley Priory, South Pallant, Chichester PO19 1SY Company number 16666009	17/11/2025	Present	Declare in accordance with Conflicts of Interest Policy
Bracey	Michael	Chief Executive, Milton Keynes City Council – ICB Partner Member (Local Authority)	Yes		✓			MK:U Limited (Higher Education)	30/01/2019	Present	Declare in accordance with Conflicts of Interest Policy
Ferreira	Vitor	Non-Executive Member (Chair of Audit & Risk Committee)	Yes			✓		Treasurer and Director - St Michaels Parochial Church Council, St Micheals Street, St Albans, AL3 4SL Charity number: 1132915	01/04/2026	Present	Declare in accordance with Conflicts of Interest Policy
Ferreira	Vitor	Non-Executive Member (Chair of Audit & Risk Committee)	Yes				✓	Daughter is a doctor for the NHS working in Bristol	01/04/2026	Present	Declare in accordance with Conflicts of Interest Policy, exclusion from related decision making
Ferreira	Vitor	Non-Executive Member (Chair of Audit & Risk Committee)	Yes	✓				Shares in HSBC PLC	01/04/2026	Present	Declare in accordance with Conflicts of Interest Policy
Ferreira	Vitor	Non-Executive Member (Chair of Audit & Risk Committee)	Yes	✓				Shares in Aviva PLC	01/04/2026	Present	Declare in accordance with Conflicts of Interest Policy
Goutam	Sureena (Dr)	GP - ICB Partner Member (Primary Medical Services)	Yes	✓				Sessional GP at Sundon Medical Centre	2018	To date	Declare and act in line with Conflicts of Interest Policy i.e. at relevant meetings or forums

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Goutam	Sureena (Dr)	GP - ICB Partner Member (Primary Medical Services)	Yes	✓				Director of Sanat Practice Limited – Limited company for provision of medical services including services for independent NHS provider of services Herts Urgent Care, London Central West. Service provision for Herts Urgent Care includes a clinical transformation project from 10.122025-31.3.2026 Company number 09170717	2015	To date	Declare and act in line with Conflicts of Interest Policy i.e. at relevant meetings or forums
Goutam	Sureena (Dr)	GP - ICB Partner Member (Primary Medical Services)	Yes	✓				Director of Sanat Properties Ltd - property investment company (including a BLMK GP surgery premises) Company number 09711571	2015	To date	Declare and act in line with Conflicts of Interest Policy i.e. at relevant meetings or forums
Goutam	Sureena (Dr)	GP - ICB Partner Member (Primary Medical Services)	Yes	✓				Governance Lead at Hatters Health Primary Care Network	2022	To date	Declare and act in line with Conflicts of Interest Policy i.e. at relevant meetings or forums
Goutam	Sureena (Dr)	GP - ICB Partner Member (Primary Medical Services)	Yes		✓			Clinical Advisor for NHSE 111/IUC	2025	To date	Declare and act in line with Conflicts of Interest Policy i.e. at relevant meetings or forums
Goutam	Sureena (Dr)	GP - ICB Partner Member (Primary Medical Services)	Yes		✓			NHSE GIFRT reference group member - dermatology and urinary tract stones	2025	To date	Declare and act in line with Conflicts of Interest Policy i.e. at relevant meetings or forums
Gregson	Dorothy	Non-Executive Member	Yes				✓	Partner is Head of Robot Software and owns shares in a surgical robotic company - CMR Surgical Ltd. Company No 08863657 1 Evolution Business Park, Milton Road, Cambridge, CB24 9NG	01/07/2022	Ongoing	Declare in accordance with Conflicts of Interest Policy
Griffiths	Sarah	Executive Director of Finance, Resources and Contracts	Yes				✓	Partner is employed as a Senior Director at AstraZeneca	14/04/2025	Date	Declare in line with conflicts of interest policy and exclusion from involvement in relevant meeting or decision making
Griffiths	Sarah	Executive Director of Finance, Resources and Contracts	Yes				✓	Shares held in various FTSE100 companies including 382 shares in AstraZeneca plc	14/04/2025	Oct-25	N/A

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Griffiths	Sarah	Executive Director of Finance, Resources and Contracts	Yes				✓	Academy Board and Finance Committee Member - Trumpington Park Primary School, Cambridge	14/04/2025	Dec-25	N/A
Head	Fiona (Dr)	Executive Clinical Director Utilisation Management (Medical Director)	Yes	✓				GP Locum - East Barnwell Health, Cambridge	03/04/2023	Current	Declare in accordance with Conflicts of Interest Policy. Recuse from conversations and decisions relevant to the affairs of the practice.
Head	Fiona (Dr)	Executive Clinical Director Utilisation Management (Medical Director)	Yes		✓			Member Panel of National Data Guardian	01/07/2022	Current	Declare in accordance with Conflicts of Interest Policy
Head	Fiona (Dr)	Executive Clinical Director Utilisation Management (Medical Director)	Yes		✓			Fellow - Royal College of Physicians	01/07/2022	Current	Declare in accordance with Conflicts of Interest Policy
Head	Fiona (Dr)	Executive Clinical Director Utilisation Management (Medical Director)	Yes		✓			Fellow - Faculty of Public Health	01/07/2022	Current	Declare in accordance with Conflicts of Interest Policy
Head	Fiona (Dr)	Executive Clinical Director Utilisation Management (Medical Director)	Yes		✓			Member - Royal College of General Practitioners	01/07/2022	Current	Declare in accordance with Conflicts of Interest Policy
Head	Fiona (Dr)	Executive Clinical Director Utilisation Management (Medical Director)	Yes		✓			Member - British Medical Association	01/07/2022	Current	Declare in accordance with Conflicts of Interest Policy
Howard	James (Dr)	GP - ICB Partner Member (Partner Medical Services)	Yes	✓				Director - Eaglebond Ltd. Company number 06962597	01/07/2013	To date	Declare in accordance with Conflicts of Interest Policy
Howard	James (Dr)	GP - ICB Partner Member (Partner Medical Services)	Yes	✓				Partner, Staploe Medical Centre	05/02/2001	To date	Declare in accordance with Conflicts of Interest Policy
Hughes	Sarah	Non-Executive Member	Yes	✓				Chief Executive - Mind	09/01/2023	Current	Declare in line with conflicts of interest policy. Exclusion from involvement in related meeting or decision-making.

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Hughes	Sarah	Non-Executive Member	Yes	✓				Trustee - One Small Thing Company number 11516337	21/06/2023	Current	Declare in line with conflicts of interest policy. Exclusion from involvement in related meeting or decision-making.
Hughes	Sarah	Non-Executive Member	Yes	✓				Trustee - Comic Relief (Charity Projects 01806414)	14/01/2026	Current	Declare in line with conflicts of interest policy. Exclusion from involvement in related meeting or decision-making.
Hughes	Sarah	Non-Executive Member	Yes	✓				Fellow, RSA Sciana Saltzburg Globa	01/05/2018	Current	Declare in line with conflicts of interest policy. Exclusion from involvement in related meeting or decision-making.
Hughes	Sarah	Non-Executive Member	Yes	✓				Member - Global Leadership Exchange	01/07/2022	01/10/2025	N/A
Kamfer	Louis	Executive Director of Strategy, Planning & Commissioning	Yes		✓			Treasurer - Quay Church, Woodbridge Suffolk	01/07/2022	Current	Declare in accordance with Conflicts of Interest Policy
Kamfer	Louis	Executive Director of Strategy, Planning & Commissioning	Yes		✓			Director Longwood Fields (Melton) Management Company LTD (11006694)	09/07/2025	Current	Declare in accordance with Conflicts of Interest Policy
Midlane	Eilish	Chief Executive, Royal Papworth NHS FT - ICB Partner Member (NHS Trust & FT)	Yes	✓				Chief Executive - Royal Papworth Hospital NHS Trust	01/09/2022	Present	Declare in accordance with Conflicts of Interest Policy
Midlane	Eilish	Chief Executive, Royal Papworth NHS FT - ICB Partner Member (NHS Trust & FT)	Yes		✓			Charity Trustee - Board of East Anglia Air Ambulance (Company number 04066700)	01/12/2025	Present	Declare in accordance with Conflicts of Interest Policy
Midlane	Eilish	Chief Executive, Royal Papworth NHS FT - ICB Partner Member (NHS Trust & FT)	Yes			✓		Board Member (Director role) - Cambridge Biomedical Campus Ltd (Company number 13471389)	01/09/2022	Present	Declare in accordance with Conflicts of Interest Policy
Midlane	Eilish	Chief Executive, Royal Papworth NHS FT - ICB Partner Member (NHS Trust & FT)	Yes			✓		Board Member at Cambridge University Health Partners (Company number 07015773)	01/09/2022	Present	Declare in accordance with Conflicts of Interest Policy

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Midlane	Eilish	Chief Executive, Royal Papworth NHS FT - ICB Partner Member (NHS Trust & FT)	Yes			✓		Member - Federation of Specialist Hospitals	01/09/2022	Present	Declare in accordance with Conflicts of Interest Policy
Midlane	Eilish	Chief Executive, Royal Papworth NHS FT - ICB Partner Member (NHS Trust & FT)	Yes			✓		Member - Cambridge Ahead	01/08/2023	Present	Declare in accordance with Conflicts of Interest Policy
Midlane	Eilish	Chief Executive, Royal Papworth NHS FT - ICB Partner Member (NHS Trust & FT)	Yes	✓				CQC - Well-Led Executive Reviewer	01/07/2022	Present	Declare in accordance with Conflicts of Interest Policy
Midlane	Eilish	Chief Executive, Royal Papworth NHS FT - ICB Partner Member (NHS Trust & FT)	Yes				✓	Member - Life Sciences Advisory Council	01/09/2023	Present	Declare in accordance with Conflicts of Interest Policy
Midlane	Eilish	Chief Executive, Royal Papworth NHS FT - ICB Partner Member (NHS Trust & FT)	Yes	✓				Life Sciences Advisory Group - NHS Confederation	01/03/2023	03/2026	Declare in accordance with Conflicts of Interest Policy
Midlane	Eilish	Chief Executive, Royal Papworth NHS FT - ICB Partner Member (NHS Trust & FT)	Yes				✓	Member - NHS Blood and Transplant Stakeholder Organ Utilisation Group	28/04/2024	12/2025	Declare in accordance with Conflicts of Interest Policy
Moir	Stephen	Chief Executive, Cambridgeshire County Council – ICB Partner Member (Local Authority)	No					N/A			

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Porter	Robin	ICB Chair	Yes	✓				Chair of the Lampton Group, Company number 08468401, Southall Lane Depot, Southall Lane, Southall, England, UB2 5AG • Director, Lampton Leisure Limited, Company number 12923138 • Director, Lampton Greenspace 360 Limited, Company number 11113648 • Director, Lampton Recycle 360 Limited, Company number 10347934 • Director, Lampton Investment 360 Limited, Company number 10362770	06/05/2025	Ongoing	Declare in accordance with Conflicts of Interest Policy
Porter	Robin	ICB Chair	Yes	✓				Chair of the Board - Coalo Limited, Company number 10432434	01/10/2025	Ongoing	Declare in accordance with Conflicts of Interest Policy
Porter	Robin	ICB Chair	Yes	✓				Director, Bartholomew Square Consulting Limited, Company number 10145337	Apr-25	Ongoing	Declare in accordance with Conflicts of Interest Policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Professor of Diversity in Public Health & Director, Institute for Health Research University of Bedfordshire	2006	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Honorary Academic Contract, UK Health Security Agency	2021	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Honorary Academic Contract, Office for Health Improvement & Disparities	2021	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Expert Advisor, NICE Centre for Guidelines, UK	2011	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Facilitator, Faculty of Public Health Accredited Practitioner Program, UK Faculty of Public Health	2018	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Non-Executive Director, Forestry England	2019	Current	Declare in line with conflicts of interest policy

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Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Adjunct Professor, Ton Due Thang University, Vietnam	2017	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			National Member, National Black and Minority Ethnic Transplant Alliance, UK	2016	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Member, British Medical Association Ethics Committee, UK	2017	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Member, Donation Ethnicity Liberty Inclusion Pontifical Academy for Life (PAL) – Vatican State-led Engagement of Religious communities (DELIVER) Project	2025	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Member, Quality and safety of organs for transplantation - European Directorate for the Quality of Medicines and HealthCare (EDQM) Group of Experts, Council of Europe	2023	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			National Member, Mental Health Working Group, NHS Race & Health Observatory, UK	2024	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			National Member, Independent Stakeholder Advisory Board, National Institute for Health Research	2025	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Member, World Health Organisation (WHO), Expert Advisory Panel on Organ Donation & Transplantation	2025	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes		✓			Member, European Society of Transplantation (ESOT) – Health Equity Steering Committee	2025	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes			✓		Vice Lord-Lieutenant, Bedfordshire	2017	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes			✓		Patron of the Bedfordshire Rural Communities Charity	2023	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes			✓		Volunteer, Luton Sikh Soup Kitchen	2021	Current	Declare in line with conflicts of interest policy

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Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes			✓		Junior Cricket Coach, Harpenden Cricket club	2014	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes			✓		Patient, Davenport House Surgery, Harpenden	2006	Current	Declare in line with conflicts of interest policy
Randhawa	Gurch (Prof)	Non-Executive and Deputy Chair of HW&E ICB	Yes				✓	Extended family works at local Primary Care network	2024	Current	Declare in line with conflicts of interest policy
Ridgwell	Angie	Chief Executive, Hertfordshire County Council - ICB Partner Member (Local Authority)	Yes		✓			CEO Hertfordshire County Council	27/09/2024	Current	Declare in line with conflicts of interest policy and if necessary leave the meeting for the relevant agenda item
Ridgwell	Angie	Chief Executive, Hertfordshire County Council - ICB Partner Member (Local Authority)	Yes		✓			Member Capita Advisory Board – steering board to assist in the development of new products to support the local government sector. No monies received and £2,000 per meeting donated by Capita directly to Hertfordshire Community Foundation - an independent grant giving charity registered in England under number 08794474.	01/02/2026	Current	Declare an interest and leave the meeting for the relevant agenda item
Solanki	Rachel	ICB Board Partner Member	Yes	✓				Superintendent and Director - Quadrant Pharmacies Ltd – Mulberry House, Ayot St Lawrence, Welwyn, Hertfordshire. AL6 9BY Company number 04748706	01/09/2000	Current	
Solanki	Rachel	ICB Board Partner Member	Yes		✓			Chair and Committee Member - Community Pharmacy Hertfordshire – Weltech Centre, Ridgeway, Welwyn Garden City, Hertfordshire. AL7 2AA	24/06/1905	Current	
Solanki	Rachel	ICB Board Partner Member	Yes	✓				Clinical Pharmacist (Consultancy) – Harpenden Health PCN	01/09/2019	Current	

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Solanki	Rachel	ICB Board Partner Member	Yes				✓	Husband – Senior Key Account Manager Menarini Stemline Oncology – Menarini House, Mercury Park, Wycombe Lane, Wooburn Green, Buckinghamshire. HP10 0HH	01/10/2023	Current	
Solanki	Rachel	ICB Board Partner Member	Yes	✓				Community Pharmacy Integration Lead – ICB role	01/05/2023	31/03/2026	
Stanley	Sarah	Deputy Chief Executive Officer & Executive Clinical Director Total Quality Management	No								
Taylor	Karen	CEO Hertfordshire Partnerships University NHS FT - ICB Partner Member (NHS Trust & FT)	Yes	✓				Chief Executive and employee of HPFT	Dec-21	Current	Declare in accordance with Conflicts of Interest Policy
Taylor	Karen	CEO Hertfordshire Partnerships University NHS FT - ICB Partner Member (NHS Trust & FT)	Yes		✓			Board Trustee - NHS Alliance	Apr-26	Current	Declare in accordance with Conflicts of Interest Policy
Taylor	Karen	CEO Hertfordshire Partnerships University NHS FT - ICB Partner Member (NHS Trust & FT)	Yes		✓			East of England Provider Collaborative Lead CEO 2024	Jul-24	Current	Declare in accordance with Conflicts of Interest Policy
Taylor	Karen	CEO Hertfordshire Partnerships University NHS FT - ICB Partner Member (NHS Trust & FT)	Yes		✓			Board Trustee - NHS Providers	Jul-23	Jul-26	N/A
Thomas	Jan	Chief Executive, BLMK ICB, C&P ICB and H&WE ICBs	Yes				✓	Spouse provides private medical secretary services to local consultants	01/07/2022	Present	Declare in accordance with Conflicts of Interest Policy

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Thomas	Jan	Chief Executive, BLMK ICB, C&P ICB and H&WE ICBs	Yes			✓		Appointed as Trustee of Ashley Pavilion CIO - this is a small charitable organisation dedicated to supporting community wellbeing and local engagement through the provision and maintenance of the local village pavilion. The role is unpaid and will be carried out alongside existing commitments.	01/04/2026	Present	Declare in accordance with Conflicts of Interest Policy
Vaughton	Kate	Executive Director for Neighbourhood Health Place & Partnership	Yes		✓			Vice Chair -St Nicholas Hospice, Bury St Edmunds	01/05/2022	Present	Declare in accordance with conflicts of interest policy.
Vaughton	Kate	Executive Director for Neighbourhood Health Place & Partnership	Yes		✓			Trustee – Abbeycroft Leisure, Bury St Edmunds	19/05/2022	Present	Declare in accordance with conflicts of interest policy.
Winn	Mathew	Chief Executive, Cambridge Community Services NHS Trust - ICB Partner Member (NHS Trust & FT)	Yes	✓				Chief Executive of East of England Community Health and Care NHS Trust. Trust is directly commissioned by the ICB and by partners from the Board in Local Authorities.	01/04/2026	Present (31/03/2027)	Declare any specific interest at the time of discussion. Absent from relevant discussion and decisions where there is a clear conflict of interest.

Annual Accounts – Review

Sarah Griffiths
Executive Director of Finance,
Contracts & Resources

Financial Summary

The Annual Accounts explain how funding was received, how it was spent, the assets and liabilities held, and the financial position at year end. The Accounts were prepared in accordance with NHS England and Department of Health and Social Care requirements.

Financial Duties Achieved

All three ICBs achieved their statutory financial duties to keep expenditure within the resources available.

	Bedfordshire Luton & Milton Keynes (BLMK)	Cambridgeshire & Peterborough (C&P)	Hertfordshire & West Essex (HWE)
Expenditure does not exceed funding allocation	✓	✓	✓
Stay within Running Cost Allocation	✓	✓	✓
Mental Health Investment Standard (MHIS)	✓	✓	✓

In addition, all three ICBs met the requirements for the Mental Health Investment Standard, under which all ICBs were required to increase their spending on mental health services by a percentage set by NHS England.

Independent Audit Opinion

- The Annual Accounts were independently audited by external auditors. The auditors issued an unqualified audit opinion, confirming that the Accounts provide a true and fair view of the financial position and performance of each organisation.
- In BLMK ICB and HWE ICB auditors did not identify any significant weakness in respect of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources.
- In HWE the external auditors did identify a significant value for money weakness relating to the governance of Continuing Healthcare (CHC) services. This reflected workforce pressures, operational backlogs, delays in implementing improvement actions and ongoing financial challenges. Since the establishment of NHS Central East ICB in April 2026, strengthened governance arrangements and a dedicated improvement programme have been put in place, with progress subject to regular oversight and monitoring.

How we Spent Public Money in 2025/26

Across the three predecessor ICBs, £9.44 billion was spent in 2025/26. All three ICBs delivered financial balance.

£9.44bn
Total health expenditure

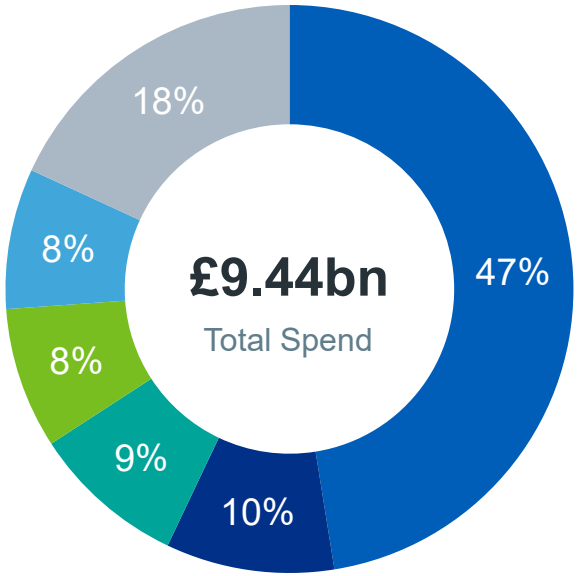
£15.8m
Combined surplus

3 of 3
ICBs delivered financial balance

47%
Spent on Acute Services

Where the money was spent

Share of total expenditure across the three predecessor ICBs



Acute services	£4,481.7m	47%
Specialised commissioning	£905.5m	10%
Mental health	£828.7m	9%
Primary medical	£758.8m	8%
Community health	£754.9m	8%
Other services	£1,712.2m	18%

Financial position by ICB

Surplus / (deficit) against allocation

Bedfordshire Luton & Milton Keynes	**£11.9m**	0.4% of allocation
Cambridgeshire & Peterborough	**£3.9m**	0.2% of allocation
Hertfordshire & West Essex	**Break-even**	0.0% of allocation

✓ **All three predecessor ICBs met their financial duty**

Forward Look

Organisational Change

Since its establishment on 1 April 2026, NHS Central East ICB has successfully completed the transfer of services, contracts, assets and financial responsibilities from its predecessor ICBs. Our focus is now on embedding a single organisation, aligning processes and ways of working, reducing duplication and delivering more consistent outcomes for our population.

Delivering Our Long-Term Priorities

The NHS has introduced a multi-year planning framework covering 2026/27 to 2028/29, providing greater stability to support longer-term transformation. Our plans reflect national and local priorities, with a focus on prevention, reducing health inequalities, digital transformation and providing more care closer to home. We will continue working with partners to improve outcomes while ensuring services remain sustainable and financially resilient.

Delivering Financial Sustainability

From 2026/27, each ICB and NHS provider is required to deliver financial balance in its own right. This is a change from 2025/26, when organisations collectively supported delivery of financial balance across their wider system. Individual accountability remains alongside the need for close collaboration. We will continue working with providers to align plans, address local healthcare needs and ensure that available resources are used effectively and efficiently.

Changing How Care Is Funded

National payment arrangements have changed for 2026/27, including a new approach to funding urgent and emergency care. Payment arrangements increasingly reflect activity, outcomes and more efficient ways of delivering services. These changes are intended to improve productivity and support the shift towards prevention, earlier intervention and community-based care. We are working with providers to ensure that financial arrangements support sustainable service delivery.

NHS
Central East
Integrated Care Board

Draft Minutes
Formal Meeting in Public Central East ICB

Date: Friday 26 June 2026
Time: 12:00 – 14:30
Venue: MS Teams

Members in Attendance:

Members		
Robin Porter	Chair	RP
Sharon Allen	Voluntary Community Faith and Social Enterprise Member	SA
Karen Barker	Transition Director and Executive Director of Corporate Services and ICB Development	KB
Alison Borrett	Non-Executive Member	AB
Vitor Ferreira	Non-Executive Member	VF
Dorothy Gregson	Non-Executive Member	DG
Sureena Goutam	Primary Medical Services Provider Partner Member	SGo
James Howard	Primary Medical Services Provider Partner Member	JH
Sarah Griffiths	Executive Director of Finance, Resources and Contracts	SGr
Fiona Head	Executive Clinical Director Utilisation Management (Medical Director)	FH
Eilish Midlane	NHS Foundation Trust Partner Member	EM
Stephen Moir	Local Authority Partner Member	SM
Angie Ridgwell	Local Authority Partner Member	AR
Gurch Randhawa	Non-Executive Member	GR
Rachel Solanki	Primary Medical Services Provider Partner Member	RS
Sarah Stanley	Executive Clinical Director Total Quality Management	SSt
Karen Taylor	NHS Foundation Trust Partner Member	KT
Jan Thomas	Chief Executive	JT
Kate Vaughton	Executive Director for Neighbourhood Health, Place and Partnerships	KV
Matthew Winn	NHS Trust Partner Member	MW
Participants		
Kelly O'Neill	Director of Public Health, Luton Borough Council and Public Health Representative	KO'N
Neil Tester	Chief Executive, Healthwatch Hertfordshire and Healthwatch Representative	NT

In attendance:

Elizabeth Disney	Director of Strategic Planning and Commissioning	ED
Laura MacSweeney	Senior Corporate Governance Officer (Minutes)	LMS
Stephen Madden	Associate Director for Major Projects	SMa
Andrew Palmer	Director of Population Health, Analytics and Evaluation *(item 8 only)*	AP
Simone Surgenor	Deputy Chief of Staff – Governance and Policies	SSu

There were 5 members of the public in attendance

Apologies from members:

Michael Bracey	Local Authority Partner Member	MB
Sarah Hughes	Non-Executive Member	SH
Louis Kamfer	Executive Director of Strategy, Planning and Evaluation	LK

No.	Agenda Item	Action
	Opening Items	
1.0	**Chair** The Chair **welcomed** all present to the Board meeting of Central East Integrated Care Board (ICB). The Chair **introduced**: • Rachel Solanki – New Primary Medical Services Provider Partner Member • Kelly O'Neill – Participant as Public Health Representative • Neil Tester – Participant as Healthwatch Representative Apologies were **noted** as above and the meeting was confirmed as **quorate.** The Chair noted for the record, that the Board of the Central East ICB met earlier in private. At the start of that session, the statutory resolution to exclude members of the press and public under Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960 was read out, and Board members confirmed their agreement by assent. The Chair acknowledged the serious rail incident that had occurred within the Central East footprint one week earlier, noting that more than 100 people had been conveyed to hospital following the incident and that local hospitals had responded admirably in managing the significant demand alongside normal operational pressures. The Chair further noted that a number of individuals remained in hospital and expressed condolences following the death of a member of the public. The Board observed a minute's silence in memory of those affected by the incident and in recognition of the ongoing impact on patients, families, staff and emergency responders.	
2.0	**Relevant Persons Disclosure of Interests** Members of the Board of the ICB were asked to confirm that the Register of Interests was up to date in respect of their declarations. Members were also asked to declare any gifts or hospitality that had been received**.** The Chair advised a change to their representation on Coalo Limited from Director to now being Chair of the Board. **No further declarations** were made.	

3.0	**Approval of Minutes** The Board Meeting held in-common in public with NHS Bedfordshire, Luton and Milton Keynes ICB, NHS Cambridgeshire & Peterborough ICB and NHS Hertfordshire and West Essex ICB held on 27 March 2026 were **approved** by the Board as an accurate record of the meeting. The minutes of the meeting held on 1 April 2026 were **approved** by the Board of Central East ICB as an accurate record of the meeting.	
4.0	**Questions from the Public** The Board received nine questions from members of the public. The questions and full answers can be found at Appendix A to these minutes and are also available on the ICB website here.	
5.0	**Chairs Report** *Presented by Robin Porter, Chair* The Chair provided a verbal update on key activities undertaken since the previous Board meeting and highlighted several matters of note: • Sarah Hughes, Non-Executive Member, had recently been awarded a CBE in recognition of her significant contribution to mental health services. The Chair congratulated Sarah on this achievement and acknowledged the positive reflection this brought to both Central East ICB and Mind. • The Chair also thanked Kate Vaughton for her contribution to the Board, noting that this was KVs final meeting before taking up a new role. The Board was advised that Maria Wogan, Director of Neighbourhood Health and Partnerships (BLMK), would join the Board to cover the Executive Director role going forward. • The Chair further expressed appreciation to Vineeta Manchanda for her service as Chair of the Audit Committee and for her contribution as a Board member. **Engagement and System Activity** The Chair reported a busy period of engagement across the Central East footprint and wider NHS system. Activities included visits to healthcare services, stakeholder meetings and participation in national and regional forums. Key activities included: • Visiting the Milton Keynes NHS 111 Service and Emergency Hub to gain insight into operational pressures and patient pathways. • Meeting with the Cambridgeshire Chief Constable to discuss prevention and cross-sector partnership working. • Participating in a Non-Executive Member Development Session to support ongoing Board development. • Visiting the Mental Health Urgent Care Centre at Lister Hospital. • Attending the NHS Confederation event and regional meetings across Hertfordshire, Cambridgeshire and Peterborough. • Supporting discussions regarding the expansion of a Family Drug and Alcohol Court model, building on the established approach in	

	Bedfordshire and Milton Keynes to help reduce the number of children entering care. • Attending Central East ICB staff orientation events as part of the organisation's transition programme. • Completing an Innovation in Healthcare programme at Imperial College. • Visiting Peterborough Hospital, including the Urgent and Emergency Care Department, and the Light Project, a homelessness charity operating in Peterborough. • Speaking at the Central Bedfordshire Healthwatch Conference. • Attending the groundbreaking ceremony for the Luton and Dunstable Community Diagnostic Centre, recognising its importance in improving access to diagnostics, prevention and early intervention services. • Participating in the East of England Chairs and Non-Executive Directors Forum. The Board **noted** the verbal update.	
6.0	**Chief Executives Report** *Presented by Jan Thomas, Chief Executive* JT presented an update on organisational performance, strategic priorities and the continuing development of Central East ICB. Key points highlighted were: • The ICB remained focused on both establishing the new organisation and addressing current performance and operational challenges. The first two months of the financial year had highlighted significant financial pressures, particularly in relation to increasing demand and service utilisation. Work was underway to identify, understand and mitigate these risks at an early stage. • Key areas of financial pressure include: ○ Growth in elective care activity and waiting lists. ○ Increased demand for neurodiversity assessment and support services. ○ Continuing Healthcare (CHC) demand and expenditure, including variation in the cost of care packages across the system. • The importance of directing resources towards interventions that deliver the greatest benefit for the population was emphasised and JT confirmed that the ICB was working with providers, clinicians and residents to identify sustainable solutions. **Strategic Priorities and Neighbourhood Health** JT updated on the development of neighbourhood-based models of care reporting that work had commenced on the first neighbourhood service specification, focused on frailty, and highlighted the importance of continuing to develop neighbourhood health services and multidisciplinary approaches to care. Key points highlighted: • The development of neighbourhood health centres would build on existing assets and facilities rather than relying solely on new infrastructure.	

- Consideration was being given to how existing buildings and services could be adapted to better support integrated neighbourhood working.
- Existing examples of effective multidisciplinary and integrated care across the footprint would form part of future delivery models.
- Neighbourhood teams would bring together partners across health, social care, voluntary sector organisations and community services to support residents with the most complex and vulnerable needs.

Mental Health and Learning Disability Services
The importance of maintaining focus on mental health and learning disability services alongside wider performance priorities was highlighted. It was noted that:

- There are currently 41 mental health patients placed out of area.
- There are 13 people with learning disabilities placed outside the area.

JT acknowledged the ongoing work being undertaken by providers to reduce out-of-area placements and emphasised the importance of developing local capacity and strengthening prevention and community support services.

Organisational Development and Workforce Transition
JT updated on the continuing transition of the three legacy ICBs into Central East ICB, noting that:

- Recruitment and workforce transition activity remains ongoing.
- Staff have continued to engage constructively throughout the process.
- Orientation events have commenced to support the induction of staff into the new organisation.
- Significant focus was being placed on embedding the principles of Our Way, organisational culture and the delivery of value-based care.

JT expressed her appreciation to staff for their continued professionalism, resilience and engagement throughout a challenging period of organisational change.

Community Pharmacy and Local Assets
The importance of community pharmacy and other primary care services as key neighbourhood assets was highlighted. The challenges facing community pharmacy providers were recognised and JT welcomed the contribution of pharmacy representation at Board level to help inform future service development.

Board Discussion

Neighbourhood Health, Population Health Management and the Voluntary, Community, Faith and Social Enterprise Sector
SA welcomed the focus on neighbourhood health and sought assurance regarding the role of the voluntary, community, faith and social enterprise (VCFSE) sector within future neighbourhood health models. Clarification was also sought regarding the application of the DELPHI population health management system and whether VCFSE organisations would be included. JT and KV emphasised that effective neighbourhood health models would require strong VCFSE sector involvement and confirmed that future service models

	would be based on collaborative partnership working and evidence of population need. It was also noted that DELPHI would support a better understanding of population needs, outcomes and service effectiveness through integrated system data, helping to inform future commissioning and resource allocation decisions. **Continuing Healthcare and Partnership Working** AR welcomed the focus on CHC and highlighted the importance of close partnership working between the NHS and local authorities to support vulnerable individuals and ensure seamless care across organisational boundaries. SGr acknowledged that CHC remained an area of sustained demand and financial pressure and confirmed that work was underway to understand variation in demand, care packages and expenditure across the inherited systems. It was further noted that opportunities for joint working with local authorities, including contractual arrangements and market management, were being explored to ensure individuals receive the right care at the right time in a financially sustainable manner. **Neurodiversity Services and Long-Term Transformation** DG sought assurance regarding the approach to managing demand within neurodiversity services whilst maintaining a focus on longer-term transformation. JT advised that the ICB was adopting a balanced approach, addressing current operational pressures while continuing to invest in longer-term solutions. The importance of partnership working, particularly through Special Educational Needs and Disabilities (SEND) programmes, was highlighted as a key enabler of sustainable improvements for children, young people and families. The Board **noted** the content of the report.	
7.0	**The Lampard Public Inquiry – Update** *Presented by Sarah Stanley, Executive Clinical Director of Total Quality Management* SS presented an update on the ICB's arrangements to support the Lampard Inquiry. Key points highlighted were: • The Lampard Inquiry is an independent investigation into the deaths of mental health inpatients receiving care from Essex Partnership University NHS Foundation Trust (EPUT) between 1 January 2000 and 31 December 2023. • The Inquiry has now moved into the evidence-gathering phase, including engagement with bereaved families, clinicians and other stakeholders. • SS advised that following the establishment of Central East ICB, governance arrangements had been updated to reflect the new organisational structure. Executive leadership responsibilities are shared across the affected ICBs, with Dr Matthew Sweeting, Executive Medical Director of NHS Essex ICB acting as SRO and SS and Lisa Nobes, Chief Nurse NHS Norfolk and Suffolk ICB, representing the other ICBs involved. It was noted that:	

	• Public hearings are scheduled to commence in July and continue into October.
	• The Inquiry is currently focusing on several emerging themes, including:
	  ○ Observation of patients in inpatient settings, including the use of cameras and monitoring technology.
	  ○ Resuscitation practices.
	  ○ Evidence from bereaved families.
	  ○ Core participant submissions.
	  ○ EPUT's engagement with, and compliance during, the Inquiry process.
	• Central East ICB has received three Rule 9 requests for information, evidence and witness statements and has responded within the required timescales.
	• The Inquiry may issue interim recommendations, particularly in relation to patient observation and resuscitation practices.
	
	SS confirmed that any recommendations relevant to the ICB would be reported to the Board and acted upon as appropriate.
	
	In concluding, SS expressed sympathy to the patients, families and loved ones affected by the issues being examined by the Inquiry. Also acknowledged, were the staff required to provide evidence, recognising the challenges and sensitivities associated with participating in the process. The ICB remained committed to supporting all those involved and to learning from the Inquiry's findings and recommendations.
	
	The Board **noted** the content of the report and arrangements for the continued support to the Lampard Inquiry undertakings.	

8.0	**Our Way: Priority Programme Stocktake** *Presented by Karen Barker, Executive Director of Corporate Services and ICB Development* KB introduced the first formal report from the newly established Delivery Unit, explaining that the purpose of the Delivery Unit was to provide oversight of the ICB's priority programmes and to enable the Board to monitor progress against strategic objectives. The report represented the first phase of this work and set out: • The Senior Responsible Officer (SRO) for each priority programme. • The aims and objectives of each programme. • Progress against the commissioning lifecycle. • Initial arrangements for resident involvement and co-production. Future reports would continue to develop and provide clearer information on programme delivery, outcomes and progress. **Cardiovascular Utilisation Management Programme** FH, SRO for the programme, provided an update on work focused on reducing avoidable utilisation of cardiovascular services through earlier intervention. Key points highlighted included:	

- Analysis of system data identified emergency admissions for heart failure as a key area of focus.
- The programme is exploring the factors driving emergency presentations and admissions for heart failure.
- Work is underway across system partners to identify opportunities for prevention and earlier intervention.
- The programme remains at an early stage of development (DP0) within the Our Way commissioning lifecycle.

Advanced Illness Programme
SS, SRO for the programme, presented an update on the Advanced Illness Programme. The programme built on work established in Bedfordshire and aims to improve care coordination for people with advanced illness, including those receiving palliative and end-of-life care. Key points highlighted included:

- The model had been developed collaboratively by hospices, community providers, acute services, clinicians and residents.
- A single point of access was available 24 hours a day, seven days a week, enabling residents to access advice, support and clinical interventions.
- Patients are supported to receive care in community settings wherever appropriate and avoid unnecessary hospital attendance.
- Clinical teams are working collaboratively through shared systems, documentation and care pathways.
- Early outcomes indicated a 17% reduction in emergency hospital attendances for the target population.
- Resident feedback had been highly positive.
- Future work will focus on expanding the model, with the ambition of developing a single coordination centre for Central East.

Board Discussion

Programme Governance, Assurance and Delivery
GR welcomed the report and the ambition of the programmes, requesting that future reports included greater detail regarding programme timelines and milestones, organisational capacity and capability requirements, partner contributions to delivery and assurance measures to support Board oversight. The Chair confirmed that programme updates would become a standing item on future Board agendas and that reporting arrangements would continue to mature as the programmes developed. SM welcomed the establishment of the Delivery Unit, and the transparency and accountability provided through the reporting process, recognising that the programmes remained at an early stage of development and supporting the continued refinement of reporting and programme assurance arrangements.

Resident, Patient and Community Engagement
SA sought assurance that resident involvement would be embedded across all priority programmes and requested clarification regarding future patient and resident voice arrangements in light of the proposed abolition of Healthwatch. NT welcomed the explicit focus on involvement and engagement, highlighting the importance of maintaining consistency across the Central East footprint whilst ensuring approaches remained responsive to local communities and neighbourhoods. In response, SS confirmed that resident and clinician

	involvement was fundamental to all priority programmes and that co-design principles would continue to underpin programme development. KB advised that the ICB was reviewing future approaches to engagement in light of national legislative changes and was developing a comprehensive engagement framework incorporating a range of methods, including patient forums, participation groups, surveys and co-production approaches. KV further advised that place-based engagement resources were being established and that future arrangements would seek to balance local flexibility with Board assurance regarding the consistent inclusion of patient and resident voices in programme design, delivery and evaluation. **Programme Delivery and Population Health Priorities** SA welcomed progress on the Advanced Illness Programme and sought clarification regarding implementation timescales. SS advised that work was underway with hospice partners to develop a model for wider rollout across the Central East footprint. AR highlighted the importance of ensuring that all-age, needs-led approaches reflected the differing requirements of specific groups, including children and families, particularly within the neurodiversity programme. FH confirmed that a core principle of the priority programmes was to align services more closely with the needs, expectations and experiences of residents through partnership working between clinicians, residents and wider system stakeholders, noting the particular importance of this approach in complex areas such as neurodiversity. **Mental Health and Strategic Alignment** KT welcomed the visibility the report provided regarding delivery of the Our Way strategy and highlighted the importance of the proposed Acute Care Pathway for Mental Health Programme (B5), emphasising the need to maintain a strong mental health and all-age perspective across all priority programmes. In response, KV advised that baseline work for the programme had commenced and that recruitment to key programme roles was underway. It was noted that the programme would need to align closely with neighbourhood health and other strategic programmes. The Chair welcomed the progress made in establishing the Delivery Unit and priority programme framework, noting the Board's shared ambition to improve outcomes for the 3.5 million residents served by Central East ICB. The Chair reiterated the Board's role in both supporting and constructively challenging the Executive Team as the programmes continued to develop. The Board: • **Noted** the development of the ICBs Priority Programme Aims and Priority Measures. • **Noted** the status of each on the Central East Commissioning Lifecycle.	
	Governance and Assurance	
9.1	**Audit and Risk Committee Chair's Report** *Presented by Vitor Ferreira, Non-Executive Member and Chair of the Audit and Risk Committee*	

	VF presented the Committee's update, noting that work had been undertaken following the establishment of Central East ICB to consolidate outstanding internal audit actions from the three legacy organisations and to prioritise those presenting the greatest risk. The Committee received assurance that overall control arrangements remained effective despite the challenges associated with ledger integration during the transition, with no resulting financial losses reported. The Committee noted: • Overall internal controls were assessed as effective. • Areas receiving lower assurance related to contract register completeness and CHC, both of which remained subject to management action and ongoing monitoring. VF advised that development of the Board Assurance Framework (BAF) and organisational risk appetite remained ongoing, with a revised framework expected to be presented to the Board in September. The appointment of Grant Thornton as external auditor was noted and arrangements for internal audit and counter fraud services were being finalised. Despite the significant challenges associated with organisational merger and financial system implementation, the Committee received assurance that: • A balanced financial position had been achieved. • Annual accounts had been submitted within required timescales. • Clean audit opinions had been received. On behalf of the Committee, VF expressed appreciation to staff, external audit partners and Vineeta Manchanda for their support and professionalism throughout the transition period. The Board **noted** the report of the meeting on 8 May 2026.	
9.2	**Finance Planning and Payer Function Committee Chair's Report** *Presented by Dorothy Gregson, Non-Executive Member and Chair of the Finance Planning and Payer Function Committee* DG presented the Committee update, noting the significant achievement of delivering balanced year-end financial positions across the three legacy ICBs despite a challenging operating environment and ongoing organisational transition. The Committee also considered progress in establishing governance arrangements for the new organisation, including: • Development of capital planning arrangements. • Oversight of commissioning and contract management approaches. • Establishment of a contract management and assurance subgroup. • Continued development of reporting and governance processes to support effective financial oversight. An update was also received on the ICB's priority programmes and the implications for future commissioning arrangements as the Our Way programme develops.	

	The Committee received assurance that governance and oversight arrangements continued to mature and there had been no loss of focus on critical organisational responsibilities during the transition period. DG noted that the Committee had made a positive start and was receiving increasing levels of information and assurance as governance arrangements became established. Appreciation was also expressed for the efforts of the Executive Team in maintaining focus on operational delivery and financial management alongside the organisational change programme. The Board **noted** the report of the Finance, Planning and Payer Function Committee meeting held on 15 May 2026.	
9.3	**Utilisation Management and Quality Improvement Committee Chair's Report** The Chair advised that Sarah Hughes, Chair of the Utilisation Management and Quality Improvement Committee, had submitted apologies for the meeting. As no additional comments were raised, the report was taken as read. The Board **noted** the report of the Utilisation Management and Quality Improvement Committee meeting held on 22 May 2026.	
9.4	**Bedfordshire, Luton and Milton Keynes Neighbourhood Health Delivery Committee Chair's Report** *Verbal update provided by Kate Vaughton, Executive Director for Neighbourhood Health, Place and Partnerships* KV provided a verbal update on behalf of the Bedfordshire, Luton and Milton Keynes (BLMK) Neighbourhood Health Delivery Committee. All Neighbourhood Health Delivery Committees across Central East had now completed their initial workshop phase and were operating in line with their agreed terms of reference. The Committee meeting held on 1 May 2026 focused on the development of neighbourhood health priorities for 2026/27. Members agreed the priority areas for delivery across the BLMK system, including confirmation of frailty as the first system-wide focus area, aligned to the wider Our Way priority programme. The Committee also reviewed arrangements for testing, codifying and scaling neighbourhood health models across BLMK. Partners agreed to promote and embed the quality improvement approach within their respective organisations to support delivery. In addition, the Committee considered and approved a number of national submissions, including: • Better Care Fund plans. • Neighbourhood Health Centre proposals. • Primary Care Action Plans. The Committee received assurance regarding the use of Better Care Fund resources and noted how funding is being utilised to support:	

	• Neighbourhood-based models of care. • Home First approaches. • Intermediate care services. • Greater integration of services within local communities. The Board **noted** the verbal update from the BLMK Committee meeting held on the 1 May 2026.	
9.5	**Cambridgeshire and Peterborough Neighbourhood Health Delivery Committee Chair's Report** *Verbal update provided by Dorothy Gregson, Non-Executive Member and Chair of Cambridgeshire and Peterborough NHDC and Kate Vaughton, Executive Director for Neighbourhood Health, Place and Partnerships* DG provided a verbal update on behalf of the Cambridgeshire and Peterborough Neighbourhood Health Delivery Committee, summarising discussions from meetings held on 28 May and 4 June 2026. It was reported that the Committee had now moved beyond its initial development phase and was focused on progressing delivery against its agreed priorities. Members approved the Committee's Terms of Reference and membership arrangements, and DG was appointed Chair to provide a direct link between the Committee and the Central East ICB Board. The Committee also approved a Cultural Charter, underpinned by principles of population health, equality and collaboration, to support integrated working and shared accountability across partner organisations. The Committee: • Received and approved the Better Care Fund submission. • Reviewed arrangements for primary care assurance and oversight. • Considered the development of enhanced data and performance reporting to strengthen assurance regarding primary care services. • Received updates from the North and South Place partnerships and gained assurance that place-based leadership and collaborative working arrangements continue to mature. • Supported the extension of a specialist dental contract. Members also discussed the importance of the forthcoming implementation of the DELPHI population health management system, recognising its potential to support evidence-based decision-making, system-wide analysis and the evaluation of change at scale. It was advised that a development session is scheduled for 7 July 2026, which will focus on the use of DELPHI and its application to neighbourhood health and population-based decision-making. The Committee noted new governance arrangements within the North Place area, linked to North West Anglia, which are expected to support the development of future commissioning arrangements. The Committee received the emerging People and Community Strategy and discussed arrangements to strengthen public involvement and resident engagement in neighbourhood health planning. Members considered how the	

	ICB's developing insight and engagement functions could support neighbourhood-level decision-making and ensure community perspectives inform service development. Members also identified children and young people and mental health as key themes requiring further exploration, with future work planned to consider how neighbourhood health arrangements can support delivery in these areas. The Board **noted** the verbal update from the C&P NHDC held on 28 May and 4 June 2026.	
9.6	**Hertfordshire Neighbourhood Health Delivery Committee Chair's Report** *Verbal update provided by Kate Vaughton, Executive Director for Neighbourhood Health, Place and Partnerships and Gurch Randhawa, Non-Executive Member and Chair of Hertfordshire NHDC* GR and KV provided a verbal update on the development of the Hertfordshire Neighbourhood Health Delivery Committee. GR reported that a series of development discussions had taken place with key system partners, including the Hertfordshire Health and Wellbeing Board, voluntary, community, faith and social enterprise (VCFSE) sector representatives, healthcare partnerships and local system leaders. These discussions had focused on ensuring that the new neighbourhood arrangements complement existing structures and add value rather than duplicate activity. The Committee had also undertaken a development session with members ahead of its first formal meeting, which is scheduled for July. The Committee focused on: • Establishing relationships with existing partnership structures across Hertfordshire. • Ensuring alignment between neighbourhood health arrangements and wider system governance. • Benchmarking against national neighbourhood health guidance and development frameworks. • Considering how to deliver neighbourhood health consistently and equitably across the county. • Ensuring residents, partners and communities are fully involved in the development of neighbourhood approaches. KV advised that work had also been undertaken to align local governance and reporting arrangements with those being developed across the wider Central East footprint. The Committee had: • Confirmed frailty as a priority area for neighbourhood health development, aligned to the wider Central East priority programme. • Agreed a continued focus on prevention and reducing health inequalities. • Begun considering how existing data and intelligence can be brought together to support neighbourhood delivery and assurance. • Explored how neighbourhood-level reporting and oversight will align with the wider governance arrangements operating through the Hertfordshire	

	Health and Wellbeing Board and existing healthcare partnership structures. Members highlighted the relative maturity of existing partnership arrangements within Hertfordshire and noted the opportunity to build upon these established foundations as neighbourhood health models continue to develop. The Committee was encouraged by the positive engagement from partners and by the progress made in establishing governance arrangements, priorities and system alignment ahead of commencing formal business. The Board **noted** the verbal update.	
9.7	**ICB Governance Report** *Presented by Karen Barker, Executive Director of Corporate Services and ICB Development* KB presented an update on governance matters requiring Board approval and noting. **Joint Transition Committee** KB advised that the Joint Transition Committee had fulfilled its purpose of overseeing the closure of the three legacy ICBs, Bedfordshire, Luton and Milton Keynes ICB, Cambridgeshire and Peterborough ICB, and Hertfordshire and West Essex ICB, and supporting the establishment of Central East ICB on 1 April 2026. It was noted that while work to fully embed the new organisation continues, the specific transition programme has now concluded. The Joint Transition Committee therefore recommended that it be formally stood down, with any remaining actions and ongoing work transferred into the ICB's established governance structure and committee framework. DG sought assurance that risks associated with workforce transition and organisational change would continue to receive appropriate oversight. KB confirmed that all outstanding actions had been allocated to the relevant committees and that the Remuneration and Workforce Committee would assume responsibility for the majority of workforce and organisational change matters. **Governance Arrangements** An amendment to the Scheme of Reservation and Delegation that had previously been approved through virtual Board decision was noted. KB also advised that, following the appointment of Rachel Solanki as the Board's final Primary Medical Services Partner Member, the Governance Handbook required updating to reflect the appointment and associated term of office. **Legacy ICB Annual Accounts** It was noted that the Audit and Risk Committee and an Extra-ordinary Board meeting had been held on 16 June 2026 to consider and approve the final annual reports and accounts for the three legacy ICBs.	

	Members were advised that: • The legacy accounts and annual reports had been approved for submission to NHS England. • Formal publication of these documents would take place at the ICB's Annual General Meeting in September 2026. The Board: **Approved:** • The recommendation from the Joint Transition Committee, that the Committee be stood down with any areas relating to the transition now being picked up through ICB governance. • Amendments to the Governance Handbook following the appointment of the Primary Medical Services Partner Member. **Noted:** • The virtual approval granted by the Board on 15 May 2026 for amendments to the Scheme of Reservation and Delegation with the Governance Handbook to be amended and published. • The Audit and Risk Committee met followed by an Extra-ordinary Board on 16 June 2026 to receive the legacy ICB accounts and final annual report. Reports were approved for submission to NHS England at the Extra-ordinary Board.	
10.0	**Any Other Business** The Chair invited items of any other business with no further business raised. *The meeting finished at 13:35*	
Details of Next Meeting: Friday 25 September 2026, venue TBC		

Approval of Draft Minutes by Chair only:		
Name	**Role**	**Date**
Robin Porter	Chair	10 July 2026

Public Questions

The following questions have been raised by Justin Jewitt on behalf of the East North Herts Patient Participation Group

Response read out by Dr Fiona Head, Executive Clinical Director Utilisation Management

1. **Given the increasing importance of digital access, could the ICB explore providing simple, patient-friendly online video guides that help people complete GP surgery digital access forms? This could be a straightforward way to improve confidence, reduce barriers, and support wider adoption of digital services, particularly for those less familiar with online system?**

   Thank you for this suggestion. There are already a number of NHS-produced videos available to help people access digital services, including using the NHS App to manage appointments, prescriptions and health information. NHS England has produced versions with British Sign Language (BSL) support online: Help with using the NHS App - YouTube. There is also the You and Your General Practice website – patients should contact their practice in a way that suits them and if they need help to use online systems the practice team should support this. NHS England » You and your general practice – English

2. **Would members of the Board be interested in seeing the Patient Engagement Platform website, (www.thepatientengagementplatform.org.uk) funded by Paul Campion, which is building a growing library of trusted NHS health information, analysis and healthy living advice drawn together from NHS sources and local Patient Participation Group activities? It seems a valuable example of how we can make reliable health information more accessible and engaging for patients and communities.**

   Thank you for sharing this resource. We will ensure that the relevant teams are made aware of the website.

3. **Given the importance of patient choice and reducing waiting times, what steps will the ICB take to develop and maintain a transparent, regularly updated patient-facing website showing waiting list sizes, average waiting times, and treatment capacity for each hospital in the system, and what barriers currently prevent this information from being made publicly available?**

Providing patients with clear information about waiting times is important. Nationally, the NHS already provides information through the My Planned Care website, which allows patients to view waiting time information for hospitals and compare waiting times for different providers. The site is updated regularly and is available to anyone.: Home - My Planned Care NHS

As a recently established organisation, we continue to develop our website and will keep under review how best to signpost patients to relevant information. At present, we believe it is preferable to direct people to established national sources rather than duplicate information that is already publicly available and updated regularly.

4. **Recognising the significant efforts already made to improve patient experience, could the Board provide an update on what is being done to strengthen communication between hospitals and patients — particularly around appointment notifications, cancellations, and rebooking? Specifically, what assurance can the Board give that a reliable, consistent system is in place (or being developed) so that no patient is left without clear, timely information when their appointment changes?**

   Communication about appointments is primarily the responsibility of the NHS organisation providing a patient's care. The ICB receives information about patient experience and service performance as part of its oversight of commissioned services.

   Patients who experience issues relating to appointment notifications, cancellations or rebooking should raise these directly with the provider responsible for their care so that the matter can be investigated and addressed.

5. **Last minute cancellation of elective surgery seems to be a problem reported by many patients, often no reason for the cancellation is given and rarely is a new date confirmed at the same time - is the ICB aware of the scale of this problem and can/would they consider any public monitoring of the problem?**

   We recognise that the cancellation of planned procedures can be distressing patients.

   Individual NHS providers are responsible for managing their services and communicating directly with patients ng to forward to seeing what you do cancellations and rebooking arrangements. The ICB receives information on quality, performance and patient experience as part of its oversight of commissioned services.

Patients who experience problems with their care should, in the first instance, raise these directly with the provider concerned through its Patient Advice and Liaison Service (PALS) or complaints process. This helps ensure that individual issues can be investigated and addressed appropriately.

6. **Are there going to be any public reporting on league tables for GP surgeries on number of appointments per GP, mortality rates, DNA rates, vaccination rates, LD annual health-checks, Cancer screening attendance rates, Medication review rates and AAA screening rates?**

   Some information about GP practices is already published through national NHS reporting systems.

   The ICB uses a range of information to support the planning, commissioning and improvement of primary care services. At present, there are no plans to publish local league tables covering the measures listed.

Question raised by Justin Jewitt

Response read out by Karen Barker, Executive Director of Corporate Services and ICB Development

Is there an 'anchor' point clearly identified for any of the risks that shows where the risk is at the start of its journey? How can progress of mitigating actions be accurately measured if you don't have the starting measurement of the risk?

The ICB is currently working through its Board Assurance Framework which will highlight the key risks for the organisation. As part of this document there will be a starting measurement for each risk on this framework. This Board Assurance Framework will be presented to the Board held in public in September.

Question raised by Robin Pike

How does the Board intend to commission services such as Urgent Care, Patient Transport and the Out of Hours GP Provision?

Response read out by Kate Vaughton, Executive Director of Neighbourhood Health and Partnerships

The Board intends to commission Urgent Care, Patient Transport and Out of Hours GP services as part of an integrated urgent and emergency care system, rather than as standalone services. Guided by our strategic commissioning approach, we will focus on improving outcomes, reducing fragmentation, supporting neighbourhood health teams and delivering value for money.

We expect services to work seamlessly across primary care, community services, NHS 111, ambulance services and urgent community response teams, helping patients access the right care in the right setting and reducing avoidable hospital admissions.

For Patient Transport, our focus is on equitable access, efficient patient flow and coordinated care, with commissioning decisions informed by population need, service performance and value for money.

Question raised by Helen Ruggles

Who is responsible for implementing Oliver McGowan training and what patient engagement are you doing to check? Do you regard this as a patient safety issue?

Response read out by Sarah Stanley, Executive Clinical Director Total Quality Management

We recognise that safety links to how effectively we listen to residents and patients. Every CQC-registered provider has responsibility for ensuring appropriate provision.

Across Central East, delivery currently varies. Some areas have centrally commissioned models covering all providers, while others use different arrangements across health and social care.

We are in year two of a three-year programme to ensure staff are trained to the appropriate level, although national guidance on refresher training is still awaited. Progress also varies across systems, and current figures are cumulative rather than a precise reflection of the workforce at any one time.

Assurance is provided through CQC processes and through regular reporting of training data to NHS England. Going forward, we are working towards a more consistent, provider-led approach to strengthen delivery and support longer-term sustainability.

NHS
Central East
Integrated Care Board

Report to the:	Board of the NHS Central East ICB in Public
Date of meeting:	25 September 2026
Item 9:	Our Way Priority Programmes: Delivery Progress
Executive leads:	Sarah Stanley, Deputy Chief Executive; and Karen Barker, Executive Director Corporate Services and ICB Development
Report authors:	Gary Hardy, Head of Delivery Unit Danielle Bond, Delivery Unit Lead Priority Programme Leads
Reason for the report to the Board	Oversight of progress across the ICBs highest priority programmes is required as defined in Our Way strategy
Recommendation/s:	The Board is asked to **note** the update on each of the nine programmes, as presented in Annex A.

1.0 Executive Summary - The report sets out:

- Whether the programme is at the "improve, codify, or scale" stage of maturity;
- For the five "starter programmes" – B1 to B5 – the Delivery Assessment Rating for each. This assessment, developed by the ICB's Delivery Unit, has been established to provide a more consistent way of assessing progress across programmes;
- The 'measurable aim' each programme has established, and, wherever possible, the baseline data relevant to it;
- The expected impact of the programme on the ICB's commissioning intentions;
- The current (Q2) 'lifecycle stage' of each programme, as per the Our Way strategy, alongside the Q1 position, and when the move to the next stage is predicted; and,
- The actions each programme is pursuing, over what timescale, and when we expect to understand the impact of these.

2.0 Key Implications -

2.1 Financial implications - No direct financial implications, though noting all Priority Programmes are rooted in reducing the utilisation of healthcare and improving health outcomes, with consequent financial impacts.

2.2 Equality and/or health inequalities implications - These are reflected in the focus of the individual programmes themselves, based on the latest population health data.

2.3 Engagement – Our ambition is for residents to be equal partners in the development and delivery of these priority programmes. The specifics for each programme are covered in Annex A, or can separately be reported verbally to the ICB Board.

2.4 Green Plan commitments – None

3.0 Report - Presented in **Annex A** is a summary of progress across the Central East's 9 Priority Programmes.

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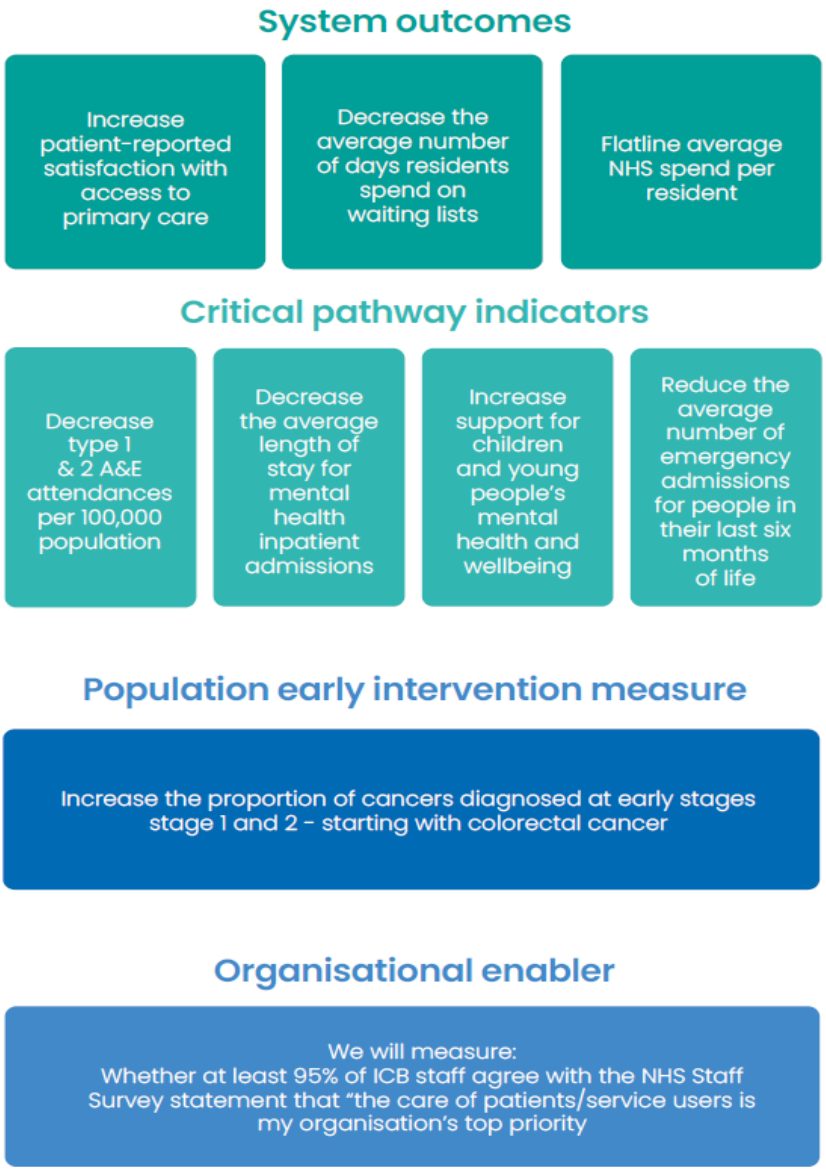
3.1 Key context and data - Baseline and performance data have been included wherever available. Future reports will focus on how this data changes over time, using Statistical Process Control (SPC) charts where appropriate, to give the clearest possible picture of variation and impact for each programme. Attached at **Annex B** is the latest data on the headline metrics presented in the Our Way strategy.



4.0 Next steps – We will respond to the Board's feedback on this report ahead of the next iteration of the Priority Programme update for the ICB Board in December. This will also reflect the feedback from the UMQIC Committee which met in September. The Committee were keen to see more detail on the evidence-based rationale for the specific Programme Aims, and further assurance on how achieving programme aims will always translate into better health outcomes for residents.

List of appendices

- **Appendix A – Our Way Priority Programmes Delivery Progress – September 2026;**
- **Appendix B – Our Way Priority Measures – Latest Data – September 2026**

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Appendix A

NHS
Central East
Integrated Care Board

Our Way Priority Programmes For ICB Board

September 2026

Based on stocktakes conducted in August 2026

Portfolio Delivery Snapshot

ID	Programme Name	Q1 June 2026 Lifecyle Stage	Q2 September 2026 Lifecycle Stage	Maturity Stage (Improve/Codify/Scale)	Projected Date to Next Lifecycle Stage	Delivery Assessment
B1	Prevention & Screening for Cancer	A Identify & Improve	A Identify & Improve	Improve	December 2026	Substantial
B2	Self Care for MSK	B PDSA to Product	B PDSA to Product	Codify	September 2026	High
B3	Utilisation Risk Management in Cardiology	A Identify & Improve	A Identify & Improve	Improve	January 2027	Substantial
B4	Care Coordination for Advanced Illness	B PDSA to Product	B PDSA to Product	Codify	December 2026	Substantial
B5	Acute Care Pathway for Mental Health	A Identify & Improve	A Identify & Improve	Improve	March 2027	Limited
C1	Dermatology	C Business & investment Decision	D Commission & Mobilise	Scale	September 2026	
C2	Diabetes	A Identify & Improve	A Identify & Improve	Improve	December 2026	
C3	Neurodiversity	A Identify & Improve	B PDSA to Product	Codify		
C4	Neighbourhood Health Teams	B PDSA to Product	B PDSA to Product	Codify	September 2026	

ID	Programme Name	Overall Assessment	Domain 1 (Ownership & Oversight) Assessment	Domain 2 (Outcomes & Strategic Clarity) Assessment	Domain 3 (Delivery & Improvement Execution) Assessment	Domain 4 (Evidence, Sustainability & Scale) Assessment
B1	Prevention & Screening for Cancer	Substantial	High	High	Substantial	Moderate
B2	Self Care for MSK	High	High	Substantial	High	Substantial
B3	Utilisation Risk Management in Cardiology	Substantial	Substantial	High	High	Moderate
B4	Care Coordination for Advanced Illness	Substantial	High	Substantial	High	Moderate
B5	Acute Care Pathway for Mental Health	Limited	Limited	Limited	Moderate	Limited

Delivery Assessments will be completed during Q3 for the ‘C’ programmes.

Please refer to Page 28 for more information on the Delivery Unit Assessment Framework and Methodology

Strategic commissioning plan & statutory requirements

A	B	C	D	E	F
Identify & improve	**PDSA to product**	**Business & investment decision**	**Commission and mobilise**	**Assure, learn and optimise**	**Evolve or sunset**
Demonstrate the real problem can be improved in a real setting	Demonstrate the real problem can be improved in a real setting	Decide whether to invest at scale	Move from approval to controlled safe spread	Ensure the service continues to deliver value and adapt	Avoid service inertia make intentional decisions to adapt or stop
Improvement methodology	Demonstrate the real problem can be improved in a real setting	NHS business case discipline	Commissioning for quality and outcomes	Improvement and performance assurance	Strategic value and opportunity cost
Residents and partners with commissioner sponsorship	Demonstrate the real problem can be improved in a real setting	Commissioner	Commissioner with providers	Commissioner with provider	Commissioner
1. Clear problem statement and target population 2. Improvement aim and measures 3. Evidence of PDSA cycles in life settings 4. Early signal of benefit	1. Defined service model 2. Clear description of the solution 3. Workforce digital estates and dependency assumptions 4. Early cost envelope and capacity assumptions	1. Strategic case 2. Economic case 3. Financial case commercial and governance assumptions 4. Benefits realisation plan with measures	1. Commissioning route agreed 2. Mobilisation plan with milestones 3. Clear quality outcome and reporting requirements 4. Ongoing improvement expectations embedded in contract	1. Commissioning route agreed 2. Continuous improvement capability maintained 3. Active benefit tracking against the business case 4. Periodic strategic review (every two years)	1. Predefined review triggers 2. Options appraisal: evolve, replace, or stop 3. Managed transition plan 4. Learning captured for future services
DP0 Is it in the commissioning plan or statutory requirement?	**DP1** Is there enough evidence of benefit to justify investing and scaling this design?	**DP2** Is this service sufficiently defined and stable to justify a business case?	**DP3** Should this be commissioned as a standard offer?	**DP4** Is this service delivering at the expected scale?	**DP5** Is this still the right service in the right form?	**DP6** Do we recommission, redesign, or retire?

Programme Summary, Aim & Baseline

B1 | Prevention & Screening for Cancer

Measurable Aim

By March 2027, reduce colorectal cancers diagnosed at stages 3–4 from 40% to 35%, and increase stages 1–2 from 43% to 48%.

Commitment made in Our Way

Identify & Treat Colorectal Cancer Earlier. To improve bowel cancer outcomes and reduce variation (inequalities).

Overall Delivery Assessment

Substantial

Domain 1: Ownership & Oversight	Domain 2: Outcomes & Strategic Clarity	Domain 3: Delivery & Improvement Execution	Domain 4: Evidence, Sustainability & Scale
High	High	Substantial	Moderate

Commissioning Intentions

Commission or embed targeted screening support, GP education, FIT/4Fs adoption, data-quality improvement and inequalities outreach.

Baseline Data

Diagnosis Age, Stage & Referral Route

- On average approximately 1,050 people are diagnosed within BLMK and Hertfordshire each year.
- 521 of these are within the screening age group.
- Of those in the screening age group 382 were identified by routes other than screening.
- When identified by screening 64.2% were identified at stage 1&2.
- This falls to 46.2% for those identified via other routes.
- This differs between areas with 41% in BLMK and 50% in Herts

Screening age group

3 Year Average by Age Group

Age Groups	Early		Late		Total
	#	%	#	%	
Under 50 Years	52	44%	67	56%	119
50–74 Years	264	51%	258	49%	521
75+ Years	207	50%	206	50%	413
Total	523	50%	530	50%	1,053

Screening

- Central East achieves a higher rate of screening coverage than England, however there are still approx. **130,000** people aged between 50 and 74 that have not accessed screening.
- There is significant variation between practices. 116/265 do not achieve the England standard for screening this equates to **58,000** people within these practices.
- 20 practices (7.5% of practices) in the ICB achieve lower than 60% coverage, this equates to **9,500** people within these practices.
- The practices with the lowest rates of screening are in Bedford, Peterborough and Luton.

Sub ICB	Screened	Not Screened	% not screened
BLMK	107,760	43,475	28.7%
C&P	108,405	37,604	29.8%
Herts	142,780	47,963	22.8%
Grand Total	358,945	129,042	26.4%

Coverage	Number of Practices	% of Practices
Under 60%	20	7.5%
60%–70%	62	23.4%
70%–80%	151	57.0%
>80%	32	12.1%

Screening characteristics

- People of a non-white British ethnicity are less likely to be screened vs people who are recorded as white British.
- Due to the screening programme, age is a big driver in screening uptake with people aged under 60 much less likely to be screened.
- The Herts data does not show a large impact of IMD on screening, but note we are looking at Hertfordshire data where the sample size for more deprived areas is much smaller. National data suggests a link with deprivation and uptake.
- LD/Autism has slightly lower screening rate compared to no LD/Autism, although it is only a **3%** difference.
- Social Vulnerability sees high screening rates **(98%)** than those who are not socially vulnerable. They have comparable screening rates to people aged 70–79.

Programme Delivery and Change Ideas

B1 | Prevention & Screening for Cancer

Current Lifecycle Stage

A Identify & Improve

Improve / Codify / Scale

Improve

Measurable Aim

By March 2027, reduce colorectal cancers diagnosed at stages 3–4 from 40% to 30%, and increase stages 1–2 from 43% to 48%.

Our Way Strategic Measures

Increase the proportion of cancers diagnosed at early stages, starting with colorectal cancer.

Bowel Cancer Survival Rates at five years:
- 10% for stage 4 – 1 in 10
- 90% for stage 1 – 9 in 10

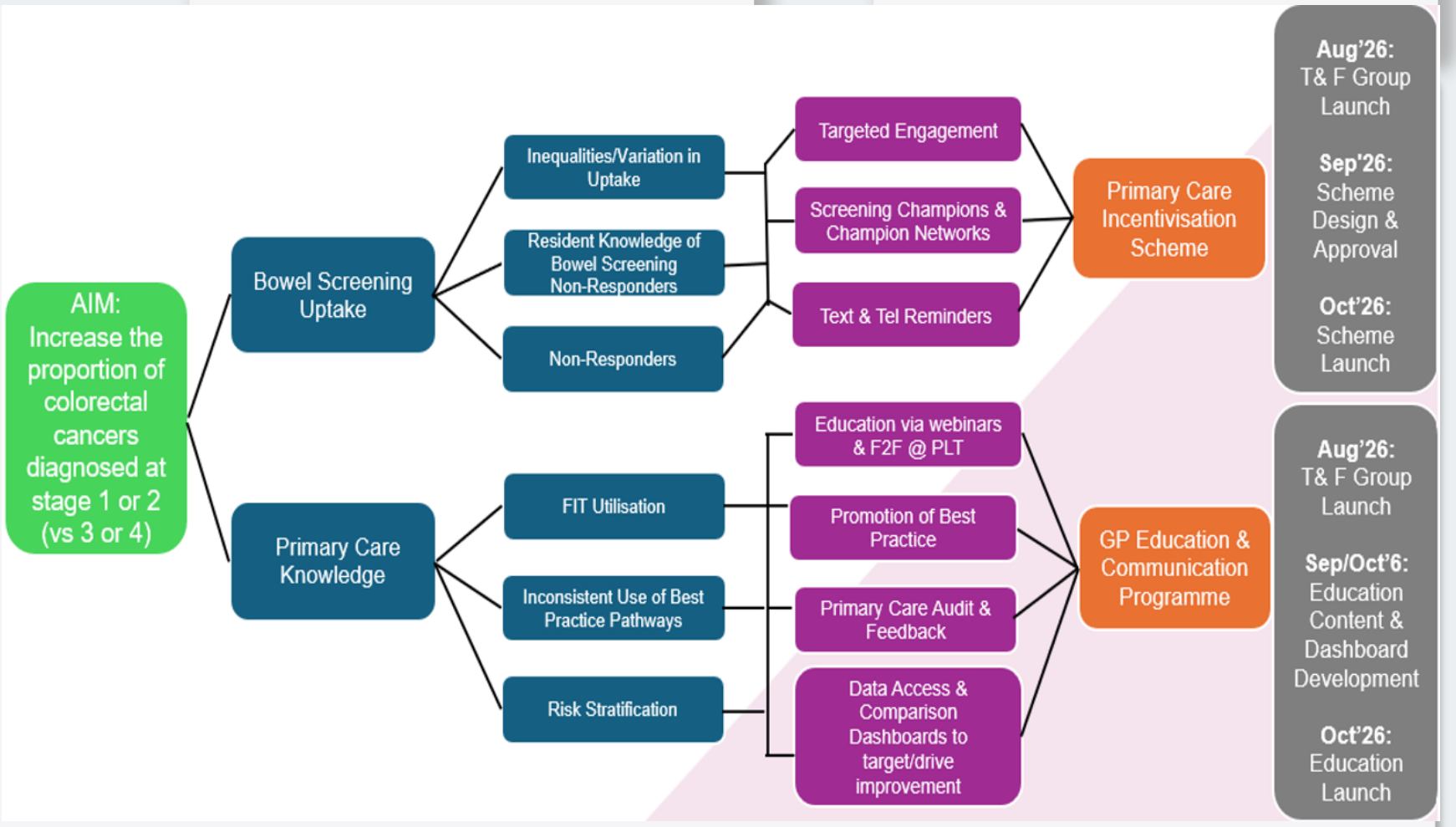
Latest data informs us that for colorectal cancers:
- 43.0% diagnosed at stage 1 & 2
- 40.3% diagnosed at stage 3 & 4

Early diagnosis improves outcomes and reduces costs:
- Treating colorectal cancer at an early stage costs 27% less than treating late-stage disease.£7,890 saving per patient diagnosed earlier.

Significant inequalities exist in bowel screening uptake, ranging from 75% in Central Bedfordshire to 61% in Luton.

Bowel Screening Coverage Rates:
- Hertfordshire and West Essex (HWE)
  - 76.2% (71,340 people screened).
- Cambridgeshire and Peterborough (C&P)
  - 74.1% coverage (108,510 people screened).
- Bedfordshire, Luton and Milton Keynes (BLMK)
  - 71.2% coverage (107,765 people screened).

Across England, bowel screening coverage ranges from 59.7% (lowest) to 79.9% (highest), demonstrating variation in uptake nationally.



Programme Delivery and Change Ideas

B1 | Prevention & Screening for Cancer

Next steps	Geography	Key Measures Note – outcome and wider measures under development	Priority Actions	By when	Movement to next phase
Task & Finish Group 1 **Primary Care General Practice Incentivisation Scheme:** Improving Bowel Cancer Screening Uptake Through Incentivised Targeted GP Action	Central East Wide	• Increased no's of patient undertaking bowel screening. • Increase in individual GP Practice bowel screening uptake performance.	• Launch an ICB wide Improving Bowel Screening Uptake GP incentivisation scheme • Proactively engage low-uptake practices, cohorts and underserved groups through recalls, reminders, calls and texts. • Monitor uptake, evaluate outcomes, share learning, and implement improvements to drive sustained uptake.	• Oct-26 • Oct-26 • Mar-27	Moving from A to B to C Mar-27
Task & Finish Group 2 **GP Education and Communication (PRIMARY CARE HUB SUPPORTED):** Building Capability Through Learning, Audit, Feedback and Data-Driven Improvement	Central East Wide	In development	• Primary Care Education and Awareness: Deliver PLT sessions and webinars to promote best practice, early diagnosis, and targeted approaches to address inequalities. • Performance Feedback and Data-Driven Improvement: Provide regular practice and PCN feedback, supported by dashboards and benchmarking data, to monitor uptake, referral activity, identify improvement opportunities, and target support where needed.	• Oct-26 – Jan-27 • Monthly post Oct-27	Moving from A to B to C Mar-27
FOCUS GROUP **Communications and Engagement:** Using Patient Insight and Community Partnerships to Improve Screening Uptake	Central East Wide – some local variation expected for targeted initiatives	In development	• Embed patient feedback and NCPES learning to identify and implement targeted improvement opportunities through partnership working. • Deliver targeted awareness campaigns, co-produced with patients and carers, to improve engagement and participation.	• ICB Partners engaged, workup in development. Aiming for Nov-26 awareness campaign launch.	Moving from A to B to C Mar-27
Focused wider actions planned /underway in Primary and Secondary Care Referral Pathways: Data-Driven Improvement, Enhanced Diagnostic Capacity and Optimised Referral Quality	Central East Wide	• All Acute Providers in Central East participating in FIT@80 • CE ICB GP Practices meeting the 80% standard for FiT Utilisation in primary care • All Acute Providers compliant with Nottingham 4F's • All Acute Providers meeting the 80% staging data completeness standard.	• FIT@80 National Programme Implementation • FIT Utilisation in Primary Care (80%+) • ColoFIT Implementation • Nottingham 4Fs Adoption • Improving staging data completeness (80%)	• Underway • Underway • Regionally driven likely launch Q3 26/27 • Underway • Underway	Limited if any ICB business/investment decision required. Moving from A to B Mar-27

Programme Summary, Aim & Baseline

B2 | Self Care for MSK

Measurable Aim

100% resident access to a digital self-care pathway for lower back pain by March 2027, reducing waits for treatment.

Commitment made in Our Way

Improve Self Care for Lower Back Pain. Broad aim is to reduce the time residents are waiting to access MSK treatment.

Overall Delivery Assessment

High

Domain 1: Ownership & Oversight	Domain 2: Outcomes & Strategic Clarity	Domain 3: Delivery & Improvement Execution	Domain 4: Evidence, Sustainability & Scale
High	Substantial	High	Substantial

Commissioning Intentions

Commission an integrated digital self-care pathway for lower back pain where unavailable. Future 2027/28 intentions will depend on utilisation, patient experience, equity, outcomes and cost evidence.

Baseline Data

PLACE	PROVIDER	REFERRAL DATA for lower back pain 25/26 (of total MSK service referrals)	WAITING TIMES for lower back	Comments
BLMK	Cora Health (from Oct 2026)	Lower back data requested	Establishing	- 3 incumbent Providers identifying wait list transfers to new Provider. New Provider will report across a range of MSK conditions
C&P	EEC	11%	Digital pathway Flok – 0 week waits	- Increase of referrals to Service seen last 2 years (2%) - All referrals:101,000 patients in 25/26 - Formal evaluation of outcomes will be available Jan 2027 (ICB SVU and EEC)
			Overall Service pathway - average 15 weeks wait (June 26)	
HERTS	HCT	21%	10% all patients waiting over 18 weeks (June 26)	- Increase of referrals to Service seen last 2 years (6%) - All referrals: 41,000 patients in 25/26
	Circle	21.3%	0% all patients waiting over 18 weeks (June 26)	- Increase of referrals to Service seen last 2 years (6%) - All referrals: 43,000 patients in 25/26 - ICB waitlist investment in 25/26

Our key steps to improvement

August 2026

Programme board to review data and confirm baseline metrics by 31/08/2026, identifying available and outstanding data and establishing reporting for improvement and assurance.

October 2026

BLMK go-live and Hertfordshire mobilisation by 31/10/2026, subject to approvals, contracts and technical readiness, testing expansion beyond the current C&P evidence base.

January 2027

C&P formal evaluation by 31/01/2027 will assess impacts and outcomes, informing wider commissioning and scaling decisions.

Programme Delivery and Change Ideas

B2 | Self Care for MSK

Current Lifecycle Stage

B PDSA to Product

Improve / Codify / Scale

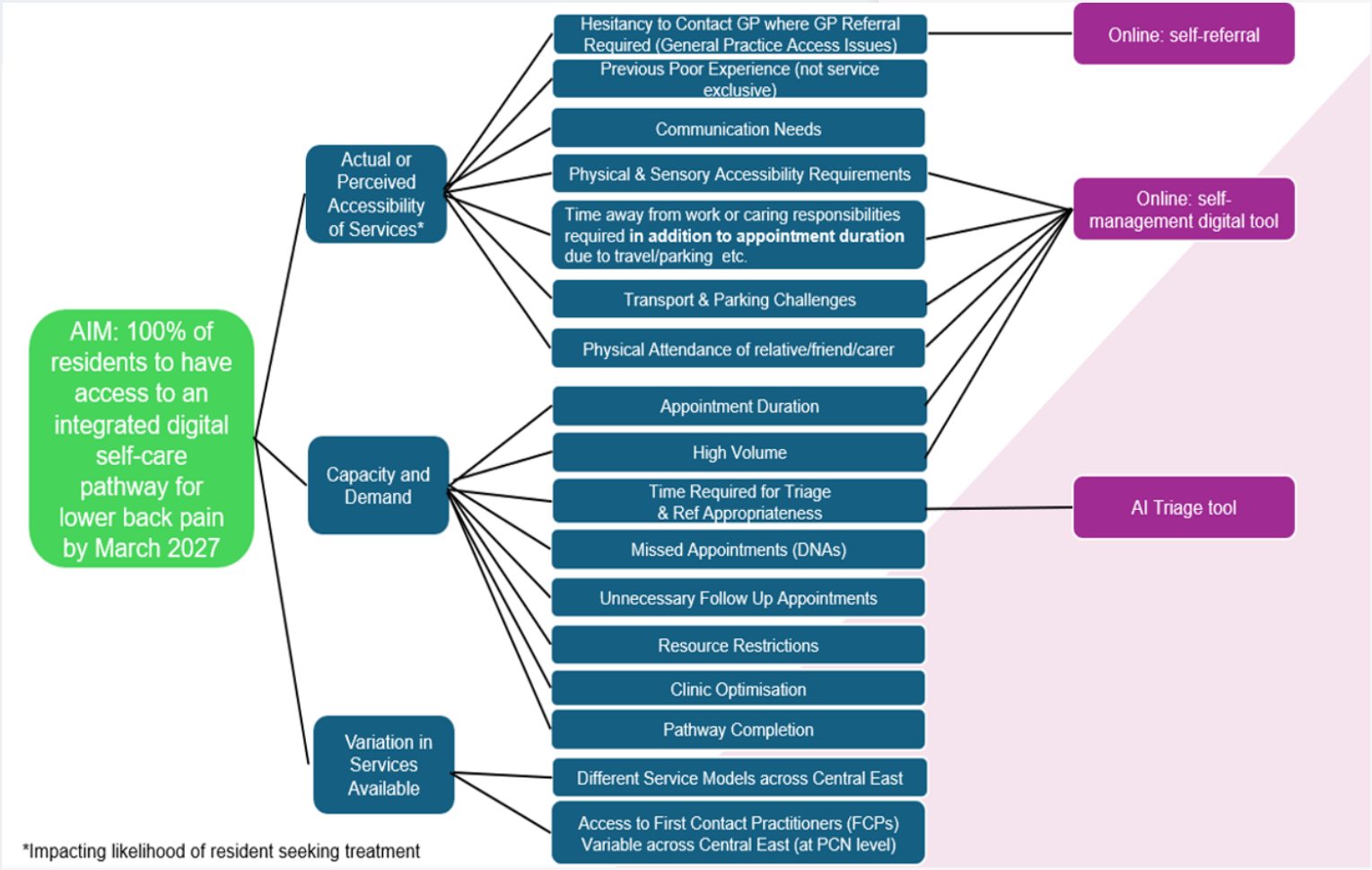
Codify

Measurable Aim

100% resident access to a digital self-care pathway for lower back pain by March 2027, reducing waits for treatment.

Our Way Strategic Measures

Primary measure: reduce average waiting-list days



Programme Delivery and Change Ideas

B2 | Self Care for MSK

Current Lifecycle Stage

B PDSA to Product

Improve / Codify / Scale

Codify

Measurable Aim

100% resident access to a digital self-care pathway for lower back pain by March 2027, reducing waits for treatment.

Our Way Strategic Measures

Primary measure: reduce average waiting-list days

MSK – LOWER BACK PAIN

Data & evidence snapshot | baseline and early implementation position

SPC not yet available

1 Starting position

The programme is establishing its baseline and expanding AI-enabled digital self-management across MSK services, initially focused on lower back pain.

100%	0 weeks	15 weeks
expected CE ICB population coverage	digital lower-back pathway wait	average overall MSK pathway wait
by Q4 2026/27	C&P / EEC (Flok)	C&P / June 2026

2 Current provider position

BLMK	Cora Health / Phio	Baseline establishing	New provider from Oct 2026
C&P	EEC / Flok	0-week digital wait	101k referrals in 2025/26
Herts	HCT / Phio (tbc)	10% >18 weeks	Build & mobilise Q3–Q4
Herts	Circle / Phio	0% >18 weeks	Mobilise Q3

Lower-back-specific referral data is still being requested in BLMK and Herts.

3 Evidence from existing pilot

EEC 12-week Flok interim evaluation (Feb–Apr 2025) provides the strongest early evidence of potential impact.

2,566	patients received same-day digital assessment & treatment	98%	digitally managed / retained
55%	waiting-list reduction in core service	66%	lower pathway cost
54%	reported symptom improvement	78%	patient satisfaction

Also reported: 2,568 clinician hours saved.

4 Proxy scale of opportunity

EEC Q1 2026/27

Total MSK Service referrals	24,842 (8%)
Lower back coded referrals	2,011 (11%)
Patients who choose digital lower back pathway	631 (31%)

Using EEC as a proxy: potential CE ICB impact ≈ 30,500 residents.

5 What this tells us now

Programme data maturity

IMPLEMENTATION / BASELINE

Not yet sufficient for an SPC impact chart

- **Coverage**
  Digital pathways are being deployed across all places, with full population coverage expected by Q4 2026/27.
- **Access**
  C&P already demonstrates a zero-week wait on the digital lower-back pathway, compared with a 15-week average overall pathway wait.
- **Scale**
  EEC pilot evidence suggests meaningful potential to reduce waits, cost and clinician time while maintaining high patient satisfaction.
- **Next data step**
  Lower-back-specific referral, uptake and outcome data are needed consistently across providers before programme-level impact can be shown over time.

Programme Summary, Aim & Baseline

B3 | Utilisation Risk Management in Cardiology

Measurable Aim

10% reduction of emergency presentations for heart failure for Segment 3 cohort by June 2027

Commitment made in Our Way

Reducing avoidable utilisation of health services in cardiology by identifying high risk people and intervening proactively.

Overall Delivery Assessment

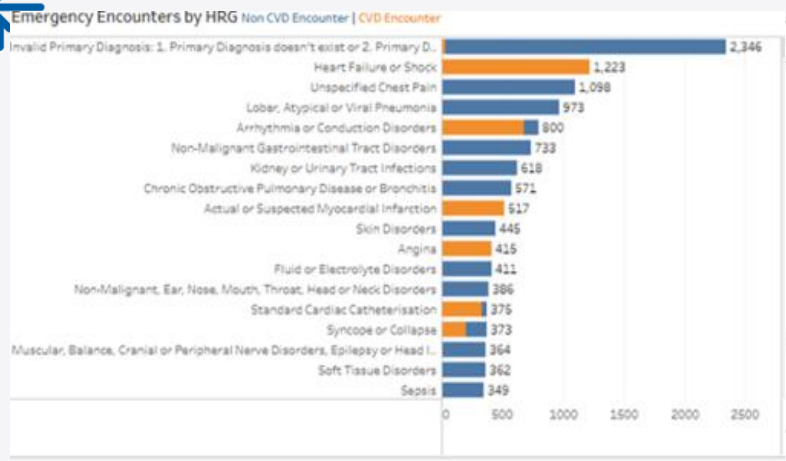
Substantial

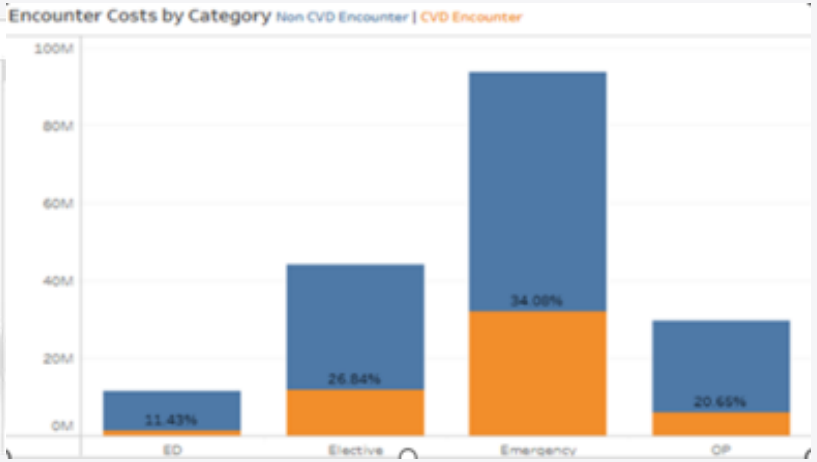
Domain 1: Ownership & Oversight	Domain 2: Outcomes & Strategic Clarity	Domain 3: Delivery & Improvement Execution	Domain 4: Evidence, Sustainability & Scale
Substantial	High	High	Moderate

Commissioning Intentions

Potential commissioning implications include NT-proBNP testing, echocardiography access, medicines optimisation and cardiac rehabilitation. No proposals are approved and no decommissioning opportunities identified yet.

Baseline Data





EoE CVDR Cardiac Dashboard shows CEICB has a significantly higher rate of directly age-standardised rate admissions for heart failure when looking at per 100,000 registered populations at 166.3 compared to EoE average of 150.3 (April 26 Data)

Programme Delivery and Change Ideas

B3 | Utilisation Risk Management in Cardiology

Current Lifecycle Stage

A Identify & Improve

Improve / Codify / Scale

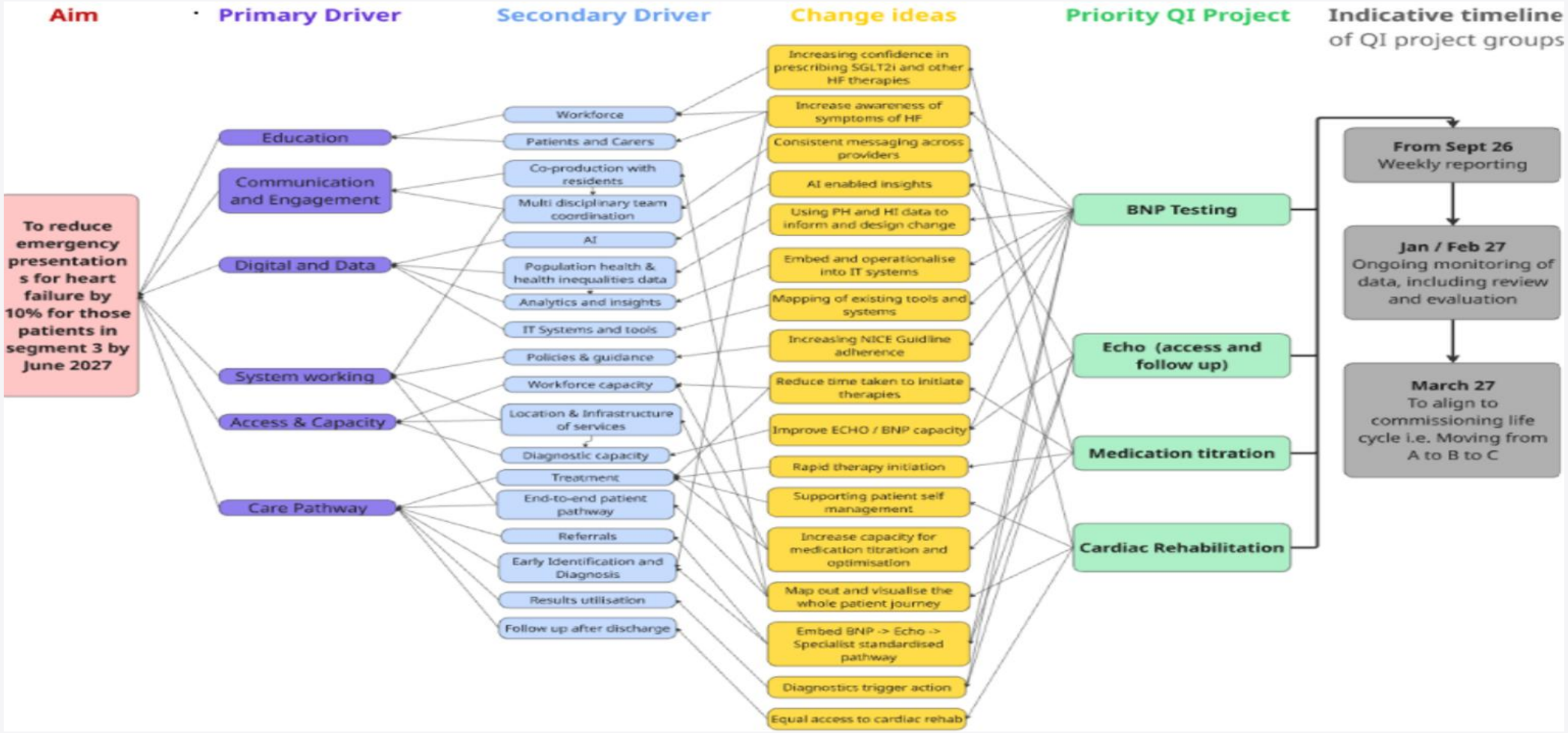
Improve

Measurable Aim

10% reduction of emergency presentations for heart failure for Segment 3 cohort by June 2027

Our Way Strategic Measures

Supports Our Way ambitions for population health and inequalities, targeting a 10% reduction in emergency presentations among heart failure patients; the exact strategic measure is to be mapped.



Programme Delivery and Change Ideas

B3 | Utilisation Risk Management in Cardiology

Aiming for a 10% reduction in emergency presentations among segment 3 heart failure patients (typically under 80, at high risk of avoidable admission, without advanced illness, end-stage Heart failure or significant frailty) benefitting from proactive early intervention. Measures are % HF emergency presentations, monthly cost per presentation, and four T&F QI process measures. For segment 3 in Hertfordshire alone there are approximately 640 admissions per year. Work is underway to map a proxy figure for CE.

Next Steps	Geography/ cohort	Key measures Note - outcome and wider measures under development	Priority actions	By when	Movement to next phase
BNP Task and Finish Group – is BNP testing available and is it used as expected.	Milton Keynes	• % of GPs with access to a lab BNP test (outcome) • No of onward referrals to cardiology after BNP test • No of Advice & Guidance requests for BNP results	Review approach to ensure BNP referrals are timely and accessible. Lab BNP testing is accessible to all appropriate clinicians. Clear BNP test results direct clinicians to the right course of action and referral routes.	30th Sept 30th Nov 30th Nov	Moving from A to B to C – June 2027
Echo Task and Finish Group – is Echo accessible and focused advise if indicates heart failure.	Cambridge and Peterborough	• % patients with suspected HF seen under 6 weeks • % patients with severe HF being seen in 2 weeks • No of patients on waiting list for echo • No of echo referrals (not including BNP results)	Echo capacity is understood and fully utilised. Patient needs are prioritised as per NICE guidance / aligned to timelines and risk. Echo results shared with primary care, informing clearly how to support patient management/treatment.	30th Sept. Scope by 30th Sept. Scope by 30th Sept.	Moving from A to B to C – June 2027
Medication Titration Task and Finish Group – up titrating and what happens during admission/advice back to primary care.	Peterborough	• No of patients on all 4 pillars • No of HF patients with coded EF • No. of patients on SGLT2 inhibitors	Review discharge letters to ensure they clearly outline patient medication requirements. Review Up-titration process to make sure this can occur quickly/safely via MDT working including clarification of the role of heart failure nurses.	30th Sept. 15th Oct.	Moving from A to B to C – June 2027
Cardiac Rehabilitation Task and Finish Group – access and usage.	TBC by mid Sept	• % of patients that have access to cardiac rehab • No of HF patients attending cardiac rehab • Average waiting time for HF patients to access cardiac rehab • % of HF patient readmissions	An agreed referral threshold for cardiac rehab is established across CE footprint. Exploring effectiveness / efficient deployment of remote cardiac support. Identification and access to community resources and social prescribing for patients with less severe heart failure.	Scope by 30th Sept. Scope by 30th Sept. Scope by 30th Sept.	Moving from A to B to C – June 2027

Programme Summary, Aim & Baseline

B4 | Care Coordination for Advanced Illness

Measurable Aim

Reduce the average number of emergency admissions for people in their last six months of life

Commitment made in Our Way

Establish a coordinated, system-wide model for advanced illness across Central East, centred on care coordination hubs that provide a single point of access, improve early identification, and deliver personalised care aligned to patient preferences.

Overall Delivery Assessment

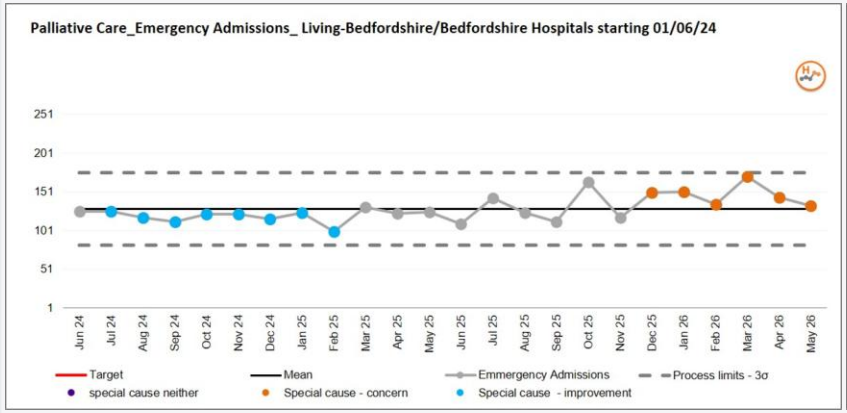
Substantial

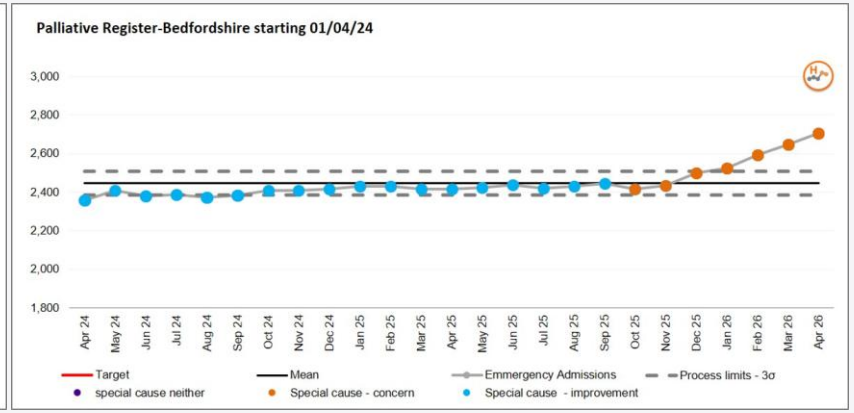
Domain 1: Ownership & Oversight	Domain 2: Outcomes & Strategic Clarity	Domain 3: Delivery & Improvement Execution	Domain 4: Evidence, Sustainability & Scale
High	Substantial	High	Moderate

Commissioning Intentions

Potentially commission a standardised Central East care coordination model, including capacity, digital enablement, referral pathways and infrastructure. No formal proposal or decommissioning is identified.

Baseline Data





S1 Primary Care & Hospice Data (Bedfordshire)

Further analysis of emergency admissions is a key next step to understand progress against the Programme's outcome measure of reducing admissions in the last six months of life. Improved identification continues, with the register growing by an average net 14.1 patients per month.

The Bedfordshire Palliative Coordination Service supported 2,063 patients in July 2026, receiving a record 239 referrals and completing 189 advance care planning discussions. Referrals to specialist palliative care and hospice services have increased by 95% since April 2026, strengthening coordinated community-based support.

Programme Delivery and Change Ideas

B4 | Care Coordination for Advanced Illness

Current Lifecycle Stage

B PDSA to Product

Improve / Codify / Scale

Codify

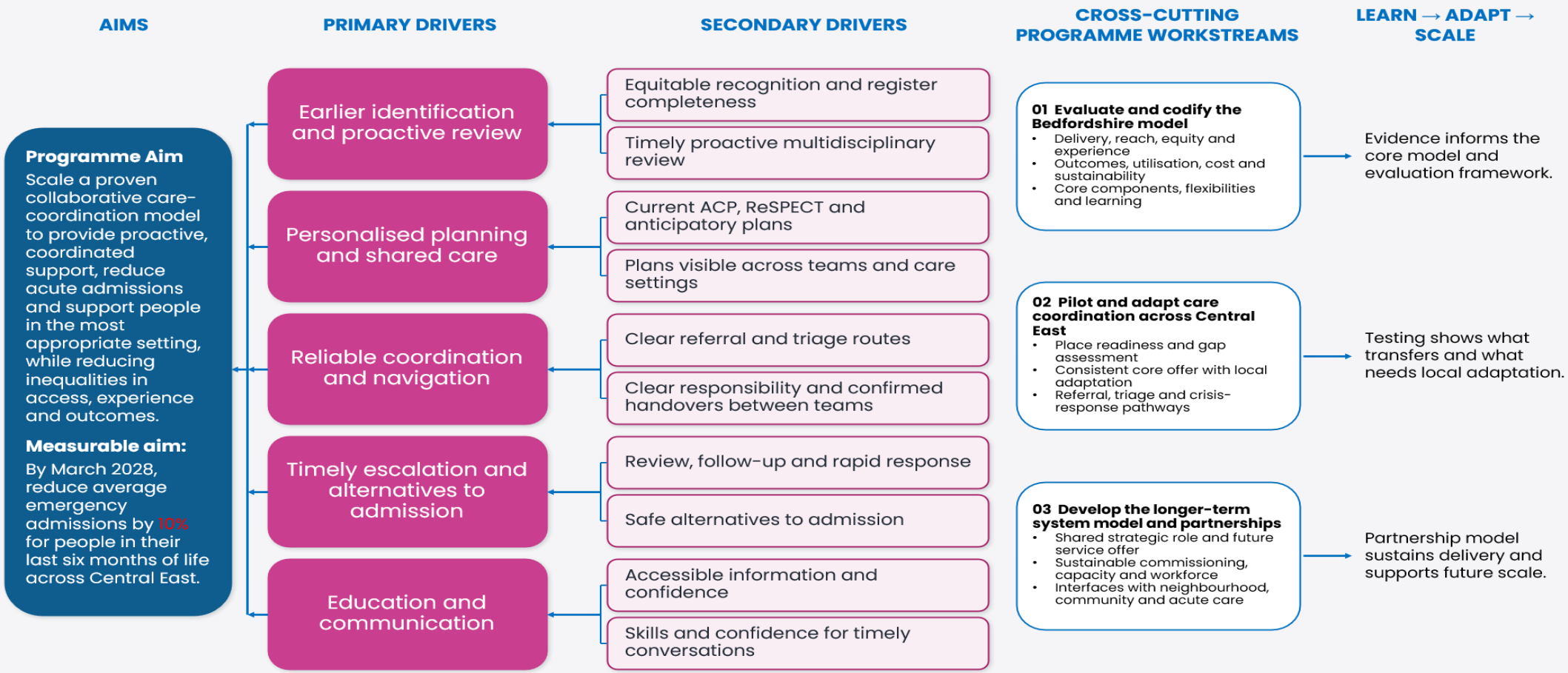
Measurable Aim

Reduce the average number of emergency admissions for people in their last six months of life

Our Way Strategic Measures

Reduce the average number of emergency admissions for people in their last six months of life.

Driver Diagram *(Draft)*



Programme Delivery and Change Ideas

B4 | Care Coordination for Advanced Illness

Key Programme Workstreams	Geography / Cohort	Key Measures	Next Steps	By When
01 Evaluate and codify the Bedfordshire & other pilot models Delivery, reach, equity and experience; outcomes, utilisation, cost and sustainability; core components, flexibilities and learning.	**Central East**	• % of people on EoL register • % of ACPs for EoL cohort • % of emergency admissions for EoL register cohort • % of admissions avoided for EoL register cohort • Average LOS/bed days for EoL register cohort • Patient experience • System workforce experience • Staff confidence • Service utilisation & access	1. Detailed analysis of baseline data and service impact to inform forecasting across the system 2. Finalise DRAFT Bedfordshire Palliative Coordination Service (BPCS) operating model 3. Agree approach & data sets with PHM/Total Quality Management/SVU leads for BPCS evaluation 4. BPCS evaluation 5. Create lessons learned log for PCS	1. Sep/Oct 2026 2. Sep 2026 3. Sep/Oct 2026 4. Nov 2026 5. Sep 2026/Ongoing
02 Pilot and adapt care coordination across Central East Place readiness and gap assessment; consistent core offer with local adaptation; referral, triage and crisis-response pathways.	**Central East** BLMK > Herts > C&P	• Achieving outlined tasks in accordance with timescales • Positive and engaged system response to pilots and referrals into PCS • Consistent core offer achieved across places with appropriate local adaptation • Evaluation of pilots supports achievement of key measures	**BLMK:** 1. Wider onboarding of coordination model 2. Identify opportunities for enhanced BPCS Model – QI approach to target identification (care homes/ED) & strengthening provision (virtual ward) 3. Evaluation of BPCS – pilot activity, outcomes, system insight **Herts:** 1. Assess readiness through mapping existing service provision and pathways 2. Agree timelines for mobilisation and pilot launch date 3. Identify methods implemented for successful identification/ACPs to inform longer-term system model **C&P:** 1. Assess readiness through mapping existing service provision and pathways in comparison with BPCS model	1. Oct 2026 2. Ongoing, monthly updates 3. Nov 2026 --- 1. Oct 2026 2. Oct 2026 3. Sep 2026 --- 1. Nov 2026
03 Develop the longer-term system model and partnerships Shared strategic role and future service offer; sustainable commissioning, capacity and workforce; interfaces with neighbourhood, community and acute care.	**Central East**	• Partner engagement and alignment • Agreed future service offer • Workforce and capacity alignment • Commissioning and funding sustainability • Clarity of roles and interfaces • Scalability and system coverage • Technology/system infrastructure	1. Identify opportunities for continuous improvement based on PCS lessons learned log and wider system learning & successes 2. Develop commissioning strategy to align with national directives, such as MSF, NHTs, and population health	1. Ongoing 2. TBC

Programme Summary, Aim & Baseline

B5 | Acute Care Pathway for Mental Health

Measurable Aim

To be identified

Commitment made in Our Way

Improve outcomes and experience for people with severe mental illness by ensuring rapid access to the right care first time

Overall Delivery Assessment

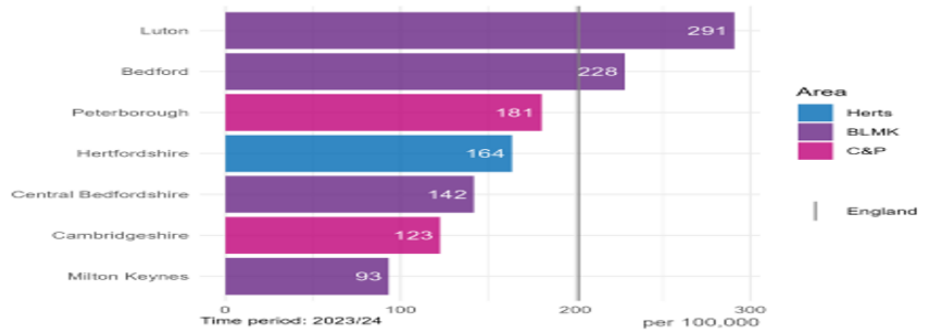
Limited

Domain 1: Ownership & Oversight	Domain 2: Outcomes & Strategic Clarity	Domain 3: Delivery & Improvement Execution	Domain 4: Evidence, Sustainability & Scale
Limited	Limited	Moderate	Limited

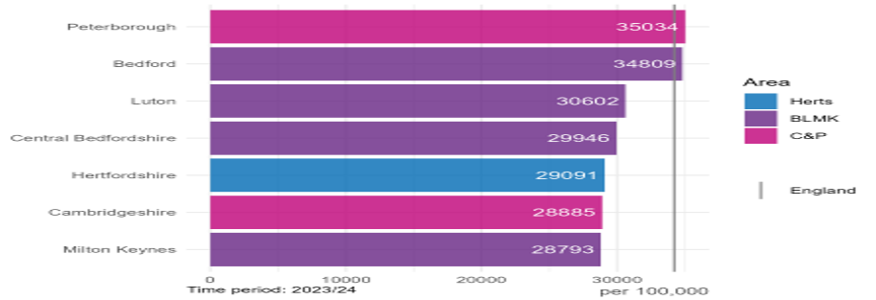
Commissioning Intentions

Likely requirements include redesigned or expanded community crisis alternatives, clearer VCSE and crisis specifications, and outcome-based commissioning. Evidence cannot yet confirm commissioning, reduction or decommissioning decisions.

Inpatient stays in secondary care mental health services per 100,000



Attended contacts with community and outpatient mental health services per 100,000



Change date to September
Inaugural programme meeting, review baseline data, commence programme charter. Agree measurable aim.

Change date to October
Confirm change ideas to be tested. Agree measures, implement task and finish groups.

Change date to November
Implementation of change ideas, ongoing monitoring.

Priorities identified through early review of Delphi data

- Coordinated community urgent care
- All-age crisis pathways
- Improved urgent mental health care for children and young people
- Neighbourhood multidisciplinary teams
- Whole-school approaches
- Psychosis pathways for people with severe mental illness
- Trauma-informed support
- Improved transition support
- Co-produced redesign of crisis pathways

Programme Delivery and Change Ideas

B5 | Acute Care Pathway for Mental Health

Current Lifecycle Stage

A Identify & Improve

Improve / Codify / Scale

Improve

Measurable Aim

To be identified

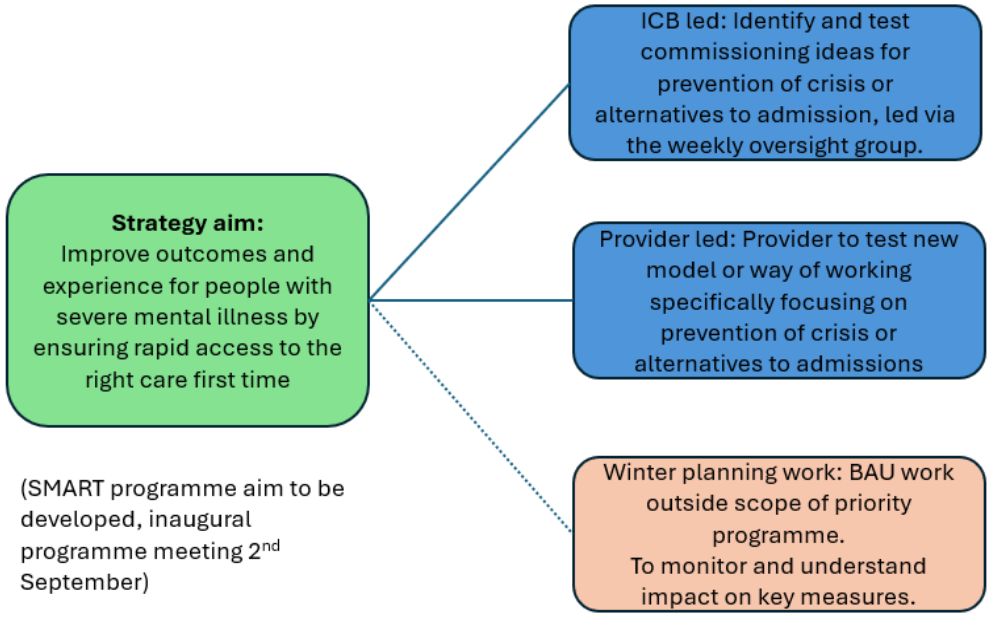
Our Way Strategic Measures

Primary alignment: reduce mental health inpatient length of stay. It may also reduce emergency demand, but current evidence most clearly supports inpatient flow and alternatives to admission.

Driver diagram showing key workstreams for programme

B5. Acute care pathway for mental illness

SRO: Elizabeth Disney; Lifecycle stage A- Identify and Improve



Next steps

- Inaugural programme meeting 2nd September.
- Development of SMART aim
- Improvement focus for ICB led work, using data to identify potential interventions for testing.
- SRO discussions with provider ongoing to progress provider led workstream. Agreement of scope, outcomes and timeline.
- Development of programme charter, including key measures
- Understand baseline and trajectories for improvement.

Next steps

- Inaugural programme meeting 2nd September 2026
- Development of SMART aim
- Improvement focus for ICB led work, utilising data to identify potential areas for testing.
- SRO discussions with provider ongoing to progress provider-led workstream. Agreement of scope, outcomes and timeline.
- Development of programme charter, including key measures.
- Understand baseline and trajectory for improvement.

Programme Summary, Aim & Baseline

C1 | Dermatology

Measurable Aim

To deliver a sustainable and equitable dermatology service, that improves patient experience and clinical outcomes, across Central East by March 2027.

Commissioning Intentions

Recommission an integrated community-enabled pathway, shifting appropriate hospital activity and retaining specialist care for complex need.

Baseline Data

Challenges in Cancer Waiting Times performance in NWAFT and CUH and rising demand in referrals across C&P and BLMK with associated increases in waiting list trends.

Drivers for transformation associated with a need to improve performance, patient experience and outcomes, while making better use of system resources

Skin - 28-Day FDS

Trust	Jan-26
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	87.60%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	83.20%
EAST AND NORTH HERTFORDSHIRE NHS TRUST	92.90%
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	96.90%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	82.00%
MILTON KEYNES UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	97.30%
ENGLAND	72.80%

Skin - 31-Day

Trust	Jan-26
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	84.60%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	52.70%
EAST AND NORTH HERTFORDSHIRE NHS TRUST	95.60%
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	100.00%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	45.90%
MILTON KEYNES UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	84.80%
ENGLAND	69.20%

Skin - 62-Day

Trust	Jan-26
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	88.60%
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	65.40%
EAST AND NORTH HERTFORDSHIRE NHS TRUST	93.80%
WEST HERTFORDSHIRE TEACHING HOSPITALS NHS TRUST	93.00%
NORTH WEST ANGLIA NHS FOUNDATION TRUST	67.60%
MILTON KEYNES UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	96.20%
ENGLAND	69.20%

Provider	Demand trend	Waiting list trend	Flow pattern (follow-up intensity)	Pathway characteristics	Key issue signal
BHFT	↑ Increasing	↑ +1,000+	Medium–high	Repeat-heavy pathways (phototherapy impact)	Capacity pressure driven by repeat activity
CUHFT	↑ Increasing	↓ -500	Moderate (~1.5)	Strong front-door, bottlenecks in treatment stage	Downstream flow constraints (31/62-day performance)
NWAFT	↑ Increasing	↑ +1,000+	Very high (2.4–3.5)	Heavy follow-up, strong A&G/telederm use	Over-utilisation of follow-ups driving demand + cost
MKUHFT	↑ Increasing	Stable	Low (~1.4)	Streamlined pathway, fewer repeats	Lower intensity model (best practice comparator)
ENHT	↔ Static/↓	Stable	Moderate	Conventional pathway, no major outliers	↔ Static/↓
WHTT	↔ Static/↓	Stable	Not explicitly benchmarked	Resilient delivery under pressure	↔ Static/↓

Programme Delivery and Change Ideas

C1 | Dermatology

Current Lifecycle Stage

D Commission & Mobilise

Improve / Codify / Scale

Scale

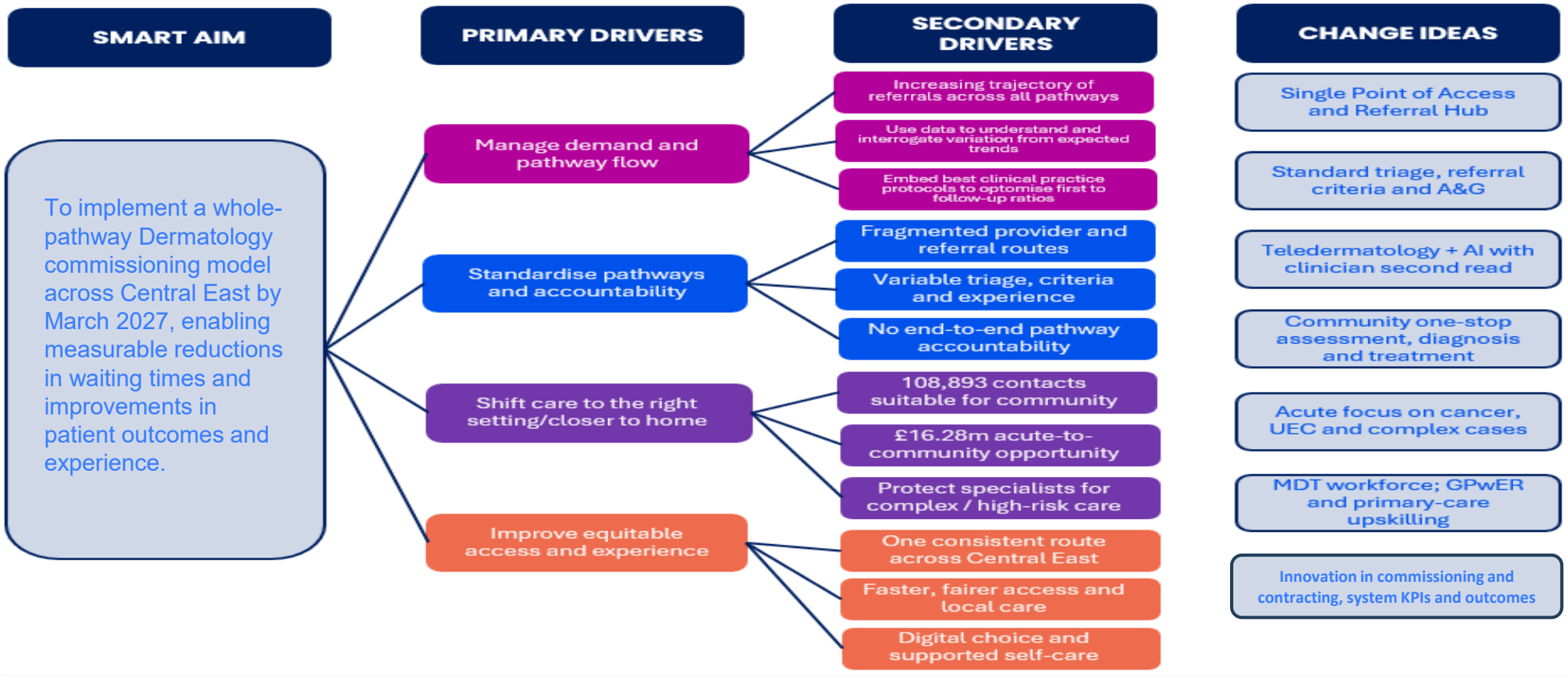
Measurable Aim

To deliver a sustainable and equitable dermatology service, that improves patient experience and clinical outcomes, across Central East by March 2027.

Our Way Strategic Measures

Decrease average days residents spend on waiting lists; flatline average NHS spend per resident.

Dermatology Driver Diagram



The Dermatology Driver Diagram remains in development, with support of the Improvement Advisor.

Programme Delivery and Change Ideas

C1 | Dermatology

Current Lifecycle Stage

D Commission & Mobilise

Improve / Codify / Scale

Scale

Measurable Aim

To deliver a sustainable and equitable dermatology service, that improves patient experience and clinical outcomes, across Central East by March 2027.

Our Way Strategic Measures

Decrease average days residents spend on waiting lists; flatline average NHS spend per resident.

Summarise the progress made since project kick off.	What next steps are planned to move to the next stage of the lifecycle?	When do you expect data to be available demonstrating the impact of the intervention on patient outcomes?	Outline the resident/community involvement.
▪ New pathway finalised. ▪ Public engagement completed. ▪ Governance structure established. ▪ Business case approved. ▪ Route to commissioning identified. ▪ Service specification under review.	▪ Approve service specification. ▪ Consult providers and residents. ▪ Confirm commissioning approach. ▪ Complete PSR and legal review. ▪ Launch commissioning process.	▪ Benefits realisation reporting from April 2027.	▪ Public engagement completed. ▪ Feedback shaped service design. ▪ Concerns raised about access and waits. ▪ Support for local, digital care. ▪ Ongoing stakeholder engagement planned.

Programme Summary, Aim & Baseline

C2 | Diabetes

Measurable Aim

Support 10 lowest performing practices in C&P to achieve a 20% point improvement in the proportion of eligible people with type 2 diabetes achieving all three treatment targets by 31 March 27

Commissioning Intentions

Uphaul, transform and develop Neighbourhood integrated community diabetes services to support primary care (particularly to level up and improve the treatment targets for the practices in the lowest quartile (with particular focus in C&P).

Baseline Data

8 Care Processes (8CP)

Deprivation Gradient
People from the least deprived quintile are most likely to have all 8CP completed

16.7% to 98.1% Significant variation in completion of 8CP at GP practice level

Urine albumin and Foot surveillance
Lowest completion rates

Inequalities
In Herts:
- Older people are the more likely to have all 8CP completed
- People from an Asian or white background have higher rates of completion

3 Treatment Targets (3TT)

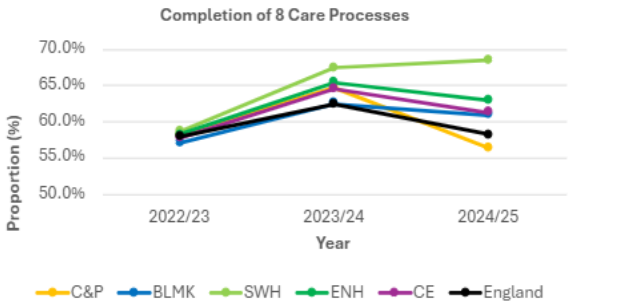
Achievement
All paces show an increasing trend in achievement rates *(except for SWH)*

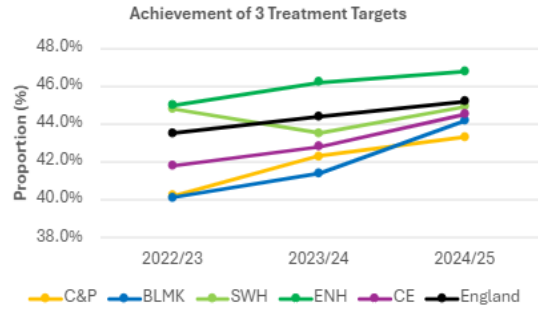
20.0% to 68.9% Significant variation in achievement of 3TT at GP practice level

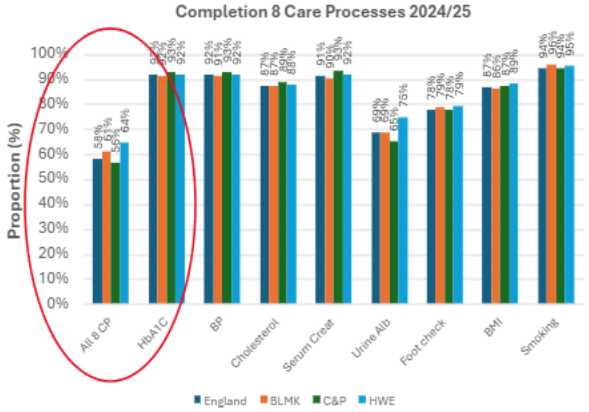
Inequalities
- Highest proportion of people achieving 3TT are from a white background
- Lowest is among people from a Black background.

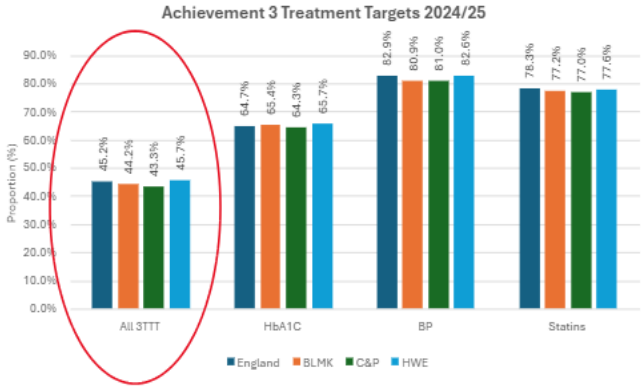
HbA1C target
Lowest achievement rate

Variation
Across CE, ENH has the highest achievement of 3TT









Achievement of 3 Treatment Targets across Central East (April 2025 – March 2026)

261 GP Surgeries
Best performing achieved 69.0%
Worst performing achieved 29.4%

10 worst performing GP surgeries scored under 39%, 5 of which are within the C&P footprint.

Programme Delivery and Change Ideas

C2 | Diabetes

Current Lifecycle Stage

A Identify & Improve

Improve / Codify / Scale

Improve

Measurable Aim

Support 10 lowest performing practices in C&P to achieve a 20% point improvement in the proportion of eligible people with type 2 diabetes achieving all three treatment targets by 31 March 27

Our Way Strategic Measures

To be confirmed.

Aim

Wider Programme aim: Improve outcomes and reduce complications for people with diabetes across Central East ICB by reducing unwarranted variation, improving care for frail populations, and developing a sustainable integrated cardiometabolic model of care.

Specific aim to reduce variation: By 31 March 2027, to support the ten lowest-performing practices in Cambridgeshire and Peterborough to achieve a 20%-point improvement from their individual 2025/26 baseline in the proportion of eligible people with type 2 diabetes achieving all three treatment targets, while maintaining safe, personalised care.

Primary Driver
What we need to ensure …

Secondary Driver
Which requires …

Change ideas
To make this happen …

Indicative Delivery Timelines

Reduce unwarranted variation in diabetes care - C&P focus
Quality Assurance working with Neighbourhood

- Improve visibility of variation
- Benchmark GP practices
- Spread best practice
- Support Targeted Improvement

Task and Finish Group 1: Unwarranted variation in 3TT performance at practice level
Actions likely to include;
- Validate baseline and confirm initial ten-practice cohort.
- Undertake structured practice-level diagnostic reviews.
- Agree tailored improvement actions
- Evaluate the intervention and agree whether, and how, to scale across Central East.

Sep 26 – Mar 27: BAU to recover the NICE Quality standards

Improve care for frail people
Strategic Commissioning

- Better Identification of Frail Cohorts
- MDT Care Coordination
- Reduce avoidable harm
- Personalised Care Planning

Task and Finish Group 2: Building diabetes specific requirements into Neighbourhood Frailty Specification.
Areas to consider;
- Shared MDT reviews involving primary care, community diabetes teams, geriatricians and pharmacists.
- Standardised insulin management, medication review and hypoglycaemia prevention protocols.
- Frailty-focused diabetes care plans incorporating patient goals, quality of life and treatment optimisation.

Sep 26 – Mar 27: Develop Service specification for neighbourhood integrated diabetes service

Apr 27 onwards: Testing and commissioning

Integrated Cardiometabolic Care
Quality Planning

- Risk stratification
- MDT care bundle
- Shared care plans
- Outcomes evaluation (evidence for scale-up)

Task and Finish Group 3: Cardiometabolic Cohort Pilot to design and evaluate a new neighbourhood-based model of care
Areas to consider;
- MDT case management, shared care plans and risk stratification
- Single pathway across diabetes, obesity, hypertension, renal disease, lipids and cardiovascular disease
- Measure clinical outcomes, patient experience, admission avoidance and cost-effectiveness to inform future commissioning

Sep 26 – Mar 27: Testing, scoping developing

Apr 27 onwards: Float model for commissioning discussions

Programme Summary, Aim & Baseline

C3 | Neurodiversity

Measurable Aim

Future model: Net change in ND waiting list size and reduction in longest waits, increase in number of referrals diverted from diagnostic assessment

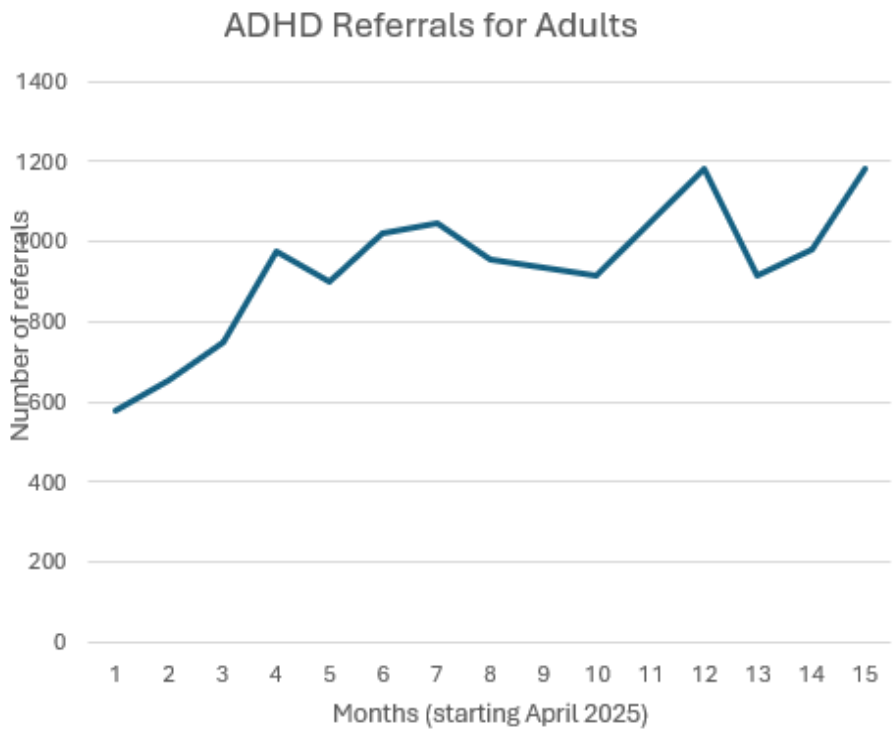
Commitment made in Our Way

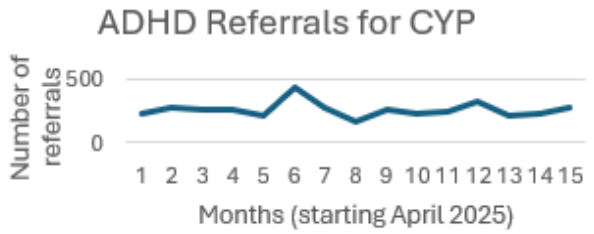
Demand Management & Build Future Model.

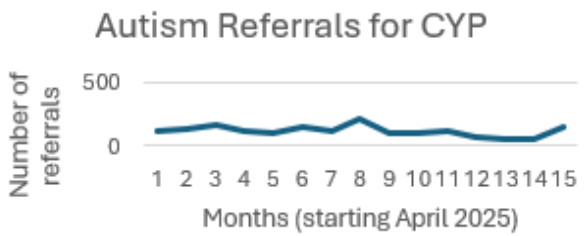
Commissioning Intentions

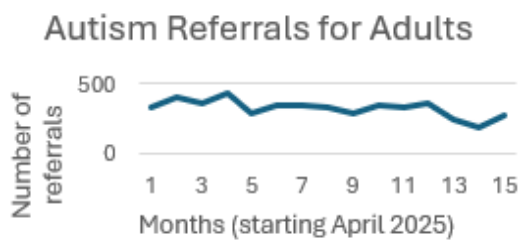
Redesign all-age neurodiversity pathways around needs-led support, single access, equitable triage and sustainable provider capacity.

Baseline Data









Data next steps

- Additional data reporting is under development and will provide further waiting time data including 104 week waits, individual NHS provider reports, completed assessment data, titration data (ADHD) and annual review data.
- Access to the Mental Health Services Data Set (MHSDS) via DELPPHI will enable further data analysis of activity delivered through Right to Choose providers

Programme Delivery and Change Ideas

C3 | Neurodiversity

Current Lifecycle Stage

D Adults

A CYP

Improve / Codify / Scale

Codify

Measurable Aim

Future model: Net change in ND waiting list size and reduction in longest waits, increase in number of referrals diverted from diagnostic assessment with alternative support

Our Way Strategic Measures

Decrease average days on waiting lists; increase support for children and young people's mental health and wellbeing.

Immediate next steps

- Agreement of Indicative Activity Plans for majority of known IS providers – in place from M4 but based on overall 2526 figures. Requires monitoring and ongoing management
- Adult ADHD referral management solution may lead to up to 30% of adults referred being redirected to earlier support services.
- Clinical policy. To be in place for October 2026
- Work to be supported by clear communication strategy for referrers, providers and residents.

Further changes being worked through

- Data availability for real-time utilisation management of IAPs
- Invoice validation backlog and data quality
- Overall model redesign options – initial review of results from Hertfordshire CYP pilot

Our key steps to improvement

Complete invoice backlog, BI baseline and validation design by 30/09/2026.

Mobilise referral management centre and implement clinical threshold policy by 31/10/2026.

Evidence waiting-list transfers and early pathway impact by 31/03/2027; target unconfirmed.

Anticipated Outcomes

Validation of waiting list data to confirm all listed individuals still require assessment. This work has, in other NHS organisations, led to potential for 20% reduction in the numbers of people found to still require assessment.

We are working to model what outcomes could be achieved from scaling of the Hertfordshire CYP Pilot.

Programme Summary, Aim & Baseline

C4 | Neighbourhood Health Teams

Measurable Aim

A NHT in every neighbourhood, prioritising people with frailty as the initial cohort by 1 April 27

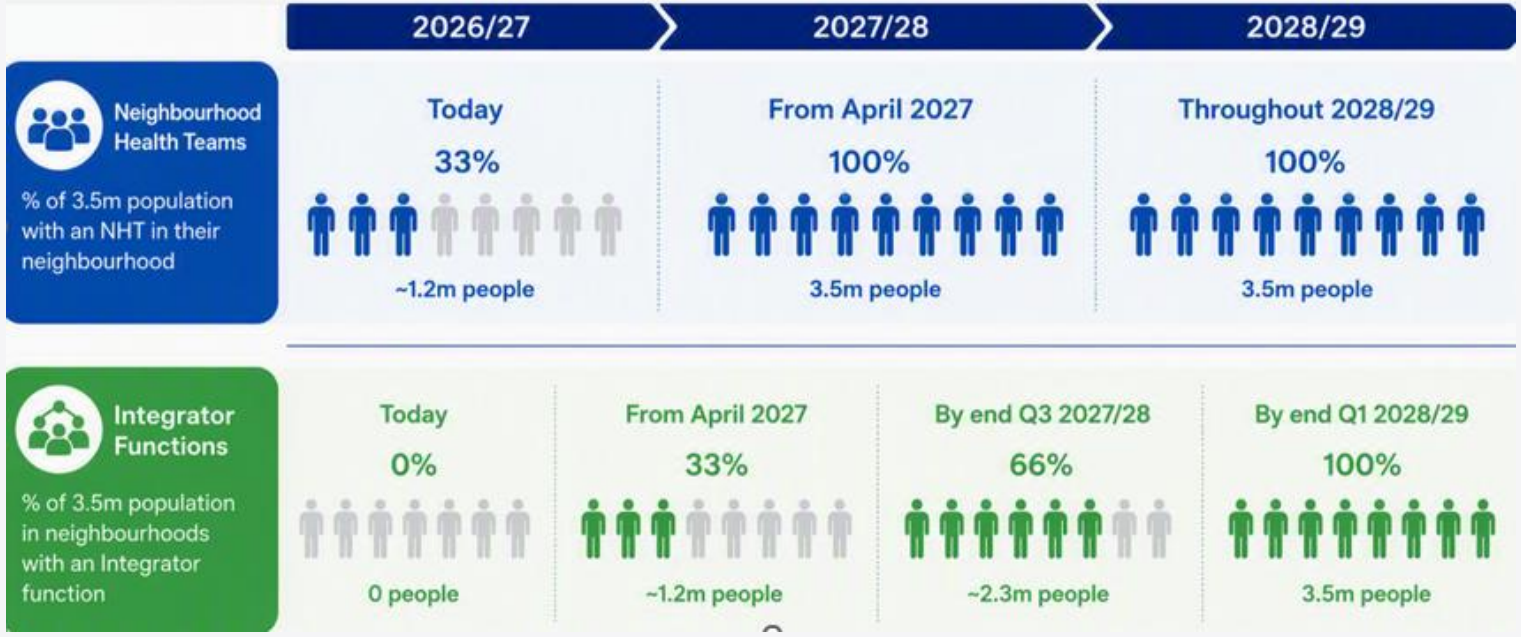
Commitment made in Our Way

Establish a NHT in every neighbourhood, prioritising people with frailty as the initial cohort.

Commissioning Intentions

Single Neighbourhoods: Frailty First NHTs commissioned across all neighbourhoods from 2027/28, with aligned provider contracts and incentives. Integrators: Test in 2026/27; first wave live Apr 2027, scaling by readiness, with sub-contracts delegated to integrators.

Baseline Data



Programme Delivery and Change Ideas

C4 | Neighbourhood Health Teams

Current Lifecycle Stage

B PDSA to Product

Improve / Codify / Scale

Codify

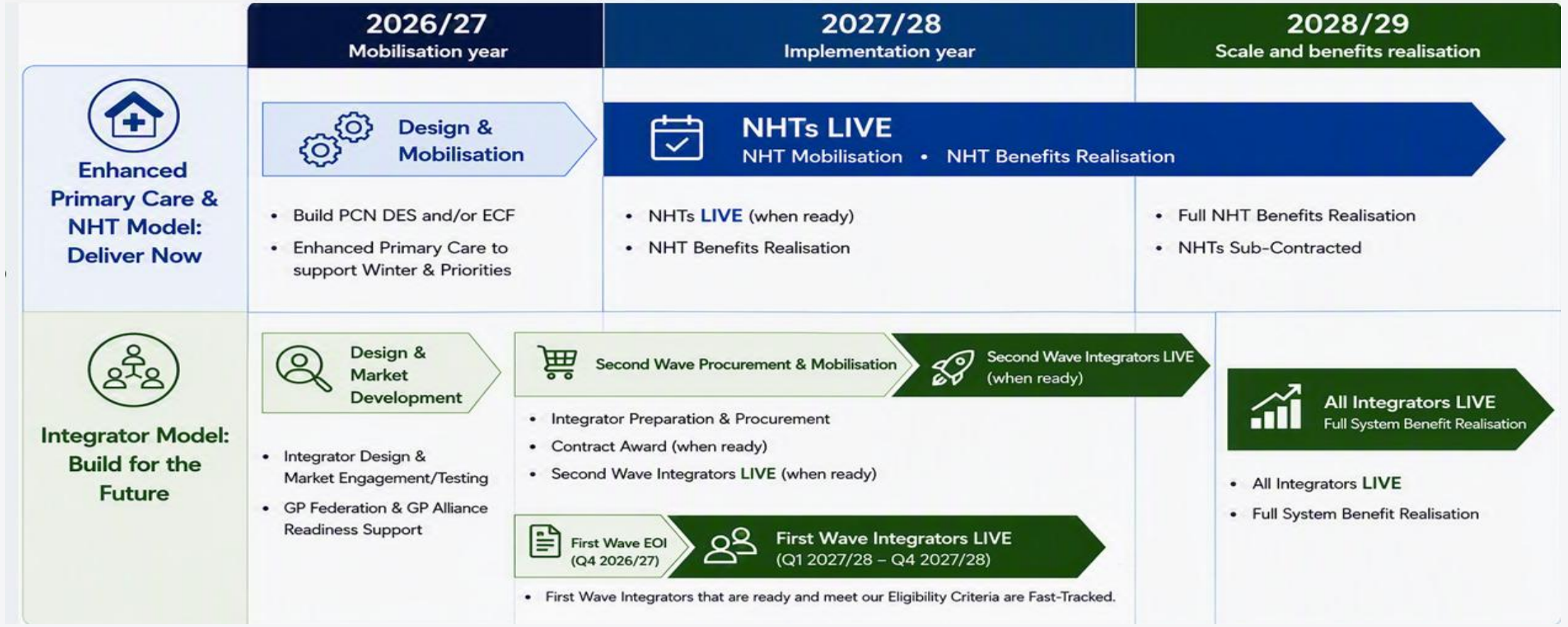
Measurable Aim

To be Idenfified

Our Way Strategic Measures

Primary measure: reduce type 1 and 2 A&E attendances per 100,000. Secondary measures may cover NHS spend and avoidable end-of-life admissions; cancer and CYP mental health alignment is weaker.

High-Level 3-Year NHT Roadmap



Delivery Unit Assurance Approach

Purpose
The Delivery Unit provides independent assurance, insight and targeted support to strengthen delivery confidence across the Central East ICB Priority Programme Portfolio.

Evidence Base
Assessments are informed by programme stocktakes, documentation reviews, performance data and discussions with SROs, programme leads and wider delivery stakeholders.

Assessment Framework & Assurance View
Evidence is reviewed against a consistent framework covering ownership and oversight, outcomes and strategic clarity, delivery and improvement execution, and evidence, sustainability and scale. The assessment provides an evidence-based view of delivery confidence, identifying where programmes are well-positioned to deliver and where additional focus, assurance or support may be required.

Reporting and Oversight
Findings are reported transparently to Executives, Committees and Board to support informed decision-making, strengthen oversight and maintain a clear line of sight on delivery progress, risks and dependencies.

Delivery Unit Proceess
Assess: Review programme evidence, delivery plans, outcomes, risks and current progress.
Understand & Engage: Review delivery progress, risks and dependencies with programme teams.
Assure: Assess delivery confidence using the agreed framework.
Support: Identify targeted actions to strengthen delivery grip and benefits realisation.
Report: Provide transparent reporting to Executives, Committees and Board.

Assessment ratings are determined by the Delivery Unit using a methodology approved by Executives in August 2026. Judgements are informed by programme evidence, documentation reviews and stocktake discussions and represent an independent Delivery Unit assurance view.

Purpose & Methodology
The Delivery Assessment Framework is applied consistently across all nine priority programmes. Developed jointly by the Delivery Unit and Quality Improvement Team, the framework provides a transparent, evidence-based assessment of delivery confidence, programme progress, risk and the likelihood of achieving intended outcomes. The framework combines monthly programme stocktakes with structured review of programme documentation, evidence of delivery in practice and discussions with programme leads and improvement advisors. Assessments are reviewed with programme teams for factual accuracy prior to onward reporting, while final judgements remain the independent view of the Delivery Unit.

Assessment Domains
Programmes are assessed across four domains:
1. **Ownership & Oversight**
2. **Outcomes & Strategic Clarity**
3. **Delivery & Improvement Execution**
4. **Evidence, Sustainability & Scale**

Scoring Approach
Each domain contains five evidence-based questions, creating a total of twenty assessment questions. Responses are recorded using a binary Yes/No methodology to support consistency, transparency and comparability across programmes. Domain ratings are assigned as:

- **Limited:** 0-2, material gaps in assurance
- **Moderate:** 3, foundations in place with further work required
- **Substantial:** 4, good assurance with some areas to strengthen
- **High:** 5, strong evidence of delivery assurance

Overall Delivery Confidence
Overall delivery confidence is determined by the ratings across the four individual domains, rather than by a simple aggregate score.

Appendix B

NHS
Central East
Integrated Care Board

Our Way Metrics

September 2026

Summary

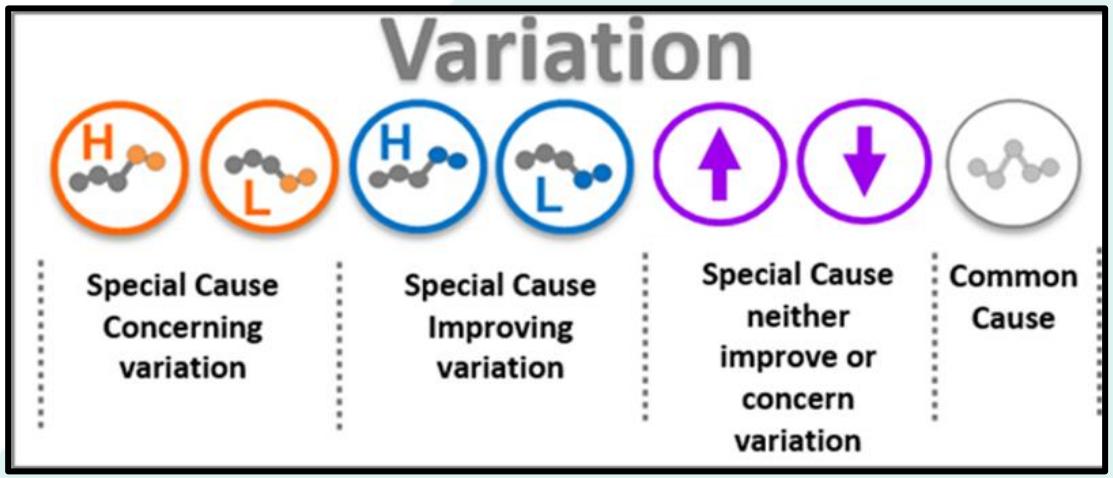
- Our Way metrics have been updated to include additional data published since the report in June 2026. Indicators are being transitioned to Statistical Process Control (SPC) charts.

Key messages

- SPC charts: 3 of 5 indicators are moving in the intended direction (primary care access, mental health length of stay and early colorectal cancer diagnosis); none are moving the wrong way. CYP mental health support and percentage of people who died who had three or more emergency admissions in their last 90 days of life are stable (show common cause variation).
- Waiting lists: average time fell from 144.5 to 115.1 days over 24 months; 456,020 pathways remain open.
- Other measures: ED attendance 2,131 per 100,000; spend £2,301 per resident; staff priority 72.3% versus 68.8% regionally (2024 data).

SPC Chart Details/Key

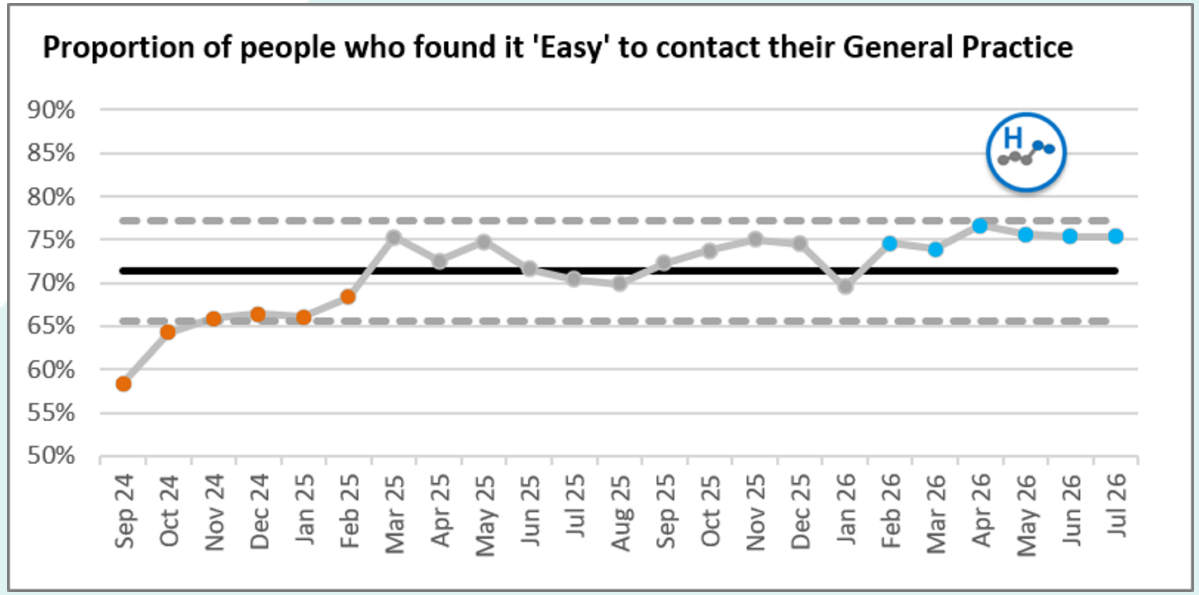
Statistical process control Statistical process control (SPC) is an analytical technique that plots data over time.



1.1. Increase patient reported satisfaction with access to primary care

Commentary

- The most recent figures from monthly general practice surveys continue to show, more than three quarters of people who responded to the GP Survey found it 'Easy' or 'Very Easy' to access an appointment with general practice.
- Trend analysis shows that the levels have remained similar over the past 12 months, following an increase in Q3 of financial year 24/25.
- The Central East ICB figure is above both the regional and national average. However, this is not statistically significant.



Percentage of patients who describe booking a general practice appointment as easy, March '26			
Baseline	Central East	East of England	National
	75.4%	74.7%	75.3%
Data Source (current)	Health Insight Survey (Question GPP-06-2a) (NB: GP Survey)		
Frequency	Monthly		

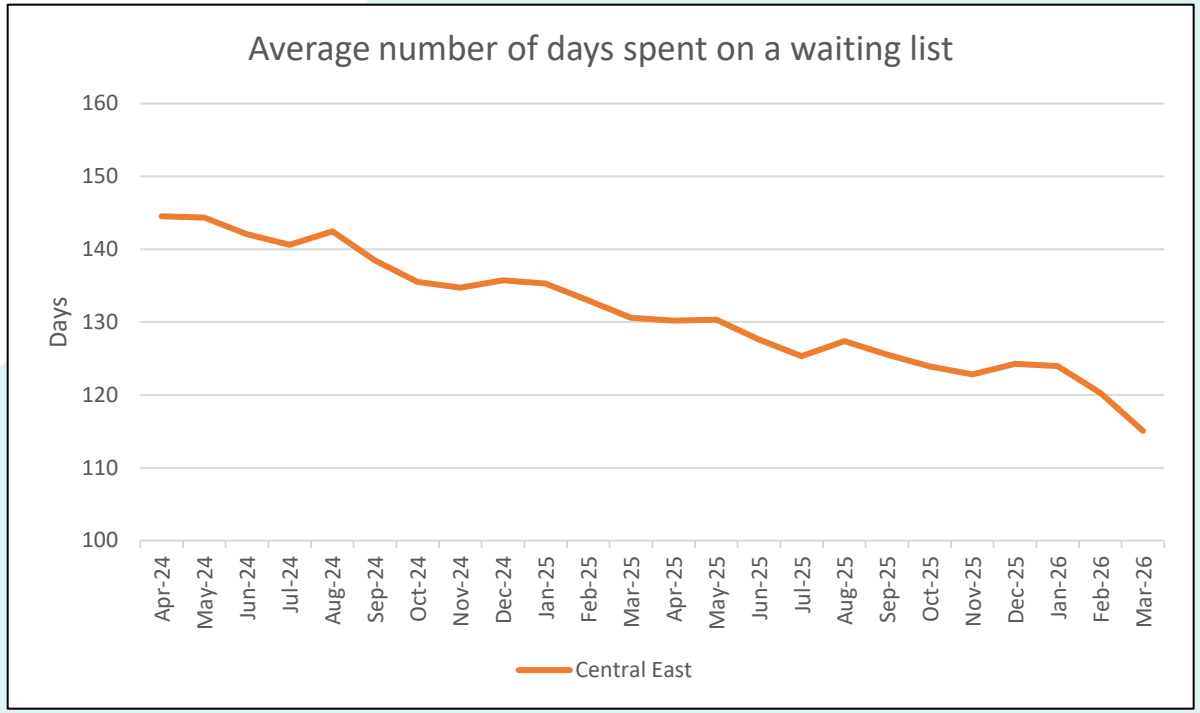
Information notes

- Primary care access data are routinely captured monthly through the GP Survey. The most recent data is from July2026.
- This indicator measures satisfaction with access to general practice. Additional indicators on satisfaction with general practice services are available.

1.2. Decrease the average number of days residents spend on waiting lists

Commentary

- On average, people across Central East spend 115 days on a waiting list. This includes people who have completed their pathway and people who are still awaiting their pathway completion.
- The financial year 24/25 saw a steady decline in the average number of days spent on a waiting list, linked to Elective Recovery schemes. This reduction was linked to fewer people waiting more than 52 weeks.
- There are currently 456,020 open pathways in Central East. The cohort of people currently on a waiting list have collectively been waiting a total of approximately 57m days.
- The average days spent on a waiting list is similar if only completed pathways are considered.



Average number of days spent on a waiting list, March 2026			
Baseline	Central East	East of England	National
	115.1	-	-
Data Source (current)	National Waiting List Data (RTT)		
Frequency	Monthly		

Information notes

- SPC chart to replace above chart when completed

1.3. Flatline average NHS spend per resident

Commentary

- Baseline figure calculated from 2025/26 financial position.

Information notes

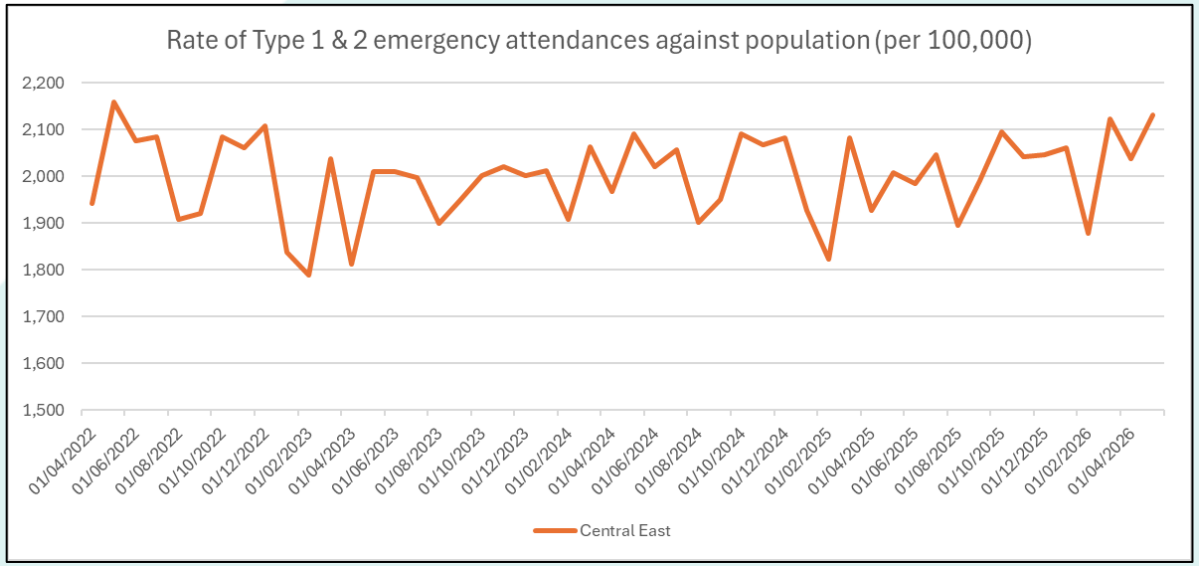
- Calculated using weighted population figure for each cohort
- Data includes the following service areas, Acute Services; Mental Health, Community Health, Continuing Healthcare, Prescribing, Other Primary Care & POD and Other Commissioned & Other Programmes
- Can be broken down into legacy ICB footprints and also by service areas in previous point – Currently being worked on by Analytics team, will be ready by next report (October)

Total CE 2025/26 Baseline	
Normalised spend (£000)	Cost per head (£)
7,343,347	2,301.22

1.4. Decrease type 1 & 2 Emergency Department attendances per 100,000 population

Commentary

- The current crude rate of attendance at a type 1 or type 2 Emergency Department is 2,131.1 per 100,000 people.



Rate of type 1 & 2 Emergency Department attendances (crude rate per 100,000), April 2026			
Baseline	Central East	East of England	National
	2131.1	-	-
Data Source (current)	Secondary Users Service (SUS)		
Frequency	Monthly		

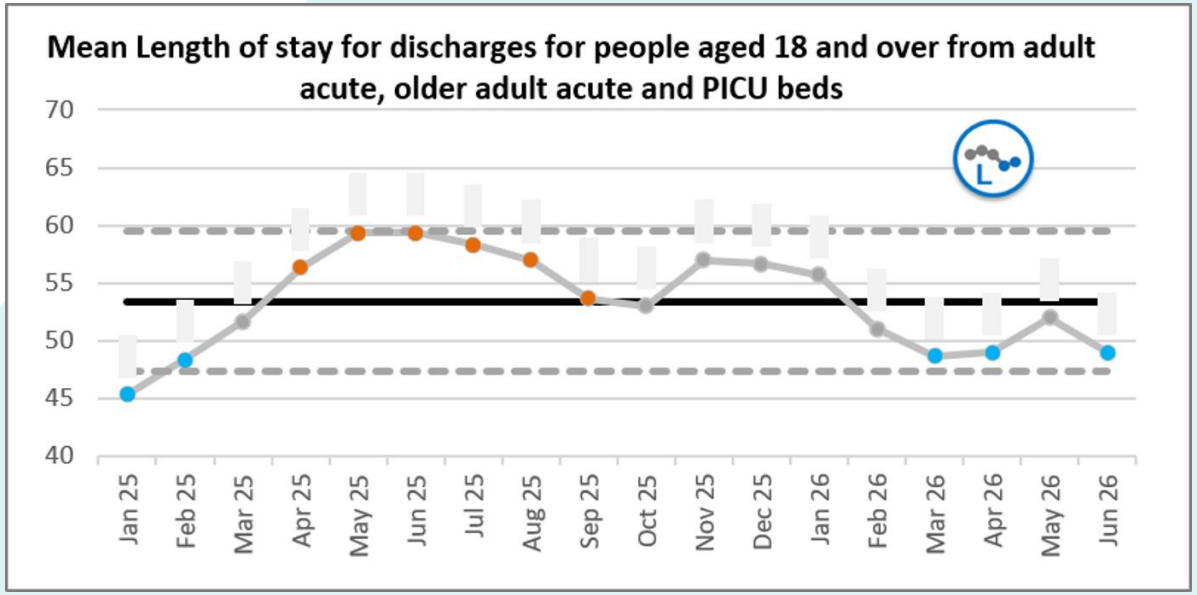
Information notes

- Current data reported as a crude rate per 100,000. Further analysis is required to convert this to a directly standardised rate per 100,000.
- SPC chart to replace the above when completed

1.5. Decrease average length of stay for mental health inpatient admissions

National MHSDS data are available to June 2026 and are used to inform the interpretation of performance below.

CE: Length of stay remains influenced by pathways outside the local footprint, including out of area placements. Each Trust is progressing local plans to improve flow through established governance with system partners.



Average length of stay for patients in adult acute mental health inpatient beds, June 2026			
June-26	Central East	East of England	National
	49	53	54
Data Source (current)	Mental Health Services Monthly Statistics – MHS156b/h - Mean Length of stay for discharges in the RP for people aged 18 and over from adult acute, older adult acute and PICU beds		
Frequency	Monthly		

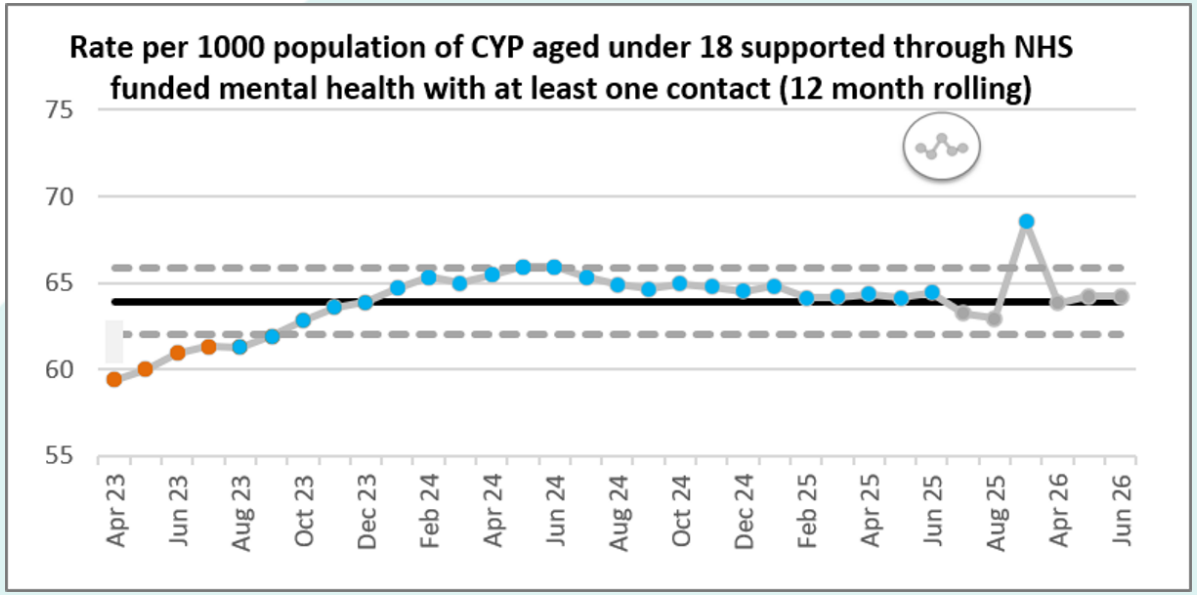
Information notes

- Months with high average length of stay reflect discharges for cases with a long length of stay.
- Further work is required to develop a Central East position, excluding West Essex.

1.6. Increase support to children and young people for mental health and wellbeing

Commentary

- The proportion of children and young people who have been supported by NHS mental health services in Central East ICB is 64.2 per 1000.
- Following a period of sustained improvement and performance above the long run average, data from the most recent months shows common cause variation.



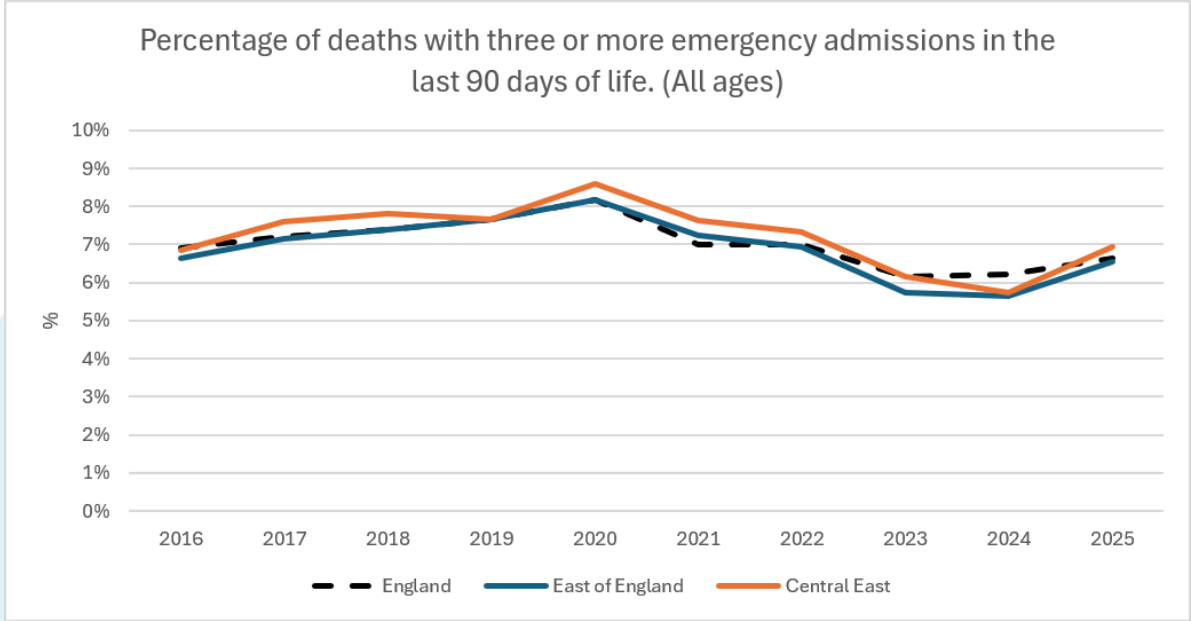
Rate, per 1000 u18 population, of CYP aged under 18 supported through NHS funded mental health with at least one contact (12-month rolling)			
June-26	Central East	East of England	National
	64.2	66.3	72.7
Data Source (current)	Mental Health Services Monthly Statistics – MHS95 Number of CYP aged under 18 supported through NHS funded mental health with at least one contact (12-month rolling)		
Frequency	Monthly		
*Current data includes West Essex			

Information notes

1.7. Reduce the average number of emergency admissions for people in their last six months of life

Commentary

- Initial analysis shows yearly trend on % of deaths with 3 or more admissions
- From 2020, the number has dropped from 2280 to 1935.
- Slightly above regional and national positions
- More frequent data being set up now
- From next month data/graph will show admission in last 6 months rather than last 90 days, as data now captured within ICB data tools



Percentage of deaths with three or more emergency admissions in the last 90 days of life. (All ages)			
Baseline	Central East	East of England	National
	6.8%	6.5%	6.6%
Data Source (current)	SUS/Mortality Data		
Frequency	Currently showing annual but monthly data set being completed and ready for next report		

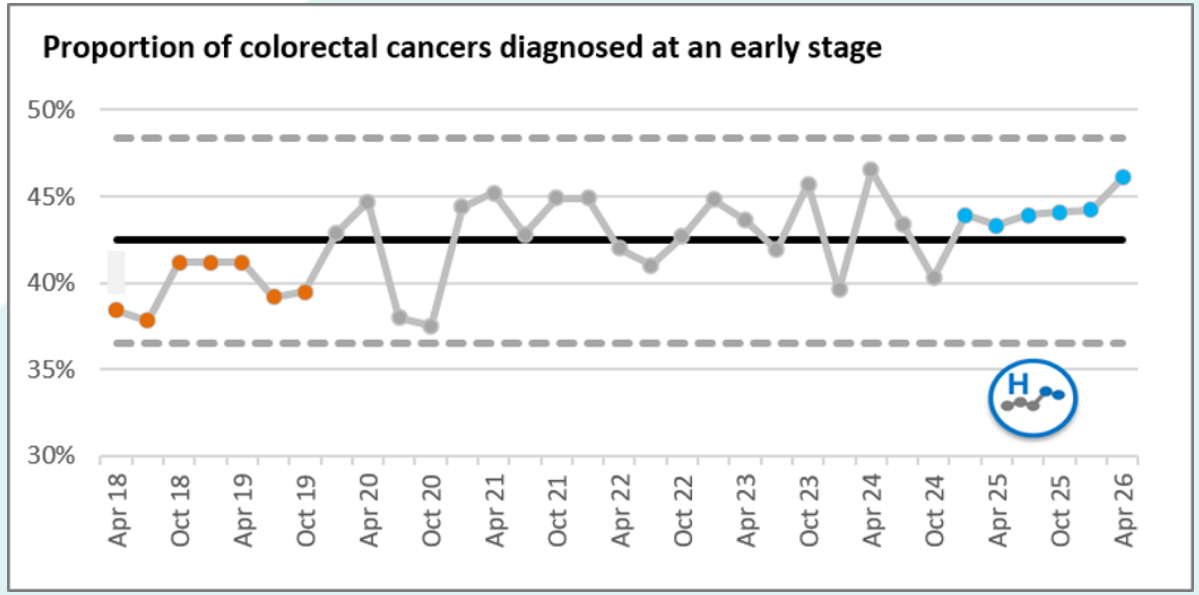
Information notes

- West Essex currently included in CE figure
- SPC chart to replace above chart when completed.
- Monthly reporting being calculated for next report

1.8. Increase the proportion of cancers diagnosed at an early stage (initial focus on bowel cancer)

Commentary

- For Central East latest data, Feb-Apr2026, shows that 46.1% of people with a new diagnosis of colorectal cancer within the last 12 months were diagnosed at an early stage.
- Data are reported on a quarterly basis, with no further data published since the last report.
- Early diagnosis of colorectal cancer significantly improves 5-year survival.



Proportion of new colorectal cancer diagnoses in the last 12 months that were diagnosed at stage 1 or 2			
Baseline	Central East	East of England	National
	46.1%*	-	-
Data Source (current)	NHSE National Disease Registration Service (NDRS)		
Frequency	Quarterly		
*Current data includes West Essex			

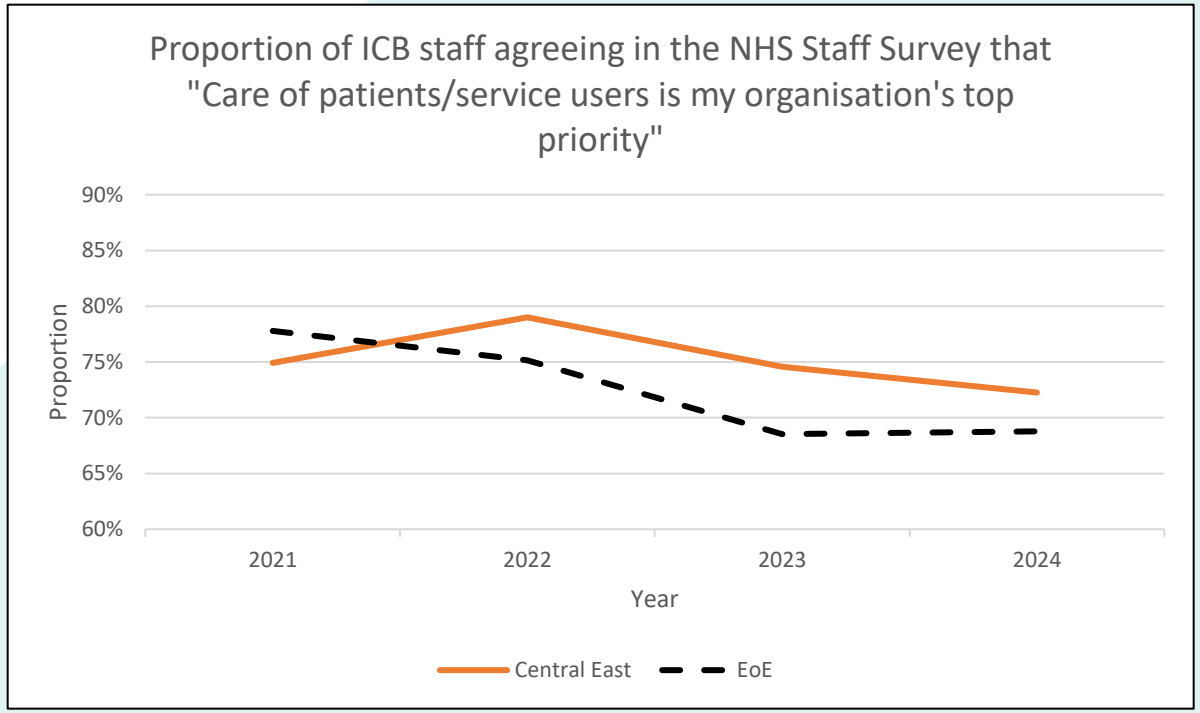
Information notes

- Data are published on a quarterly basis, with the most recent data from April 2026 .
- Colorectal cancers include all bowel and anal cancers.

1.9. Increase the percentage of ICB staff agreeing that “Care of patients/service users is the organisation’s top priority”

Commentary

- Data from the most recent available year from the ICB staff survey for Central East show that 72.3% of staff agree that “care of patients/service users is the organisation’s top priority”.
- The figure for Central East is above the regional figure (68.8%), though no statistical analysis is applied to test for significance.



Proportion of ICB staff agreeing in the NHS Staff Survey that “Care of patients/service users is my organisation’s top priority”			
Baseline	Central East	East of England	National
	72.3%*	68.8%	-
Data Source (current)	NHS Staff Survey (Q25a)		
Frequency	Annual		
*Current data includes West Essex			

Information notes

- Central East ICBs did not participate in the 2025 NHS Staff Survey. The most recent data available are for 2024.

Glossary of terms

Term	Definition
Type 1 Emergency Department	A consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.
Type 2 Emergency Department	A consultant led single specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.
Other types of Emergency attendances (including Type 3 & 4)	These include other type of A&E/Urgent Treatment Centre (UTCs)/ Minor Injury Units (MIUs)/Walk-in Centres (WiCs)/Urgent Care Centre, primarily designed for the receiving of accident and emergency patients.
Open pathway	An active referral awaiting treatment or clinical decision covering the period between the point of acceptance of referral from general practice for specialist before the point when treatment begins, is declined or not deemed clinically necessary.
Completed pathway	A referral that has been “closed” through the initiation of treatment, management advice, a decision not to treat, or discharge from the service.
Colo-rectal cancer	Cancers of the colon, rectum and anus
Early stage cancer diagnosis	Early stage diagnosis of cancer is a diagnosis that is made at stage 1 (small and localised) or stage 2 (locally invasive)

NHS
Central East
Integrated Care Board

Report to:	Board of the NHS Central East ICB			
Date of meeting:	25 September 2026			
	Meeting in public	☒	*Meeting in private*	☐
Item 10:	People Update - Culture			
Executive lead:	Tania Marcus, Director of People and Culture			
Report author:	Tania Marcus, Director of People and Culture			
Reason for the report to the Board:	To update the Board on: • the organisation's response to the Lord Mann Review; • the proposed adoption of the International Holocaust Remembrance Alliance working definition of antisemitism and the Government's non-statutory definition of anti-Muslim hostility; • implementation of the NHS Staff Standards; • implementation of the NHS Leadership and Management Framework; • the development of a Central East integrated culture, leadership and inclusion programme.			
Potential Conflicts of Interest	None have been identified			
Report History	N/A			
Recommendation/s:	The Board is asked to: • **Note** the national requirements arising from the Lord Mann Review, the NHS Staff Standards and the NHS Leadership and Management Framework, together with Central East ICB's current position. • **Note** the adoption of the International Holocaust Remembrance Alliance working definition of antisemitism; and the Government's non-statutory definition of anti-Muslim hostility, following prior approval through Chair's action.			

1.0 Executive Summary

1.1 Following a significant period of organisational transition, Central East ICB is now focused on establishing a safe, inclusive, accountable and high-performing organisational culture. As a newly formed organisation, Central East has an opportunity to bring together the strongest elements of the legacy organisations while establishing consistent expectations, behaviours and management practices across the ICB.

1.2 This work supports the ambitions of Our Way: Strategy to Delivery and the Central East Deal by translating organisational strategy into shared leadership behaviours, management practice and day-to-day staff experience. Our Way establishes a line of sight from organisational enablers and culture through to delivery and Board accountability.

1.3 This report brings together three related national and organisational priorities:

- the response to the Lord Mann Review into tackling racism and antisemitism in the NHS;
- implementation of the NHS Staff Standards
- implementation of the NHS Leadership and Management Framework

1.4 These workstreams will be consolidated into a single Culture, Leadership and Inclusion Programme aligned with the Central East Deal, Our Way: Strategy to Delivery and the organisation's six organisational development and culture priorities.

1.5 The People and Culture Directorate will coordinate the programme. However, the creation and maintenance of an inclusive, safe and high-performing culture will remain a collective responsibility of the Board, Executive Directors, senior leaders, line managers and all colleagues.

1.6 Progress will be monitored through a proportionate performance and assurance dashboard. The Remuneration and Workforce Committee will receive quarterly reports and escalate significant risks or concerns to the Board. An annual report will provide the Board with an overall assessment of progress, impact and priorities for the following year.

2.0 Key Implications

2.1 Financial implications

Initial assessment and planning will be undertaken within existing resources. Implementation will require organisational capacity for leadership and management development, policy review, engagement, training and performance reporting. Any additional investment will be considered through the established business-planning and budget-setting process.

Over time, improved management, wellbeing and staff experience should support retention, attendance, engagement and organisational effectiveness. These benefits will be monitored through the proposed performance framework.

2.2 **Equality and / or health inequalities implications**

The programme is intended to have a positive equality impact by strengthening the organisation's approach to racism, sexual safety, inclusive leadership, wellbeing and flexible working. Equality and Health Inequalities Impact Assessments will be completed for relevant policies and implementation proposals.

2.3 **Engagement**

Implementation will be developed with staff, staff networks, trade unions, managers and relevant community partners. Engagement will inform the detailed action plan, test whether reporting and support arrangements are trusted and accessible and promote shared ownership of cultural improvement.

2.4 **Green Plan commitments**

No direct environmental or carbon reduction impacts have been identified within this report.

2.5 **Risk**

The principal risks are:

- inconsistent staff experience and management practice;
- failure to meet relevant national standards and assurance expectations;
- reduced staff confidence, engagement and retention; and
- regulatory and reputational consequences.

These risks will be mitigated through baseline assessment, clear executive ownership, staff engagement, policy and process review, targeted development, performance monitoring and committee oversight.

3.0 Report

3.1 Strategic alignment

The Lord Mann response, Staff Standards, Leadership and Management Framework and EDI action plan will be delivered as one integrated culture programme. The programme will support the Central East Deal and six OD and culture priorities:

- strategic clarity and alignment;
- leadership excellence and accountability;
- a high-performance culture;
- organisational capability;
- talent, succession and workforce sustainability; and
- inclusion, wellbeing and belonging.

3.2 Lord Mann review

3.2.1 On 4 June 2026, Lord Mann published his review into tackling racism and antisemitism within the NHS. The review contains recommendations intended to support the shared objective of making NHS services safe for patients, communities and colleagues.

3.2.2 The review recognises that, like wider society, the NHS is not immune from racism, including antisemitism and Islamophobia, discrimination or wider inequality

3.2.3 Lord Mann's review set out a range of recommendations for NHS organisations and leaders. Collectively, these measures aim to:

- strengthen leadership and accountability,
- improve understanding and capability through training and development,
- set clear expectations regarding political identifiers and inclusive practice,
- improve and standardise support and protection for staff who experience racism,
- improve the consistency, quality and application of data relating to racism.

3.2.4 NHS England has set out a series of immediate actions for NHS organisations to take following the Lord Mann review. These are:

a) To join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles. The principles are:

1 – Name Racism

2 – Understand and Acknowledge

3 – Meaningfully Involve Communities

4 – Collect and Publish Data

5 – Identify Racial Bias

6 – Apply a Race-critical Lens

7 – Evaluate and Reflect

Central East ICB recognises the importance of these principles. Their emphasis on evidence, meaningful involvement, accountability and evaluation can also inform the organisation's wider approach to tackling discrimination and disadvantage. While there is already good synergy with The Our Way Strategy and The Central East Deal, adopting these principles supports us in policy development, contracting and developing the skills of our people.

b) Ensure implementation of the Violence Prevention and Reduction Standard, including data capture and use to target improvement with affected groups, this will be monitored via the NHS Oversight Framework

c) Implement the NHS Staff Standards

d) Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia

e) Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months)

f) Ensure Board agreement to undertake new anti-racism training when it becomes available.

g) Ensure colleagues, staff representatives, patients and communities are aware of your actions through your internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally

h) Ensure your Board and its relevant committees fully understand your staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress.

Some actions will depend on further national guidance, the release of national learning products and the availability of sufficiently robust local staff experience and workforce data. Central East will keep its action plan under review as these arrangements develop.

3.2.5 The legacy ICBs had established a range of EDI initiatives, including reciprocal mentoring, associate executive development, staff networks and organisational action plans. Central East will review and consolidate the most effective elements of this work into a single EDI Strategy and action plan, incorporating relevant recommendations from the Lord Mann Review. The strategy will address Central East's responsibilities as an employer, a strategic commissioner and a partner accountable to the populations and neighbourhoods it serves.

3.2.6 In addition NHSE asked for confirmation, by 31 July 2026, as to whether every NHS organisation has, or has not, adopted the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and the Government definition of anti-Muslim hostility.

3.2.7 The International Holocaust Remembrance Alliance (IHRA) definition of antisemitism is:

> "Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities."

3.2.8 The Government definition of anti-Muslim hostility is:

> "Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.
>
> It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.
>
> It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life."

3.2.9 The Remuneration and Workforce Committee considered the adoption of both definitions. Following the Committee's support, Chair's action was taken to approve their adoption. The Board is now asked to note that decision.

3.3 Central East response, governance and assurance

3.3.1 Develop a Central East EDI implementation plan and EDI policy to include compliance and assurance against legal requirements and several national standards and frameworks for EDI which will be approved at the Remuneration and Workforce committee and published online.

3.3.2 Board responsibility

The Board is responsible for providing strategic leadership and oversight of the organisation's response to the Lord Mann Review and for ensuring that Central East ICB maintains a culture in which racism, antisemitism, discrimination and exclusion are actively challenged.

3.3.3 Visible Board leadership

- regular anti-racism and inclusive leadership development;
- consideration of equality and inclusion within strategic decision-making;
- scrutiny of workforce equality and staff experience information;
- oversight of organisational responses to racism and discrimination;
- promotion of psychological safety and speaking up;
- ensuring that concerns are managed fairly, sensitively and promptly; and
- inclusion of meaningful EDI objectives within Executive Director and senior leadership appraisals.

3.3.4 Committee assurance

The Board will receive regular assurance regarding implementation of the Lord Mann Review recommendations through updates to the Remuneration & Workforce Committee. Progress will be monitored through a combination of governance oversight, workforce metrics, staff experience measures and compliance reporting.

3.4 NHS staff Standards

3.4.1 The NHS Staff Standards establish national minimum expectations for employers across six areas. Central East ICB intends to use the standards as the basis for strengthening its employment practice and staff experience, while further national guidance on implementation and assurance arrangements is developed..

3.4.2 The six Staff Standards are:

1. **Line Management** – ensuring staff receive high-quality management support and that line managers are equipped to fulfil their role effectively.
2. **Health and Wellbeing** – promoting healthy working environments, access to occupational health services, wellbeing support and appropriate workplace facilities.
3. **Violence Prevention and Reduction** – creating safer workplaces and reducing incidents of violence and aggression towards staff.
4. **Championing Sexual Safety** – ensuring that sexual misconduct, harassment and inappropriate behaviour are actively prevented and addressed.
5. **Tackling Racism** – promoting inclusion, equity and anti-racist practices across NHS organisations.
6. **Promoting Flexible Working** – supporting flexible approaches to work wherever operationally possible.

3.4.3 The standards are intended to complement existing staff experience initiatives, including the NHS People Promise, and provide a measurable framework for action

3.4.4 Successful implementation of the NHS Staff Standards and Leadership and Management Development Framework will require visible commitment and accountability at every level of the organisation.

3.4.5 An initial review has been undertaken to provide an early indication of Central East's position as a newly formed organisation and this will be reported and reviewed at the Remuneration & Workforce Committee

3.5 NHS Leadership and Management Framework

3.5.1 The NHS Leadership and Management Framework provides a national approach to developing leaders and managers. It responds to reviews of NHS leadership, including the Messenger Review and Kark Review, and supports delivery of the NHS 10 Year Health Plan

3.5.2 The framework consists of:

- a Leadership and Management Code setting out the principles and behaviours expected of NHS leaders and managers;
- nationally consistent standards and competencies for clinical and non-clinical leaders and managers; and
- a national curriculum setting out development expectations at different levels, which is expected to be published in winter 2026

3.5.3 The framework covers four broad leadership and management stages:

1. fundamental, including aspiring and first-time managers;
2. mid-level leaders and managers;
3. senior leaders and managers; and
4. Board-level leaders and managers.

The framework is designed to provide a common foundation, with expectations tailored to different levels of leadership and management. Central East will map relevant roles to the most appropriate stage and provide guidance on the development expected for each role.

3.5.4 Implementation will include alignment of:

- recruitment and selection;
- induction and orientation;
- leadership and management development;
- appraisal and objective setting;
- talent and succession planning;
- behavioural expectations;
- relevant people policies; and
- performance and accountability arrangements.

3.5.5 This work aligns with Our Way: Strategy to Delivery and the Central East Deal by supporting consistent professional standards, clear accountability, learning, collaboration, inclusion and continuous improvement.

reduce the risk of fragmented or duplicative activity.

3.6.5 The Nolan Principles will continue to inform how the organisation leads, makes decisions, manages resources and engages with staff, partners and communities.

3.6.6 The programme will be structured around six priorities:

1. Strategic Clarity and Alignment.
2. Leadership Excellence and Accountability.
3. High-Performance Culture.
4. Organisational Capability.
5. Talent, Succession and Workforce Sustainability.
6. Inclusion, Wellbeing and Belonging.

3.6.7 Programme Governance - The Executive Team will oversee the Culture, Leadership and Inclusion Programme. The Director of People and Culture will be the Executive

4.0 Conclusion

4.1 The Lord Mann Review, NHS Staff Standards and NHS Leadership and Management Framework collectively represent a significant opportunity for Central East ICB to strengthen its organisational culture, leadership capability, inclusion agenda and staff experience. Whilst each initiative has distinct national requirements, they share a common focus on creating safe, inclusive, accountable and high-performing organisations in which staff are supported to deliver the highest standards of care and service.

4.2 As a newly formed organisation, Central East is well placed to adopt an integrated approach which aligns these national expectations with Our Way: Strategy to Delivery, the Central East Deal and the organisation's wider organisational development priorities. Bringing these workstreams together within a single Culture, Leadership and Inclusion Programme will support consistency, reduce duplication and provide a clear framework for leadership accountability, staff engagement and organisational improvement.

4.3 The successful delivery of this programme will require visible commitment from the Board, Executive Team, senior leaders, managers and staff. Through strong governance, meaningful engagement and robust assurance arrangements, the ICB will seek to create an environment where everyone

feels safe, valued, respected and able to contribute fully, while ensuring compliance with national requirements and strengthening organisational effectiveness.

4.4 Progress will be monitored through the proposed assurance and performance framework, with quarterly oversight provided by the Remuneration and Workforce Committee and annual reporting to the Board on progress, impact, risks and future priorities.

4.5 The Board is therefore invited to:

- **Note** the organisation's response to the Lord Mann Review, NHS Staff Standards and NHS Leadership and Management Framework and the proposed integrated approach to implementation; and

- **Note** the adoption of the International Holocaust Remembrance Alliance working definition of antisemitism and the Government's non-statutory definition of anti-Muslim hostility, previously approved through Chair's Action.

NHS
Central East
Integrated Care Board

Report to:	Board of the NHS Central East ICB
Date of meeting:	25 September 2026
	Meeting in public ☒ *Meeting in private* ☐
Item 11:	Central East ICB Winter Plan
Executive lead:	Maria Wogan – Executive Director of Neighbourhood, Place and Partnerships
Report author:	Caroline Zwierzchowska-Dod - Head of System Coordination Centre Ed Knowles – Director of Neighbourhood, Place and Partnerships – Hertfordshire
Reason for the report to the Committee:	Decision and approval
Potential Conflicts of Interest	No potential conflicts of interest identified.
Recommendation/s:	The Board is recommended to: 1) **note** the current draft Central East ICB Winter Plan 26/27 (Annex A), 2) **confirm** that it is **assured** with the Board Assurance statements as currently drafted (Annex B) 3) **Note** the further activity required, prior to final submission on 07 October 2026, in relation to the following statements: A1.1; A1.2; B2.2; B2.4; B2.5; B3.1; B4.1 and B 5.1 4) **Agree** that the final assurance of outstanding statements and submission will be made through Chair's action with advice from the deputy chief executives.
Our Way Summary	Supports improving access to care, making the NHS financially sustainable and more productive, and supporting people to stay in work and remain economically active wherever possible.
Priority programme alignment:	Supports population health management, neighbourhood delivery, workforce resilience and system preparedness
Life cycle stage:	*Indicate which stage of the commissioning lifecycle this paper relates*

A – Identify and improve	
B – PDSA to produce	
C – Business and investment decision	
D – Commission and mobilise	
E – Assure, learn and optimise	**X**
F – Evolve or sunset	

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	O - Business as usual			
Matrix alignment:	*To be confirmed before submission*			
	Finance and contracts	x	Clinical/Quality	x
	Utilisation management	x	Population health and BI	x
	Strategic commissioning	x	NbH, place and partnerships	x
	Corporate governance/legal		Communications	x
Impact assessments	An EQIA is in process and will be submitted when complete.			

1.0 Executive Summary

Every ICB is required to submit a 2026/27 Winter Plan to NHSE. Following the publication of NHS England winter expectations and assurance letter on 17 July 2026, partners have been working to address, assess and develop arrangements to meet national and local requirements and the needs of our residents, drawing on lessons learnt from previous winters.

The Central East 2026/27 Winter Plan appended to this report is at a late draft stage. It will remain in development until commissioning decisions have been finalised and provider submissions have been assured by their own Boards and returned (due 30 September 2026). It will be submitted to the national team on 07 October.

Included in this paper, is the Central East Winter Resilience and Seasonal Pressures Plan (Annex A), a summary of Board Assurance Statements and the evidence (Annex B), and the report from the Winter simulation exercise 'Operation Aegis' (Annex C).

2.0 Key Implications

2.1 Financial implications

There are no financial implications related directly to the assurance of the plan. Any new commissioning opportunities will pass through the required processes separate to plan assurance.

2.2 Recruitment implications

As a function of winter plan preparation, recruitment of an additional 2.0WTE to the System Coordination Centre was identified and is being progressed utilising held vacancies to ensure it remains cost neutral.

2.3 Equality and/or health inequalities implications

There is a distinct Equalities Assessment process ongoing alongside the plan development and the outcomes of this will be included within the final winter plan.

2.4 Engagement

System partners have contributed their own winter plans for assurance, participated in the Central East Winter Exercise (Aegis 2026) and have been engaged through place-based and Health and Care partnerships. Engagement from Primary Care is an area which will be strengthened before winter.

2.5 Green Plan commitments

No material Green Plan impact is anticipated. Where operationally appropriate, virtual coordination and system meetings will continue to reduce avoidable travel.

2.6 Risk

Risks to winter delivery are documented within the plan and a summary table is below:

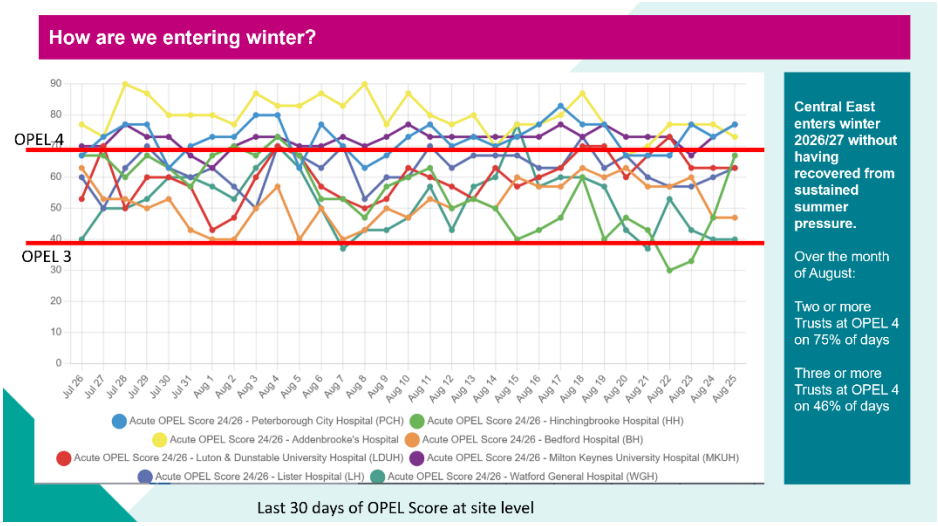
Ref	Risk	Principal mitigation
R1	Sustained UEC demand above planned capacity	Demand/capacity model and surge plan
R2	Workforce capacity and resilience	Workforce resilience and mutual aid register
R3	Seasonal infection, IPC and respiratory illness	Vaccination, IPC and health protection
R4	High occupancy 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 areas	Commissioned frailty capacity mapped by area
R10	Corridor and non-designated care	Requirement for provider submissions of plans
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

3.0 Report

3.1 Context

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. The footprint contains seven acute trusts operating nine acute sites, seven community and mental health trusts, three ambulance services, two NHS 111 providers, 267 general practices and 22 local authorities. This is the first winter planned for as a single ICB, and the plan has been written to work across three legacy ICB footprints rather than as three plans presented together.

Last winter, all eight acute sites were at OPEL 3 or 4 on 92% of days, with an average of 3.6 sites at OPEL 4 at the January peak and nineteen days on which five or more sites were at OPEL 4 simultaneously; higher demand may be anticipated this winter.



The system enters winter without the respite of a quiet summer. Providers have reported remaining in escalation areas and boarding patients through the summer months, a position typically seen only in the winter.

3.2 How the plan has been developed

The plan is structured directly 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 to B8 form the operational spine. Detailed models, evidence, provider plans and supporting procedures sit in the appendices and evidence library rather than being repeated in the narrative.

Each chapter follows the same format: current position and baseline, winter requirement or gap, winter response, assurance and evidence, and residual risk

and action. The intention is that what the Board considers and what NHS England receive are the same document.

Statement leads across the ICB have completed an assurance return for each Board Assurance Statement, setting out what good looks like, the Central East position, the actions and interventions above business as usual, the evidence base, an equalities assessment and the residual risks. Those returns are summarised at Appendix A of the plan and held in full at Appendix B of the plan.

The draft plan will be submitted for comment, to NHSE regional colleagues and circulated to partners to aid their own system planning assurance requirements, prior to final submission on 07 October 2026.

3.3 Provider assurance

All fourteen NHS provider winter plans have been assessed against a common Central East statement set. The assessment is evidence-based: each statement is located in the provider's own submission with a section or page reference, a recorded gap and a RAG rating, rather than accepted on assertion.

Every provider has received a written feedback sheet setting out the position statement by statement, with suggestions to strengthen the plan before their own Board Assurance Statement is submitted to NHS England. This further evidence will strengthen our own assurance in sections 3 & 4.

The dominant finding is that arrangements generally exist but are not quantified. Providers describe escalation capacity, isolation capacity, mutual aid and occupancy reduction without always attaching numbers, dates, owners or triggers to them. These gaps have been raised with providers and a request for further evidence has been made.

Some gaps are common to the system rather than specific to any one provider:

- Pre-Christmas and holiday-period occupancy,
- Corridor care reduction measures,
- Baselines and plans against the model discharge pathway.

In addition, three community providers have declared that bed escalation capacity is not available to them without additional funding. This is recorded on the ICB winter risk register as a commissioning matter rather than as a provider gap and will require further consideration by Central East ICB in the context of any additional activity it may choose to fund.

3.4 Learning from Exercise Aegis 2026

The Central East winter exercise was held on 08 September 2026 with over 30 acute, community, mental health, ambulance, NHS 111 and local authority partners alongside and ICB and NHSE Region participation. Gaps in

representation from primary care, children's services and voluntary sector partners have been noted and are being addressed through the remaining engagement on planning for this winter. The exercise ran a sustained extreme pressure scenario set at 15 January with all planned winter mitigations already deployed, layering community discharge failure, a mental health and primary care surge, and workforce exhaustion with industrial action. The scenario did not reset between injects.

The exercise was designed to test plans rather than to demonstrate that the system copes, and it did what was intended. It exposed where local decisions displace risk into neighbouring areas, where escalation thresholds are applied inconsistently between areas, and where shared services cannot deliver what individual areas had assumed. Providers recorded the changes they will make to their own winter plans, and those changes are being incorporated ahead of submission. Attendance also closes the national requirement that a Board Assurance Statement should not be submitted until the plan has been tested at a winter exercise.

3.5 What the plan commits the ICB to

The plan is not solely an assurance of provider arrangements. It sets out what Central East commissions and coordinates, and the areas where the ICB itself must act. The ICB is responsible for:

- convening the whole-area winter plan;
- commissioned capacity in primary care,
- community services and mental health;
- jointly commissioned social care and intermediate care;
- coordination of the winter response through the System Co-ordination Centre;
- assurance of infection prevention and control;
- leading prevention, vaccination of flu, COVID-19 and RSV uptake and proactive support for those most at risk.

3.6 Position on the Board Assurance Statements

ICB		
	Overall Assessment Rating: 5 - Full assurance	
		Rating
Section A	Governance	**5 - Full assurance**
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**

Of the statements the Board is asked to assure, the majority are well-evidenced. The following are the areas where the Board's attention is most useful. Partial assurance indicates where further work is in progress prior to completion of the submission on 7th October:

Statement	Position at 25 September
A1.1 Board assurance of the plan	This paper. Sign-off is sought subject to delegation to Chair's action on advice from the Deputy CEOs
A1.2 Quality and equality impact assessment	In progress. The outcome will be included in the final plan before submission.
B2.2 Corridor care	Partial. Baselines, safety thresholds and Board oversight are absent at several providers and have been requested
B2.4 Model discharge pathway baseline	Partial. A baseline and actions have been requested from providers who have not yet submitted them.
B2.5 Pre-Christmas occupancy reduction	Partial. Agreed and dated at some providers and requested from others.
B3.1 Whole system demand and capacity modelling	This is still in progress.
B4.1 Primary care demand	Assured. Capacity is commissioned and operating and will be further assessed once system demand and capacity modelling is complete
B5.1 Urgent community capacity commissioning	Assured. Capacity is commissioned and operating and will be further assessed once system demand and capacity modelling is complete

3.7 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 following are in progress: 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 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. B3.2 on workforce, mutual aid and NHS 111 arrangements are waiting on further provider submissions but are anticipated to be 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 organisation the ICB is building its ability to demonstrate from its own data that capacity is sufficient and being used effectively.

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 an ICB 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 ICB 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 Central East. 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 when seven or more sites are at OPEL 4.

3.8 Practice worth noting

The assessment also identified work and examples of best practice that we can share across providers in Central East as system learning. Examples include :

- West Hertfordshire Teaching Hospital's Stronger Systems, Safer Care pre-Christmas programme and its Model Discharge baseline with named action owners are being shared system-wide.
- North West Anglia's bed modelling, which included a worst-case scenario alongside forecast and to cost escalation capacity and also reported patients with no criteria to reside by pathway.
- East and North Hertfordshire Hospital Trust's escalation-space patient safety governance, which requires executive approval to open escalation areas, individual patient risk assessment, and monitoring of cumulative impact on patient safety, dignity and experience.
- Hertfordshire Community NHS Trust's rigorously quantified OPEL trigger framework, with thresholds set across beds, staffing, caseload and community intravenous therapy capacity.
- Bedfordshire Hospital's pre- and post-Christmas decompression events with external partner support, one of only three agreed pre-Christmas programmes in Central East.

4.0 Next steps

The Board is recommended to:

1) **note** the draft Central East ICB Winter Plan 26/27 (Annex A)

2) **confirm** that it is **assured** with the Board Assurance statements as currently drafted (Annex B)

3) **Note** the further activity required, prior to final submission on 07 October 2026, in relation to the following statements: A1.1; A1.2; B2.2; B2.4; B2.5; B3.1; B4.1 and B 5.1)

4) **Agree** that the final assurance of outstanding statements and submission will be made through Chair's action with advice from the deputy chief executives.

List of appendices

Annex	Document
A	Draft Central East Winter Resilience and Seasonal Pressures Plan 2026/27
B	Board Assurance Statement summary document – current draft
C	Winter stress test report – Operation Aegis

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Report to the:	Board of the NHS Central East ICB			
Date of meeting:	25 September 2026			
	Meeting in public	☒	*Meeting in private*	☐
Item 13:	Chief Executive's Report			
Executive lead:	Jan Thomas, Chief Executive Louis Kamfer, Deputy CEO Sarah Stanley, Deputy CEO			
Report author:	Dominic Woodward-Lebihan, Chief of Staff			
Reason for the report to the Committee:	For information as part of the business cycle.			
Potential Conflicts of Interest	Not applicable			
Report History	Not applicable			
Recommendation/s:	The Board is asked to **discuss** the report and **note** the content.			
Priority programme alignment:	Not applicable			
Life cycle stage:	*Indicate which stage of the commissioning lifecycle this paper relates*			

A – Identify and improve	
B – PDSA to produce	
C – Business and investment decision	
D – Commission and mobilise	
E – Assure, learn and optimise	
F – Evolve or sunset	
O - Business as usual	X

1.0 Executive Summary

1.1 This report provides and overview of some of the key issues facing Central East, and some headline activities of the CEO and Deputy CEOs since the last Board meeting in June.

1.2 Our Way – Next Steps

We continue to establish our new organisation around the *Our Way* strategy, approved by the ICB Board in April. To this end, the second report from the ICB's new Delivery Unit on the nine Priority Programmes presented in *Our Way* is available as part of today's Board agenda. Likewise, our draft commissioning intentions for 2027-29, also presented today, reflect the ambitions presented in *Our Way.*

Underpinning our focus on delivery is our mission the improve how we use data, as part of which we are continuing to build a single data platform based on the *DELPHI* segmentation capability already in place in Hertfordshire. We expect this to be operational in Autumn 2026.

Risks to delivery are increasingly aligned to the Board Assurance Framework (BAF), providing the Board with clear line-of-sight between strategic objectives, programme delivery, and associated risks. The latest BAF is presented to the ICB Board today.

1.3 Planning for Winter

Following the publication of NHS England's winter expectations and assurance letter on 17th July 2026, ICB colleagues have been working closely with system parters to develop our Winter Plan. Our Plan, which builds on lessons learnt from previous winters, is focussed on meeting the needs of CE residents and national requirements.

1.4 Neighbourhood Health

Neighbourhood Health is a central pillar of the government's 10 Year Health Plan, and one of the nine priority programmes presented in ICB's *Our Way* strategy. We are pleased to note the Central East Neighbourhood Health Team specification continues to receive diverse and expert input from system partners and beyond – including at recent and well attended Frailty Conferences. Further information can be found here: Neighbourhood Health Teams: Foundations, and the First Service Offer for People Living with Frailty as we work towards our clear ambition of establishing a Neighbourhood Health Team in every neighbourhood by 1 April 2027, prioritising people with frailty as the initial cohort.

1.5 Neighbourhood Health Centres

Neighbourhood Health Centres aim to provide an important physical and operational tool to support the developing neighbourhood health model. Following our return of our initial pipeline of sites for potential, new Neighbourhood Health Centres, we await a decision from NHSE & DHSC on those which are successful at this stage. We have published a update for residents here, given the keen interest in this area. Separately, we are pleased to see work to improve outcomes for patients with hypertension in Bedford be nominated for two national awards, alongside a 7.5% rise in Primary Care appointments across Central East.

1.6 ICB Transformation

We continue to move forward with our organisational transition programme. In October 2026, we will host the last of our four intensive orientation events, designed to support all new staff to feel confident in understanding the purpose, priorities, and operating model of Central East. We also continue to support those staff leaving the organisation to do so well.

Since the last Board meeting the Chief Executive and Deputy Chief Executives have met with a range of partners, including Local Authority CEOs, NHS Provider Chief Executives, Hospice Leaders, and with Central East's cohort of MPs, and Council Leaders/Health Portfolio holders. These engagements support to shape the ICB's work to reduce utilisation and improve health outcomes, and to be clear on the support we need from partners to do this well.

2.0 Recommendation

The Board is asked to **discuss** the Chief Executive's Report and **note** the content.

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Report to the:	Board of the NHS Central East ICB			
Date of meeting:	25 September 2026			
	Meeting in public	☒	*Meeting in private*	☐
Item 14:	Risk Management Update			
Executive lead:	Karen Barker, Executive Director of Corporate Services and ICB Development			
Report author:	James Bielby, Legal Lead / Corporate and Systems Risk Manager			
Reason for the report to the Committee:	Assurance			
Recommendation/s:	The Group/Committee is asked to: • **Note** the following: ○ the progress made in developing the Central East ICB Risk Management Framework. ○ the proposed role of risk appetite in supporting risk management and escalation • **Support** the following: ○ the principle that risks are owned and managed through committee structures. ○ further development of measurable indicators and early warning metrics for Board, Corporate and Operational Risks to strengthen ongoing assurance arrangements.			
Life cycle stage:	*Indicate which stage of the commissioning lifecycle this paper relates*			

A – Identify and improve	
B – PDSA to produce	
C – Business and investment decision	
D – Commission and mobilise	
E – Assure, learn and optimise	**x**
F – Evolve or sunset	
O - Business as usual	

Matrix alignment: *Indicate which teams have been involved in the production of the paper*

Finance and contracts	x	Clinical/Quality	x
Utilisation management	x	Population health and BI	x
Strategic commissioning	x	NbH, place and partnerships	x
Corporate governance/legal	x	Communications	x

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1.0 Executive Summary

1.1 This paper provides an update on the development of the Central East ICB Risk Management Framework and seeks to improve understanding of how risk will be identified, measured, managed, and escalated across the organisation.

1.2 The proposed framework establishes a clear "line of sight" from operational risks through committee oversight arrangements to the Corporate Risk Register (CRR) and Board Assurance Framework (BAF). It is designed to ensure that risks are managed at the lowest appropriate level, supported by evidence and measurable indicators, and escalated only where they exceed local authority to manage, move outside the Board's agreed risk appetite, or threaten delivery of strategic objectives and deliverables.

1.3 The framework also introduces a more data-driven approach to risk management, using strategic measures and Statistical Process Control (SPC) methodology to support objective assessment of risk trends rather than relying solely on subjective judgement.

2.0 Key Implications

2.1 **Financial implications** - There are no direct financial implications arising from this report; however, the framework enhances the ability to manage financial risk, maintain statutory financial duties, and drive value for money through improved oversight.

2.2 **Equality and / or health inequalities implications** - The inclusion of inequalities within the BAF ensures systematic identification and mitigation of risks relating to equitable access, experience and outcomes.

2.3 **Engagement** - Engagement has been undertaken with the Executive Management Team and Non-Executive Members of the Board. Further engagement will be required with risk owners and committees to embed accountability.

2.4 **Green Plan commitments** - The framework provides a mechanism for identifying sustainability and climate risks where relevant.

2.5 **Risk** - This paper strengthens the identification, escalation and management of strategic risks impacting statutory duties and delivery of objectives.

3.0 Report

3.1 The Central East ICB is developing a risk management framework to support delivery of its strategic objectives and statutory responsibilities.

3.2 The framework is based on the principle that risk management is a core leadership responsibility and forms part of normal operational and strategic decision-making. Risks should not be managed centrally in isolation. Instead, risks are owned, reviewed and controlled by the committees, teams and executives responsible for delivering the services or objectives affected by the risk.

3.3 The framework consists of three interconnected levels:

Board Assurance Framework (BAF)

The BAF contains the strategic risks most likely to prevent delivery of the ICB's strategic objectives and statutory duties. These risks are owned by the Board and receive scrutiny through the relevant committees before reporting to the Board.

Corporate Risk Register (CRR)

The CRR contains significant corporate, cross-cutting or complex risks that require Management Executive Team oversight and committee assurance. These risks may affect multiple services, programmes or strategic objectives but do not necessarily warrant inclusion within the BAF and are informed by the requirements under the National Oversight Framework.

Operational Risk Registers

Operational risk registers are maintained by committees, programmes and teams and contain risks affecting the delivery of services, programmes and operational objectives. These represent the foundation of the risk management framework and are the primary source of risk identification and management. Initial risks were informed by the committee terms or reference and the national oversight farmwork.

Risk Governance and Escalation

3.4 The proposed framework is based upon the following principle:

3.5 Risks should be managed at the lowest appropriate level and only escalated where they require organisational oversight, exceed risk appetite, or threaten delivery of strategic objectives.

3.6 This ensures that ownership remains with those best placed to understand and manage the risk whilst maintaining appropriate Board oversight.

3.7 Risk assurance will be provided through the reporting of statistical process controls (SPC), Committee review and internal audit arrangements.

Committee Ownership of Risks

3.8 Each committee is responsible for maintaining oversight of risks within its remit and ensuring:

- Risks are regularly reviewed.
- Appropriate controls are in place.
- Mitigating actions are identified and delivered.
- Performance and assurance information supports decision making.
- Risks are escalated where required.

3.9 The table at appendix A summarises the whole risk environment and responsible Committees.

3.10 Risks may move between the registers:

Operational Risk Register → Corporate Risk Register → Board Assurance Framework depending on significance, impact and organisational exposure.
Escalation is not intended to transfer ownership.
Committees remain accountable for managing and mitigating the risks within their areas of responsibility.

Requirements for Adding a New Risk

3.11 The proposed framework seeks to ensure that risks are evidence-based and capable of meaningful management.

3.12 A risk should not be added to a risk register solely because there is concern that something may happen. The Committee should be satisfied that there is evidence demonstrating that a credible risk exists.

3.13 To propose a new risk, risk owners should provide:

Evidence

As much clear measurable evidence as required to demonstrate the existence of the risk, including:

- Performance information.
- SPC analysis where applicable.
- Audit findings.
- Inspection reports.
- Incident data.
- Financial information.
- Stakeholder intelligence.
- Trend analysis.

Risk Description

- A clearly articulated risk statement explaining:
- The cause of the risk.
- The risk event.
- The consequence if unmanaged.

Mitigating Actions

3.14 Specific actions that:

- Address the root causes/ drivers of the risk.
- Have clearly identified owners.
- Have defined delivery dates.
- Are capable of being monitored and evaluated.

Expected Impact

3.15 A description of:

- How the proposed action will reduce the likelihood of the risk occurring.
- How the action will reduce consequences if the risk occurs (where possible).
- How the action will reduce risks to patients, service users, staff or organisational objectives.
- What evidence will demonstrate successful mitigation.

3.16 This approach aims to ensure that risk registers remain focused on genuine risk exposures and do not become action logs or issue registers.

Measuring Risk

3.17 The framework proposes a consistent approach to risk scoring across all levels of the organisation.

3.18 Each risk will be assessed using two key components:

Impact

3.19 Impact measures the severity of harm or consequence should the risk materialise. Impact assessments are based on agreed organisational criteria covering areas such as:

- Patient safety
- Quality of care
- Service performance
- Financial impact
- Regulatory compliance
- Workforce

- Reputation
- Strategic delivery

3.20 Impact scores remain relatively stable unless the potential consequences of the risk change significantly. It is anticipated that assessment of potential impacts will be largely qualitative and that most risk impacts will be between 3 and 5. A summary of the risk impact matrix can be found at Appendix B.

Likelihood

3.21 Likelihood reflects the probability of the risk occurring.

3.22 Unlike traditional risk models that often rely heavily on subjective judgement, the new framework proposes greater use of measurable evidence and trend analysis to determine likelihood. Appropriate measures have been agreed for the BAF, and committees should prioritise the identification of suitable measures for other risks assigned to them. A summary of the Statistical Process Control (SPC) approach is below. A task and finish group has been established which can help risk owners and risk assessors to establish risk scores.

Using Strategic Measures and Statistical Process Control

3.23 The proposed framework introduces the use of Strategic Measures (SM1-SM9) for the BAF and Statistical Process Control (SPC) to provide objective evidence regarding whether risk is increasing or decreasing over time.

3.24 The *approach shifts risk assessment from:*

- Single point performance reporting
- Target-based judgements
- Subjective confidence assessments

towards:

- Trend analysis
- Continuous monitoring
- Data-driven assessment of risk likelihood.

In simple terms, SPC helps distinguish between:

- Normal variation that occurs naturally within a system.
- Genuine signs of improvement.
- Genuine signs of deterioration requiring intervention.

Practical *Example*

3.25 If waiting times steadily worsen over several months and SPC identifies a

statistically significant deterioration, this would indicate an increasing likelihood that strategic objectives relating to access may not be achieved. The likelihood score would therefore increase. Conversely, sustained improvement would reduce likelihood scores.

3.26 The underlying principle is:

"Risk is no longer what we think; it is what the data tells us." Andrew Palmer and his team in Population Health Analytics& Evaluation have been central to the development of this process and it is advised that the committee consult them when establishing appropriate risk measures.

Risk Appetite

3.27 Risk appetite is a fundamental part of the framework and supports consistent decision making throughout the organisation.

Risk appetite can be described as:

The amount of risk the organisation is willing to accept in pursuit of its objectives.

Risk appetite helps committees determine*:*

- Whether a risk level is acceptable.
- Whether additional controls are required.
- Whether escalation is necessary.
- How quickly intervention is required.

Proposed Risk Appetite Levels

Appetite	***Description***
Averse	*Very little or no tolerance for risk*
Cautious	*Limited risk accepted with close controls*
Balanced	*Risk managed proportionately*
Open	*Greater willingness to accept risk to support transformation*
Seeking	*Risk actively accepted to pursue innovation and opportunity*

3.28 *Examples include:*

- *Patient safety and quality risks:* ***Averse***
- *Financial sustainability:* ***Cautious***
- *Transformation and innovation:* ***Open***
- *Service redesign programmes:* ***Balanced***

A summary of the ICB's risk appetite can be found at Appendix C

Impact on Escalation

- Where risk exposure exceeds the Board's appetite, the expectation is that:
- Additional mitigating actions are identified.
- Increased assurance is sought.
- The risk is reviewed by the responsible committee.
- Escalation *to EMT, ARC or Board is considered where appropriate.*

3.29 *Risk appetite therefore acts as an early warning mechanism and supports consistent escalation decisions across the organisation.*

Key Messages

3.30 *The proposed Risk Management Framework is based on the following principles:*

- Risks are owned and managed by the committees and leaders responsible for delivery.
- Risks should be managed at the lowest appropriate level.
- Escalation should occur only where organisational oversight is required.
- All risks must be supported by measurable evidence.
- Mitigating actions must clearly explain how risk exposure will be reduced.
- Strategic and corporate risks should be supported by objective performance information wherever possible.
- Risk appetite provides the basis for determining acceptable risk and escalation thresholds.
- The framework *promotes a continuous, data-driven approach to assurance and risk management.*
- There is continuity with the original strategic intent presented to the Executive

4.0 Next Steps

- Disseminate Remaining registers to the Committees for further development

List of appendices

Appendix A – Risk Environment Mapping
Appendix B – Risk Impact Matrix
Appendix C – Risk Appetite Summary
Appendix D – BAF

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Appendix A: Risk Environment Mapping

Committee	BAF Risks	Linked CRR Risks	Operational Risks
Neighbourhood Health Delivery Committees	***BAF0001*** *Access, Experience & Inequalities* ***BAF0007*** *Partnerships, Neighbourhoods & Integration* ***BAF0009*** *Population Health Outcomes*	***CRR005*** *Health Inequalities Improvement* ***CRR006*** *Primary Care Access & Sustainability* ***CRR012*** *System Partnership Effectiveness*	*NH001–NH015 (Neighbourhood health plans, health inequalities, Core20PLUS5, primary care access, community capacity, prevention, vaccination & screening, partnership working, place-based finance, population health management, community engagement, provider market stability, estates, shared budgets, integrated pathways)*
Finance, Planning & Payer Function Committee	***BAF0002*** *Financial Sustainability & Value* ***BAF0003*** *Commissioning, Contracting & Market Management* ***BAF0006*** *Data, Digital & Intelligence*	***CRR002*** *Financial Recovery & Sustainability* ***CRR003*** *NHS Productivity & Value Programme Delivery* ***CRR008*** *Data Quality & Assurance* ***CRR011*** *Provider Market Stability (CRR001 partly via BAF0010)*	*FIN001–FIN012 (financial recovery, statutory duties, productivity, activity management, elective recovery funding, CHC growth, provider finance, commissioning effectiveness, investment returns, capital affordability, value-based commissioning, contract performance)*
Utilisation Management & Quality Improvement Committee (UMQIC)	***BAF0004*** *Quality, Safety & Reliability* ***BAF0008*** *Transformation & Delivery Discipline*	***CRR001*** *National Performance Recovery* ***CRR007*** *Mental Health & Learning Disability Performance* ***CRR013*** *Transformation Portfolio Delivery* *(CRR014 linked to BAF0004 but committee ownership sits with ARC)*	*UMQI001–UMQI012 (patient safety, safeguarding, elective access, UEC, cancer, mental health, learning disability outcomes, incident learning, PSIRF, clinical variation, population health risks, quality surveillance)*
Remuneration & Workforce Committee	***BAF0005*** *Organisational Capacity, Capability & Culture*	***CRR004*** *Workforce Transformation & Capacity*	*WF001–WF010 (workforce shortages, recruitment & retention, productivity, wellbeing,*

			leadership, succession planning, organisational redesign, WRES/WDES, Fit and Proper Person compliance, engagement and culture)
Audit & Risk Committee (ARC)	*No dedicated BAF risk currently allocated, although ARC provides assurance over governance, cyber, compliance and EPRR.*	***CRR009*** *Cyber Security & Digital Resilience* ***CRR010*** *Governance & Regulatory Compliance* ***CRR014*** *EPRR*	*ARC001–ARC010 (governance failure, BAF/risk management failure, cyber incidents, IG breaches, EPRR failure, fraud, FTSU, audit actions, governance reporting, risk escalation)*

Additional Measures for risks related to the National Oversight Framework can be found in the Central NOF report.

Appendix B: Risk Impact Matrix

Risk Category	1 – Lowest Impact	2 – Minor Impact	3 – Moderate Impact	4 – Major Impact	5 – Highest Impact
Access, Experience & Inequalities	*Minimal change in access satisfaction; no measurable effect on RTT, detection or A&E.*	*Localised access delays; slight RTT increase; minor satisfaction decline.*	*Noticeable access problems across services; reduced MH treatment; inequality gap widens.*	*Widespread difficulty accessing care; Stage 1–2 cancer detection decrease; A&E increased significantly.*	*System-wide access failure; severe dissatisfaction; major KPI collapse across RTT, A&E, detection, SMI.*
Financial Sustainability & Value	*No material PPPY change; efficiencies hold.*	*<1% PPPY overspend; small avoidable utilisation increased.*	*1–5% overspend; RTT increase; time spent in A&E increase due to weak upstream investment.*	*5–10% overspend; low-value activity persists; KPIs 6,7,8 worsen.*	*>10% overspend; cannot shift care earlier; system KPIs collapse.*
Commissioning, Contracting & Market Management	*Minor contract delay; no KPI shift.*	*Local provider issues affect access/RTT slightly.*	*Multi-pathway performance decline: RTT increased, A&E increased, detection decreased.*	*Market instability harms access, early detection, MH, advanced illness KPIs.*	*Market failure stops pathway delivery; system-wide KPI collapse.*
Quality, Safety & Reliability	*Minor process issue; no KPI impact.*	*Small reliability decline; slight RTT increased or A&E increased.*	*Significant safety/quality lapses; lower cancer detection; MH crisis increased.*	*Serious safety events: SMI beds increased; advanced illness bed days increased; RTT breaches increased.*	*Widespread unsafe care; severe harm; catastrophic KPI deterioration.*
Organisational Capacity, Capability & Culture	*Small capability gap, no KPI change.*	*Local delays; training gaps cause small MH and access declines.*	*Workforce gaps delay access & MH treatment; RTT increased.*	*Unsafe staffing >5 days; SMI beds increased; A&E increased.*	*Workforce breakdown; system cannot deliver reliably; KPIs collapse.*
Data, Digital & Intelligence	*Minor data issues; no KPI effect.*	*Reporting delays slow improvement of RTT/detection.*	*Gaps in PHM data worsen A&E, MH outcomes, proactive care.*	*Major outage/digital triage failure; RTT increased; A&E increased; access worsens.*	*System-wide digital failure; screening/triage*

					collapse; catastrophic KPI impact.
Partnerships, Neighbourhoods & Integration	*Minor integration issue; negligible outcome shift.*	*Delayed info-sharing; small MH and advanced illness coordination effects.*	*Reduced neighbourhood coordination: A&E increased, SMI increased, advanced illness beds increased.*	*Breakdown in local integration: RTT delays increased; crisis presentations increased.*	*System-wide partnership failure; NHT collapse; severe KPI deterioration.*
Transformation & Delivery Discipline	*Minor schedule slip; no KPI change.*	*Slippage affects one pathway (RTT or access).*	*Several pathways fail to scale: MH access decrease; early detection decrease; A&E increase.*	*"Improve-codify-scale" fails; KPIs for detection, RTT, utilisation worsen greatly.*	*Transformation failure across system: access, detection, A&E, PPPY collapse.*
Population Health Outcomes	*Minimal outcome change.*	*Slight worsening in chronic condition outcomes.*	*Noticeable decline in detection, MH treatment, SMI outcomes.*	*Significant outcome deterioration; advanced illness crises increase.*	*System-wide failure in PH outcomes; severe KPI damage.*
Utilisation, Flow & Demand Management	*Minor inefficiency; no KPI change.*	*Slight A&E increase or RTT increase.*	*Flow issues cause RTT increase, A&E increase, SMI increase.*	*Severe, sustained delays; high emergency demand; advanced illness beds increase.*	*Demand overwhelms system; catastrophic KPI deterioration including finance failure.*

Appendix C – Risk Appetite Summary

Appetite Level	**Descriptor**	**Behavior**	**NHS Central East ICB Interpretation -Risk Score**	**Risk Score**
Very Low	Averse	Avoid risk	No tolerance for harm or safety risk	1-4
Low	Cautious	Minimise risk	Tight control (finance, inequalities)	5-9
Moderate	Balanced	Manage risk	Delivery and service change	10-12
Moderate–High	Open	Enable risk	Transformation and redesign	15-16
High	Seeking	Embrace risk	Innovation only	20-25

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Report to the:	Board of the NHS Central East ICB			
Date of meeting:	25 September 2026			
	Meeting in public	☒	*Meeting in private*	☐
Item 15:	Audit & Risk Committee Chair's Alert, Advise and Assure Report – for meeting held on 10 July 2026			
Executive lead:	Sarah Griffiths, Executive Director for Finance, Resources and Contracts			
Report author:	Vitor Ferreira, Chair of Audit & Risk Committee			
Reason for the report to the Board:	Standing Item			
Recommendation/s:	The Board is asked to **note** the report.			

Agenda items covered:

- Corporate Governance Update
- Legacy ICB Internal Audit & Local Counter Fraud Recommendations and Actions
- Risk Management Update
- External Auditor Appointment and Update
- Internal Update - Update and development of 2026/27 Internal Audit Plan
- Local Counter Fraud – Update and Development of 2026/27 Work Pan
- Information Governance Update
- Annual Cycle of Business

ALERT: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy

- None to report

ADVISE: The Board of areas subject to on-going monitoring or development or where there is insufficient assurance

- **Legacy ICB Internal Audit & Local Counter Fraud Recommendations and Actions –** The Committee was presented with a document that brought all of the outstanding legacy Internal Audit recommendations from each of the three predecessor ICBs (Cambridgeshire & Peterborough (CP), Herts & West Essex (HWE) and Bedford, Luton & Milton Keynes (BLMK) together and arranged them, where possible, under headline themes – such as continuing health care & section 117; information governance; procurement & contracts; and risk management, amongst others. The Committee supported the suggestion that the Executive work with the new Internal Audit provider to review each individual recommendation and agree the next step for each in terms of either progressing, re-visiting as part of a planned audit or agreeing to not pursue / close the recommendation as no longer relevant or too low a priority. This work is presently in progress and will be shared with the Committee Chair and members between meetings as and when ready.

  Any outstanding legacy actions relating to local counter fraud will be discussed separately with the ICB's counter fraud provider for them to be covered in the 2026/27 counter fraud work plan.

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ASSURE: Inform the Board where positive assurance has been received

- **Corporate Governance Update -** standing paper received that captures corporate governance matters worthy of reporting. The report for this meeting provide an update and/or assurance on a number of matters, including
  - update being made to the ICB's Constitution to reflect the secondment of the Chief Executive to NHSE England.
  - Fit and Proper Person Test update and confirmation that the 2025/26 submissions (for the three legacy ICBs – Cambridgeshire and Peterborough, Herts & West Essex and Bedford, Luton & Milton Keynes) had been sent to NHSE England by the required deadline of 30 June 2026.
  - Update on progress to implement the Declaration of Interests platform, CIVICA
  - Special payments – none made for the period reported
  - Use of the ICB Seal – none for the period reported

  The Committee has asked that it receive a position update on any legal matters pertinent to the ICB in future reporting.

- **External Auditor Appointment and Update –** The Committee was informed Grant Thornton had been appointed as the External Auditor for Central East ICB. The importance of early engagement between the ICB and its external auditors to manage the complexities associated with the merger arrangements was highlighted. To that end the Committee has urged there is early audit planning and clear communications between the auditors and ICB finance team to ensure that all audit requirements were fully understood well in advance of field work commencing for this year's audit.

- **Internal Audit - Update and Development of 2026/27 Internal Audit Plan –** BDO have been appointed as the Internal Audit provider for Central East ICB. Work to develop and finalise the 2026/27 Internal Audit plan, which will include a percentage of mandatory and/or '*must include'* audits, is in progress. the Committee highlighted that assurance around cyber security, given the ever increasing risk it presented, should be visible and overtly included in this year's plan. To avoid unnecessary delay and with the permission of the Chair, virtual approval of the final plan can be sought from the Committee by virtual means between meetings.

- **Local Counter Fraud – Update and Development of 2026/27 Work Pan** – BDO have been appointed as the Local Counter Fraud provider for Central East ICB. Work is presently underway, in collaboration with the Executive Director for Finance, Resources and Contracting, to develop and finalise the local counter fraud work plan for 2026/27. Similar to the Internal Audit Plan, virtual approval will be sought from the Committee once available as A&RC will not next formally meeting until November 2026.

- **Information Governance Update** – Received an update on Information Governance activity which included an overview of the organisation's compliance with the UK General Data Protection Regulations (GDPR), Data Protection Act 2018 and the Central East ICB Data Security Protection Toolkit (DSPT) action plan. The Committee in particular welcomed positive progress that had been made, despite acing significant organisational change, to address the inherited DSPT audit recommendations from the legacy ICBs. It was reported that fourteen of the original sixteen recommendations had been completed, and revised dates set for the remaining two actions. Members were also encouraged to note a new Information Governance Steering Group for Central East ICB has been established to

provide additional assurance and oversee delivery. The Committee has asked that progress on staff mandatory Information Governance training be included in future reporting.

RISK: Advise the Board which risks were discussed and any new risks identified

- **Risk Management Update -** The Committee received a paper that provided updated theme on the development of the Integrated Care Board (ICB) Risk Management Framework and the refreshed Board Assurance Framework (BAF). It was highlighted that the work undertaken to date represented a transition from a policy-led position to an embedded, strategically aligned framework that would directly support delivery of organisational objectives and population outcomes, based on a model of continuous improvement. The committee formally **supported** the ten identified strategic risk areas as presented for further discussion and approval by the Board. The Committee also agreed to set up of a Task and Finish Group - which has subsequently met - to facilitate A&RC member input and support development of the risk management framework.

  The latest version of the Risk management Framework and BAF is presented elsewhere on this agenda for Board discussion and approval.

CELEBRATING SUCCESS: Share any practice, innovation or action that the Committee considers to be outstanding

- As reflected elsewhere in the paper the Committee welcomed the positive progress that had been made in addressing a number of legacy related issues – including inherited recommendations from internal audit, local counter fraud and DSPT.
- The overall level of assurance provided to the Committee on a variety of areas despite the transitional pressures was commended. The openness and visibility demonstrated around those areas where full assurance could not yet be given was also welcomed.

Forward plan issues:

None to report.

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Report to the:	Board of the NHS Central East ICB			
Date of meeting:	25 September 2026			
	Meeting in public	☒	*Meeting in private*	☐
Item 16:	Finance Planning and Payer Function Committee (FPPFC) Chair's Alert, Advise and Assure Report – for meeting held on 17 July 2026			
Executive lead:	Sarah Griffiths, Executive Director for Finance, Resources & Contracts			
Report author:	Dorothy Gregson, Non-Executive Chair, FPPFC			
Reason for the report to the Board:	Standing Item			
Recommendation/s:	The Board is asked to **note** the report.			

Agenda items covered:

- Governance Structure Update
- Priority Programme Update: C4 Neighbourhood Health Teams
- Major Projects Update
- Strategy & Planning Update
- Public Health Management (PHM) Data Platform (DELPHI) Update
- 2026/27 Month 2 Finance Report
- Establishment of Finance Recovery Programme and Governance Arrangements
- Draft Budgetary Control Framework
- Contract Payer Assurance Report
- National Oversight Framework Update
- Draft Forward Plan

ALERT: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy

- None to report.

ADVISE: The Board of areas subject to on-going monitoring or development or where there is insufficient assurance

- **Major Projects Update –** Received update on major capital programmes and strategic capital planning across Central East. Key points highlighted included:
  - Progress on major regional capital projects such as Mount Vernon Cancer Centre and Cambridge Cancer Research Hospital and also non-acute / out of hospital capital developments.
  - Progress on the development of a strategic pipeline of Neighbourhood Health Centre schemes (NHC) schemes in line with the instruction and timelines from NHS England.
  - Development of a population health-led capital prioritisation framework.
  - The establishment of a Central East Strategic Capital Planning Group which includes representation from senior leaders from across CE Estates, Finance, Strategic Planning, Strategic Value Unit and Neighbourhoods.
  - Across all schemes Central East ICB was working closely with East of England NHSE colleagues, and with the National Hospitals Programme which has responsibility for funding and overseeing many of the schemes.

  A need to explore and better understand what the potential long-term system-wide impact of capital investment would be was highlighted. The alignment of capital investment with

population health needs and strategic commissioning intentions was also raised as a key point.

The Committee **noted** the update on major capital schemes across the Central East ICBs area and that scheme-specific papers will be presented to the Committee (where applicable) and Board in line with each stage of the business case process. It was also a**greed** that an update on major projects will be included on the agenda as a standing item.

- **Strategy & Planning Update –** An update on delivery planning in year and the development of a strategic commissioning plan and planning process for 2027/28 and beyond was received. The Committee recognised the importance of integrating national requirements, strategic priorities and business critical work programmes into a single delivery framework. The importance of issuing commissioning intentions earlier than in previous planning cycles was identified as was the need to balance ambition with organisational capacity and capability were raised as important discussion points.

  The Committee **noted** the development of the draft 2026/27 Delivery Plan and discussed proposals for the development of our strategy, planning and prioritisation process for subsequent years which will be subject to further development.

- **M2 Finance Report** – Received an update on the Month 2 2026/27 financial position of Central East ICB. At Month 2 the ICB was reporting a breakeven position year-to-date and forecasting a breakeven position for the year, in line with plan. Although the overall position was balanced at the time of reporting, underlying financial pressures were emerging and the delivery of the year-end position will continue to depend on achieving planned mitigations and efficiencies.

  In discussing risks assigned to the ICBs financial position – which included continuing health care and non-recurrent pressures associated with the costs of organisational change –which were classified as being 'red' rated, the Committee was sufficiently assured by the level of visible reporting, planned actions and mitigations in place to assess these as 'amber' risks. The Committee **noted** the Month 2 position and key risks.

- **Finance Recovery Programme and Governance Arrangements –** Received details of a finance recovery programme and supporting governance arrangements developed to strengthen oversight of financial risks, accelerate recovery actions, improve organisational accountability and ensure delivery of the ICB's statutory financial duties. This included the initial establishment of dedicated financial recovery groups. Overseen by a Financial Recovery Programme Board these groups would focus on identified priority areas of financial risk and recovery opportunity.

  A named Senior Responsible Office will lead each group with relevant support functions provided and an escalation process built in. The programme was to be implemented with immediate effect. The Committee **endorsed** the proposed Financial Recovery Programme governance arrangements as presented. It also **noted** the establishment of a Financial Recovery Programme Board and associated Financial Recovery Groups and **supported** the proposed assurance, escalation and reporting framework. The Committee will receive regular reports on delivery progress.

- **Contract Update and Contract Payer Assurance Report –** Received paper that updated the committee on current development of Central East ICB's payer assurance function, focusing on the ICBs contract management, reporting and governance arrangements.

  Although still at a developmental phase the contract payer assurance report, which will be a standing agenda item going forward will provide the latest available contract position on NHS and independent sector providers (ISP), section 75 agreements, any contract notices issued plus updates on any procurement legal challenges. In addition, the scope of the analytics section of the report will look to both inform and assure the Committee with an increased level of detail presented.

  At the time of reporting, it was confirmed 2026/27 contracts with our main NHS provider trusts had been agreed, with two exceptions. It was anticipated that this would be progressed and completed post meeting, but any ongoing delay will be reported to the Board. The Committee **noted** the update and ongoing development and population of the of the Contract Payer Assurance Report.

- **Priority Programme Update: C4 Neighbourhood Health Team**s – Neighbourhood Health Teams (NHTs) are a key component of the Central East ICB Our Way strategy and the NHS Neighbourhood Health Framework, providing the primary delivery mechanism for more proactive, integrated and population-based care at neighbourhood level. An update on progress in developing and implementing the programme, including key achievements, emerging commissioning considerations and next steps towards wider rollout from 2027 onwards was presented to the Committee.

  Positive progress was reported in developing the core components of the model, including baseline and maturity assessments neighbourhood profiling, development of a draft NHT frailty model and service specification, mobilisation of early adopter sites, and alignment of key programmes such as the Better Care Fund (BCF), Primary Care Action Plans (PCAP), Same Day Access and Neighbourhood Health Centres. Next steps in the programme will include testing and codifying the NHT model across early adopter sites. The Committee **noted** the progress, key milestones and next steps for the Central East Neighbourhood Health Teams (NHTs) programme.

- **Public Health Management (PHM) Data Platform (DELPHI) Update –** Received and **noted** a presentation which outlined how PHM capabilities can be applied and help to support Neighbourhood Team development and delivery. The presentation also covered use of DELPPHI which is a platform providing a single source of information about population, linked at the personal level. This local integrated data platform had successfully been used in Hertfordshire and plans were being progressed to use it at scale across the Central East ICB area.

- **National Oversight Framework (NOF) Update –** A verbal update was given on the work being progressed to develop a NOF dashboard. This work was at an early stage and a further report was scheduled to be brough to the Committee's November 2026 meeting.

ASSURE: Inform the Board where positive assurance has been received

- **Draft Budgetary Control Framework** – Received details of a proposed NHS Central East Integrated Care Board. (ICB) Budgetary Control Framework. The purpose of the Framework

being to establish the principles, responsibilities and controls through which the ICB plans, allocates, monitors and reports the use of financial resources and supports compliance with the ICB's statutory financial duties. Subject to amending wording to better reflect the management of demand-led and variable contract budgets, the Committee **approved** the proposed Budgetary Control Framework as presented on the basis it considered it to be to be an appropriate and proportionate system of financial control and accountability. A communication and implementation plan will be out in place to support organisational adoption.

- **Governance Structure Update –** Received a presentation which described proposals to revise the existing governance framework to incorporate a more flexible approach described as "dynamic governance". The proposition focused around the understanding that the first three tier of governance meetings (Tier 1 – Board; Tier 2 – Board Committees; and Tier 3 – formal decision-making forums) will continue to adopt 'traditional' governance arrangements, but that a more flexible approach will be adopted for meetings below this level (Tier 4) to, in particular, support delivery of priority programmes through more agile arrangements. This will include removing the need for formal terms of reference, membership being fluid and determined by who needs to be at a meeting, and action notes taken - on a prescribed template - as opposed to producing formal minutes.

  The Committee noted the presentation and was supportive of the approach. It requested that a six-month position update/ review of progress be scheduled in the Committee's work plan. The need to link this process into the ongoing development ICBs risk framework and risk appetite was also raised.

RISK: Advise the Board which risks were discussed and any new risks identified

- The Committee discussed various risks pertinent to its remit and which were reflected in the papers presented at the meeting and summarised above. No specific new risks were identified for escalation to the Board.

CELEBRATING SUCCESS: Share any practice, innovation or action that the Committee considers to be outstanding

- The Committee was pleased to learn of the successful visit and positive feedback received from Dr Claire Fuller, NHS England's national priority programme director for neighbourhood health, following a full-day visit to the ICB as part of her neighbourhood health stocktake.

Forward plan issues:

- The Committee received a first version of its forward plan. The plan will be subject to ongoing development and included as a standing item on the agenda.

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Updates from the Three Neighbourhood Delivery Committees (NDCs): Bedfordshire, Luton & Milton Keynes, Cambridgeshire & Peterborough, and Hertfordshire

25 September 2026

12 Key Themes Across Committees

5 Place-Specific Discussions

Updates from the Three Neighbourhood Delivery Committees (NDC)

Key Themes	BLMK NDC on 31 July	C&P NDC on 04 August & 01 September	Herts NDC on 23 July & 17 September
Central East Neighbourhood Health Programme Progress	Update on the Claire Fuller visit (15 July), confirmation that the frailty-first approach remains the right strategic direction, and discussion on accelerating delivery across BLMK's 16 neighbourhoods.	Continued progress in advancing neighbourhood health through strong governance, integrated commissioning, population health intelligence and performance assurance, aligned with the wider Central East direction.	Discussion and reporting on the Hertfordshire NH Delivery Committee and the development of a long-term NH health plan, governance and delivery framework. Felt that further work required around roles and responsibilities. NDC ToR approved subject to this and ensuring explicit links to the public/patient for transparency.
Neighbourhood Delivery Readiness	Agreement to formally confirm neighbourhood footprints, progress work on neighbourhood maturity assessments, sign off process for early adopters, and the development of initial draft individual Place-based Neighbourhood Health Team Delivery Plans ahead of October.	Neighbourhood models, proactive care and Place-based reporting continue to develop across North and South C&P, supported by maturity assessments and evaluation of neighbourhood and PCN readiness.	Review and discussion of Hertfordshire's readiness for neighbourhood health, including neighbourhood footprints, governance, accountability, outcomes and enabling infrastructure.
From Planning to Delivery	Focused discussion on moving from isolated examples of good practice to a consistent, system-wide model of neighbourhood delivery across all BLMK neighbourhoods. Developing a shared understanding of population need/frailty and connection to multi-neighbourhood services and pathways.	Focus on using NDC governance, commissioning levers and quality improvement to maintain a common direction and translate integrated neighbourhood working into delivery. The C&P Neighbourhood Health Plan is now in final stages of sign off at the Health and Wellbeing Board, with delivery plans developed by Place to support.	Discussion on developing a shared system-wide understanding of frailty, population need, outcomes, services, investment and gaps to inform future neighbourhood delivery.
Frailty, Urgent Care and Winter Priorities	Review of the emerging Frailty Framework, evidence base and commissioning approach, with emphasis on prevention, population health management, multidisciplinary working and proactive care for people living with frailty. Winter priorities focus on alternatives to hospital, admission avoidance and flow.	Frailty, winter planning and urgent care coordination remain key priorities, with a focus on strengthening proactive care and neighbourhood-level delivery.	Review of Hertfordshire Frailty Programme and emerging Specification, including population need, evidence-based interventions and delivery from April 2027. Discussion around sharing data from social care; effective use of best practice in areas such as CHC; importance of standardised links for VCFSE and community organisations.
Primary Care DES Variation, Integrated Commissioning and Strategic Alignment	Discussion on using a local PCN DES Variation to support neighbourhood delivery, simplify funding arrangements and create a longer-term commissioning framework for Neighbourhood Health Teams.	Support for aligning commissioning intentions across health, social care and local authority partners, with greater visibility of contract and procurement pipelines to enable joint commissioning and reduce duplication.	Discussion on the role of integrated commissioning, contracting and funding arrangements in supporting neighbourhood health delivery and incentivising integrated working.

Updates from the Three Neighbourhood Delivery Committees (NDC):

Key Themes Across Committees	BLMK NDC on 31 July	C&P NDC on 04 August & 01 September	Herts NDC on 23 July & 17 September
Primary Care Leadership, Access, Capacity, Governance and Assurance	The committee signed off the Terms of Reference for the Neighbourhood Primary Care Commissioning Sub-Committee. The Committee discussed access improvement in primary care, the developing role of Primary Care Alliances, and neighbourhood clinical leadership. The committee agreed a further discussion on challenges created by current PCN boundaries and neighbourhood footprints at the next committee would be important.	Primary care governance is being strengthened through a new commissioning sub-committee, enhanced dashboards, maturity assessments and improved risk management.	Update on the establishment of the Hertfordshire Neighbourhood Primary Care Commissioning Sub-Committee, including oversight of primary care transformation, access, performance, finance, estates and commissioning assurance. ToR was approved subject to consideration and review of membership and transparency for public/stakeholders on commissioning decisions.
Population Health Management and DELPPHI	Demonstration of the DELPPHI platform and discussion on how population health management, risk stratification and linked data can support proactive identification and management of people most likely to benefit from neighbourhood interventions.	Continued rollout of DELPPHI to support population health management, risk stratification, proactive care and outcome evaluation, with primary care engagement, data sharing, training and implementation assurance identified as essential.	Discussion on the use of population health management, risk stratification, data, intelligence and DELPPHI to support proactive identification, care coordination and neighbourhood outcomes.
Children and Young People, Mental Health and SEND Reform Programme	Update on SEND reform plans across BLMK, highlighting a shift towards earlier intervention, locality-based support, inclusion and multidisciplinary working, aligned to wider neighbourhood health principles.	Work is progressing to strengthen strategic oversight, align priorities, map existing activity and ensure appropriate reporting of Children and Young People and Mental Health programmes through neighbourhood governance arrangements.	Recognition of the need to align neighbourhood health with SEND, Families First, Best Start for Life and wider children and family reforms.
Better Care Fund	Not discussed at this meeting but considered at previous NDC meetings.	Future Better Care Fund reporting should demonstrate clearer outcomes and impact across frailty, flow, discharge, reablement and population health, aligned with the Older People's Joint Strategic Needs Assessment and wider neighbourhood priorities.	Review of Better Care Fund programmes, governance and investment, with a focus on strengthening outcomes, value for money and alignment to neighbourhood priorities.

Updates from the Three Neighbourhood Delivery Committees (NDC)

Key Themes Across Committees	BLMK NDC on 31 July	C&P NDC on 04 August & 01 September	Herts NDC on 23 July & 17 September
Neighbourhood Health Centres and Estates	Update on the national Neighbourhood Health Centre submission process and the need to manage expectations regarding the scale of available national investment.	Not discussed at this meeting but considered at previous NDC meetings.	Update on the Neighbourhood Health Centre programme and endorsed progression of a sponsorship and steering group for the Watford Health Campus feasibility work.
Citizen Voice & Resident and Community Engagement	Discussion on the need for a consistent BLMK approach to resident engagement, participation and co-production, balancing common principles with neighbourhood-level flexibility.	Not discussed as a standalone point in these meeting but considered at previous NDC meetings and as part of the Neighbourhood Health Plan development work.	Model for Citizen Voice and Insight Model to ensure residents influence the design, delivery and evaluation of neighbourhood health services was agreed – but further engagement with partners and links to governance structure being explored.
Local Government Reorganisation and Place Alignment	Not discussed at this meeting but considered at previous NDC meetings.	Local Government Reorganisation developments continue to be monitored, while maintaining momentum on neighbourhood delivery and partnership working across C&P.	July's discussion around aligning to proposed LGR reform footprints was since updated and paused at September's meeting with the further updates received.

Place-Specific Discussions	Discussion
Single Neighbourhood Provider (SNP) and Multi-Neighbourhood Provider (MNP) Consultation - BLMK NDC on 31 July	Consideration of the emerging NHSE contracting options, implications for primary care, local partnerships and neighbourhood accountability, and the need for a BLMK position to inform Central East commissioning intentions
Digital and Data Sharing Enablers - BLMK NDC on 31 July	Recognition that shared care records, data sharing arrangements and digital case management capabilities are critical enablers for integrated neighbourhood working and delivery of the Frailty Framework
BLMK Workforce Mapping and System Resource Planning - BLMK NDC on 31 July	Agreement on the need for a cross-system workforce mapping exercise to understand existing capacity, workforce deployment and future resource requirements for neighbourhood delivery
VCSE as a Core Delivery Partner - BLMK NDC on 31 July	Strong message that the VCSE sector should be viewed as a key delivery partner for neighbourhood health, particularly in prevention, community resilience, social isolation and frailty support, with a call for clearer engagement arrangements and sustainable commissioning approaches.
Neighbourhood Performance and Quality Improvement - C&P NDC on 04 August & 01 September	Enhanced dashboards are being introduced, with further development requested around neighbourhood-level metrics and qualitative quality improvement intelligence

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Report to the:	Board of the NHS Central East ICB			
Date of meeting:	25 September 2026			
	Meeting in public	☒	*Meeting in private*	☐
Item 18:	Utilisation Management and Quality Improvement Committee Chair's Alert, Advise and Assure Report – Meeting Held on 11 September 2026			
Executive lead:	Sarah Stanley, Executive Clinical Director of Total Quality Management (Nursing Director) Dr Fiona Head, Executive Clinical Director Utilisation Management (Medical Director) Lois Kamfer, Executive Director Strategy, Planning & Evaluation			
Report author:	Sarah Hughes, Non-Executive Member Chair			
Reason for the report to the Board:	Standing Item			
Recommendation/s:	The Board is asked to **note** the report			

Agenda items covered:

- Risk Management Update (UMQIC Risks
- Using Statistical Process Control to Inform Strategic Risk Management
- Establishment of a Patient Safety Partner Role for Central East ICB
- Central East Clinical Advisory and Population Risk Highlight Report
- Patient Group Directions (PGDs)
- Paediatric Audiology Programme Update
- Clinical Policies Ratification & Updates to ToR for Clinical Policies Group and IFR Panel
- Our Way Delivery Unit: Priority Programme Update
- Proposed Tier 3 Programme Boards – Clinical Advisory and Population Risk Directorate
- Forward Agenda Plan

ALERT: Matters that need the Board's attention or action, e.g. an area of non-compliance, safety or a threat to the ICS strategy

- None to report

ADVISE: The Board of areas subject to on-going monitoring or development or where there is insufficient assurance

- **Paediatric Audiology Programme Update -** The Committee received an update on the local progress implementing the national Paediatric Hearing Services Improvement Programme requirements. Three providers remain with significant work required within the national programme: Bedfordshire Hospitals NHS Foundation Trust (BHFT), Hertfordshire Community NHS Trust (HCT) and North West Anglia NHS Foundation Trust (NWAFT). A position summary was included in the paper for each Trust. UMQIC was encouraged to note that governance and oversight arrangements had been significantly strengthened with all trusts now participating in regular assurance meetings with NHS England and the ICB.

  However, despite improvement being made it was reported unlikely that all providers would achieve the national September 2026 milestone set by NHS England for completion of review, recall and reassessments or potentially the December 2026 deadline for the

completion of harm review. The Committee therefore wanted to draw this to the attention of the Board.

The Committee recognised that NWAFT at present presented the most significant risk and challenge. Regular meetings were being held with the Trust to obtain clarity on the current position and secure required improvements. UMQIC wished to record the significant improvement achieved at East and North Hertfordshire NHS Trust, which included the re-opening of all services, improved facilities. and enhanced governance and oversight.

UMQIC **noted** the update and **agreed** to receive a further report be provided to its next meeting in November 2026.

ASSURE: Inform the Board where positive assurance has been received

- **Using Statistical Process Control to Inform Strategic Risk Management –** The Committee received a presentation on the application of Statistical Process Control (SPC) methodology to support objective risk management. UMQIC strongly **supported** the use of SPC methodology and in particular welcomed a move away from subjective risk scoring approaches. The potential for SPC to provide early warning indicators was also discussed as was the importance of selecting meaningful measures, including patient-reported measures where possible. While endorsing the continued development of the SPC approach to risk management it supported a phased testing and validation approach being adopted before being formally adopted.

- **Establishment of a Patient Safety Partner Role for Central East ICB –** UMQIC strongly **supported** the proposal for the development of a Patient Safety Partner (PSP) role within Central East ICB and **supported** recruitment of up to five PSPs. The Committee emphasised the need to explore an innovative and inclusive approach to the recruitment to maximise the potential for diversity and representation.

- **Central East Clinical Advisory and Population Risk Highlight Report –** Received the second iteration of the standing committee reports that provides an overview of key areas of work, progress and risk with mitigations, relating to the Clinical Advisory and Population Risk Directorate. UMQIC noted the significant work that had been undertaken to populate the report post the last July 2026 meeting but recognised it remained subject to further development and improvement. Updates were broken down into headline sections covering quality planning, quality assurance, quality improvement, patient safety, system health and utilisation management. Discussion was held around the volume and level of detail of detail included in the report and how this could be most effectively filtered and presented as the reporting process continued to be developed. Specific points discussed by UMQIC included:
  - Welcomed development and implementation of system-wide quality risk stratification process
  - Positive regional feedback had been received concerning the maturity of the ICB's new quality assurance model.
  - Noted NHS Trust providers and Primary Care providers presently giving cause for concern.
  - Discussed maternity and perinatal services and the need for assurance around implementation of national recommendations. UMQIC agreed to schedule a deep-dive into this area.
  - Noted launch of the Quality Improvement training programme

- Four Never Events reported across CE ICB in year-to-date. Noted systemwide thematic review underway with the focus on overall learning and improvement as opposed to individual event review.
- Development of heat mapping and population intelligence approaches continuing.

UMQIC **noted** the report and **endorsed** its continued development.

- **Patient Group Directions (PGDs) –** A PGD is a written instruction that allows health care professionals specified within legislation to supply and/or administer a medicine directly to an individual with an identified clinical condition. PGDs can only be used if there is no other suitable legal mechanism for the administration or supply of the medicine such as by a prescriber or community pharmacy supply. They are designed to improve patient access to medicines if used appropriately. All PGDs must be authorized by an appropriate legal body before they can be used. Where providers are not legally able to authorize PGDs, the ICB is legally required to undertake the authorization on their behalf.

  UMQIC received two separate papers concerning PGDs. The first paper sought approval for organisational authorisation of seven Patient Group Directions post completion of required policy, legal, contractual and provider-governance assurance checks. The Committee **approved** the request (refer to table below) and **authorised** the Executive Clinical Director of Utilisation Management / Medical Director to sign the PGDs on behalf of Central East ICB once any conditions have been discharged.

Provider	PGD	Version	Valid From (as recorded on PGD)	Expiry
BPAS	Administration of lidocaine hydrochloride 1% injection	3.0	01/09/2026	31/08/2029
Cora Health	Administration of Methylprednisolone 40mg/ml Injection	5.0	01/10/2026	01/10/2029
Cora Health	Administration of Lidocaine 1% 10mg/ml and 2% 20mg/ml Injection	4.0	01/10/2026	01/10/2029
Cora Health	Administration of Methylprednisolone 4% and Lidocaine 1% Injection	4.0	01/10/2026	01/10/2029
Circle	Administration of Methylprednisolone 40mg/ml Injection	2.0	22/05/2026	22/05/2028
Circle	Administration of Lidocaine 1% 10mg/ml and 2% 20mg/ml Injection	2.0	22/05/2026	22/05/2028
Circle	Administration of Methylprednisolone 4% and Lidocaine 1% Injection	2.0	22/05/2026	22/05/2028

The second paper sought address of an error identified in the recorded expiry dates for commissioner-authorised Patient Group Directions transferred to Central East ICB governance arrangements. This concerned identification of eight PGDs for Milton Keynes Urgent Care Service (MK UCS) having expiry dates (recorded in Appendix B of the Transfer of PGDs paper presented to CE ICB Board on 1 April 2026) that extended beyond three years from the original authorisation date. UMQIC **note**d the error identified, the outcome of the rapid risk assessment, and the learning and controls now in place. The Committee also **approved** the correction and re-issue of an amended appendix (attached as Appendix 1) and to notify the Board of this.

- **Clinical Policies Ratification & Updates to ToR for Clinical Policies Group and IFR Panel –** The Committee received for consideration and approval recommendations of the Central East ICB Clinical Policies Group held on 18 Augst 2026. UMQIC:

  Approved the retirement of the following four clinical policies
  - Breast Reconstruction (after cancer or trauma)
  - Pain Relief Services
  - Gender Dysphoria – Cosmetic Interventions
  - Dyspepsia Management

  Approved the adoption of following five harmonised clinical policies
  - Cataracts
  - Benign Skin Lesions
  - Dissociative Identify Disorder
  - Liposuctions for other indications (not lipoedema or lymphoedema)
  - Carpel Tunnel

  Approved the adoption of one new clinical policy - Adult ADHD Assessments - subject to the Clinical Policies Team further reviewing the policy and bringing it back to Committee within approximately three months or earlier if national guidance changes.

  UMQIC also **approved** the updated terms of reference for the Clinical Policy Group and the Individual Funding Request (IFR) Panel as presented.

- **Our Way Delivery Unit: Priority Programme Update –** UMQIC received the latest iteration of the ICB's Priority Programme Update developed by the 'Our Way' Strategy Delivery Unit. While recognising the report remained at a developmental phase, UMQIC welcomed the improvements made which included better clarity around the maturity of the individual programmes and inclusion of measurable objectives. It was highlighted that further work is required to secure consistency of reporting standards across each of the programmes, but that this will improve as the process matures. A need to explore the possibility of arranging development sessions to support committee members (and staff) to better interpret and understand the reporting and use of the Statistical Process Control (methodology) was discussed and identified as an action. The Committee **noted** the latest report and **endorsed** the progress being made.

  The latest version of the Our Way Priority Programmes delivery report appears elsewhere on this agenda for the Board's consideration.

- **Proposed Tier 3 Programme Boards – Clinical Advisory and Population Risk Directorate -** The Committee considered and **approved** the establishment of three Tier 3 Programme Boards - for Clinical Standards, Utilisation Management Development and Total Quality Management - within the Clinical Advisory and Population Risk Directorate. The respective terms of reference for each programme board will be presented to the Committee post review. UMQIC was also informed that the requirement to establish a further programme board – for prescribing and clinical policy functions – was also under consideration.

RISK: Advise the Board which risks were discussed and any new risks identified

- **Risk Management Update (UMQIC Risks) –** UMQIC received an update on the development of the Central East ICB risk management Framework and in particular considered the risks it was being proposed will be directly owned and managed by the Committee. Key points raised during discussion included:
  - Importance of managing interdependencies of committees in regard to risk, and this should include clear escalation and feedback mechanisms between the committees.
  - Further explore workforce, capability and organisational transition risks.
  - Further review inclusion of utilisation management risks within the framework.
  - Explore suggestion developing an 'issues register' to log and manage known operational issues separately from strategic risks.

  UMQIC strongly **supported** the framework as presented and in particular the principle that risks were owned and managed through committees.

  The Board Assurance Framework and Risk Management Framework appears elsewhere on this agenda for the Board's consideration.

CELEBRATING SUCCESS: Share any practice, innovation or action that the Committee considers to be outstanding

UMQIC welcomed:

- The progress made in developing governance, assurance and delivery arrangements.
- Increasing use of data and improvement methodology; and .
- Enhanced visibility of programme delivery and organisational priorities.

Forward plan issues:

- The Committee received a first version of its forward plan that will be further developed and included on the agenda as a standing items Future items to be scheduled included a deep-dive into maternity and perinatal services and an increased in focus on utilisation management items.

Attachments

Appendix 1 Corrected Appendix B of the Transfer of PGDs to CEICB Board originally presented and agreed on 1 April 2026.

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Appendix 1 **– Corrected Appendix B of the Transfer of PGDs to CEICB Board**

The PGDs where the incorrect expiry date was recorded have been highlighted for ease of review.

Legacy ICB	Provider	Title of PGD	Version number	Expiry Date recorded in the 01/04/26 Board Paper	PGD Start Date	Corrected Expiry Date (maximum 3 years from start date)
BLMK	MK UCS	Adrenaline 1 in 1000 injection for emergency treatment of anaphylaxis PGD	2024 version	05 April 2027	March 2024	28 February 2027
BLMK	MK UCS	Amoxicillin for Acute Bronchitis Adults PGD	2023 version	06 November 2026	December 2023	30 November 2026
BLMK	MK UCS	Amoxicillin for the treatment of lower respiratory tract infection in children aged 1 to 16 PGD	2024 version	27 June 2027	August 2024	31 July 2027
BLMK	MK UCS	Amoxicillin for acute otitis media PGD	2024 version	19 November 2027	February 2025	31 January 2028
BLMK	MK UCS	Aspirin 300mg tablets for the treatment of suspected Myocardial Infarction PGD	2023 version	26 September 2026	November 2023	31 October 2026
BLMK	MK UCS	Beclometasone aqueous nasal spray for the treatment of allergic rhinitis in CYP PGD	2023 version	26 September 2026	November 2023	31 October 2026
BLMK	MK UCS	Benzylpenicillin for suspected meningitis PGD	2.0	01 March 2027	May 2024	30 April 2027
BLMK	MK UCS	Chloramphenicol eye preparations for infective conjunctivitis & blepharitis in children aged 1 month - 2years PGD	2024 version	05 February 2027	April 2024	31 March 2027
BLMK	MK UCS	Clarithromycin for treatment of cellulitis, suspected bacterial tonsillitis & pharyngitis in those allergic to penicillin PGD	2025 version	31 January 2028	February 2025	31 January 2028
BLMK	MK UCS	Clarithromycin for treatment of lower respiratory tract infection in children allergic to penicillin PGD	2025 version	31 January 2028	May 2025	30 April 2028
BLMK	MK UCS	Clotrimazole 1% cream for uncomplicated balanitis suggestive of candida PGD	2024 version	05 February 2027	This PGD has been retired by the service.	
BLMK	MK UCS	Clotrimazole 2% cream; 500mg vaginal tab for uncomplicated vaginal candida in women PGD	2024 version	02 February 2027	This PGD has been retired by the service.	
BLMK	MK UCS	Co-amoxiclav: first line treatment of human and animal bites PGD	2025 version	31 January 2028	February 2025	31 January 2028

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Legacy ICB	Provider	Title of PGD	Version number	Expiry Date recorded in the 01/04/26 Board Paper	PGD Start Date	Corrected Expiry Date (maximum 3 years from start date)
BLMK	MK UCS	Codeine 30mg tablets for moderate pain PGD	2024 version	05 February 2027	April 2024	31 March 2027
BLMK	MK UCS	Dexamethasone oral solution for the treatment of mild to moderate croup PGD	2025 version	06 June 2028	October 2025	30 September 2028
BLMK	MK UCS	Diazepam rectal tubes for the management of seizures PGD	2023 version	09 June 2026	Updated PGD approved by ICB on 28 May 2026 with an expiry date 28 February 2029 (Expiry date is present on the PGD)	
BLMK	MK UCS	Diclofenac IM injection for the treatment of renal colic PGD	2025 version	06 June 2028	October 2025	30 September 2028
BLMK	MK UCS	Docusate sodium for the treatment of constipation in children aged under 12 years PGD	2023 version	26 September 2026	This PGD has been retired by the service.	
BLMK	MK UCS	Doxycycline for Acute Bronchitis in Adults PGD	2024 version	06 November 2026	December 2023	30 November 2026
BLMK	MK UCS	Doxycycline given in conjunction with metronidazole for human & animal bites in those allergic to penicillin PGD	2025 version	11 November 2026	February 2025	31 January 2028
BLMK	MK UCS	Fluorescein 1% eye drops for detection of ocular foreign bodies, corneal ulcers, abrasions & burns	2023 version	26 September 2026	November 2023	31 October 2026
BLMK	MK UCS	Flucloxacillin for the treatment of widespread impetigo and mild cellulitis PGD	2024 version	27 June 2027	August 2024	31 July 2027
BLMK	MK UCS	Fusidic acid cream 2% for non-bullous impetigo PGD	2023 version	06 November 2026	December 2023	30 November 2026
BLMK	MK UCS	Glucagon injection for the treatment of hypoglycaemia PGD	2024 version	17 April 2027	June 2024	31 May 2027
BLMK	MK UCS	Hydrocortisone cream 1% for mild to moderate inflammatory skin disorders PGD	2023 version	06 November 2026	December 2023	30 November 2026
BLMK	MK UCS	Hyoscine Butylbromide for relief of GI or GU smooth muscle spasm PGD	2024 version	04 September 2027	September 2024	31 August 2027
BLMK	MK UCS	Ipratropium bromide for children aged 2-16 years for the relief of acute exacerbations and severe attacks of asthma unresponsive to salbutamol PGD	2025 version	31 January 2028	May 2025	30 April 2028

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Legacy ICB	Provider	Title of PGD	Version number	Expiry Date recorded in the 01/04/26 Board Paper	PGD Start Date	Corrected Expiry Date (maximum 3 years from start date)
BLMK	MK UCS	Levonorgestrel 1500mcg tablet(s) for emergency contraception PGD	2024 version	05 February 2027	Updated PGD approved by ICB on 28 May 2026 with an expiry date 28 February 2029 (Expiry date is present on the PGD)	
BLMK	MK UCS	Lidocaine 1% injection - local anaesthesia for wound closure, cleaning or examination PGD	2023 version	06 November 2026	December 2023	30 November 2026
BLMK	MK UCS	Macrogol for treatment of constipation in children from 2 years to 18 years PGD	2025 version	11 April 2028	July 2025	30 June 2028
BLMK	MK UCS	Metoclopramide injection for more severe nausea & vomiting with known cause PGD	2023 version	24 November 2026	December 2023	30 November 2026
BLMK	MK UCS	Metronidazole as an alternative treatment for human & animal bites where co-amoxiclav is contraindicated PGD	2024 version	11 November 2027	February 2025	31 January 2028
BLMK	MK UCS	Miconazole cream 2% for infected nappy rash and skin ringworm PGD	2025 version	13 October 2028	August 2025	31 July 2028
BLMK	MK UCS	Miconazole oral gel for oral candidiasis in adults, children and infants aged 2 and above PGD	2025 version	31 January 2029	April 2025	31 March 2028
BLMK	MK UCS	Naproxen 250mg tablets for acute MSK disorders PGD	2023 version	06 November 2026	February 2024	31 January 2027
BLMK	MK UCS	Nystatin oral suspension for oral candidiasis in infants aged 1 month to 2 years PGD	2025 version	04 October 2028	July 2025	30 June 2028
BLMK	MK UCS	Omeprazole 20mg caps for gastroprotection (to be used alongside naproxen PGD)	2023 version	06 November 2026	February 2024	31 January 2027
BLMK	MK UCS	Oral rehydration salts for the replacement of fluid and electrolyte loss in acute diarrhoea PGD	2024 version	17 April 2027	June 2024	31 May 2027
BLMK	MK UCS	Otomize ear spray for Otitis Externa PGD	2023 version	06 November 2026	February 2024	31 January 2027
BLMK	MK UCS	Paracetamol for the treatment of mild to moderate pain and pyrexia PGD	2024 version	17 April 2027	June 2024	31 May 2027
BLMK	MK UCS	Permethrin 5% cream for the treatment of scabies PGD	2023 version	06 November 2026	February 2024	31 January 2027
BLMK	MK UCS	Phenoxymethylpenicillin (penicillin V) for the treatment of suspected bacterial tonsillitis and	2024 version	27 June 2027	August 2024	31 July 2027

Legacy ICB	Provider	Title of PGD	Version number	Expiry Date recorded in the 01/04/26 Board Paper	PGD Start Date	Corrected Expiry Date (maximum 3 years from start date)
		pharyngitis PGD				
BLMK	MK UCS	Prednisolone 5mg tablets and oral solution STAT dose prior to transfer to hospital for children aged 1-18 with acute exacerbation of wheeze/asthma PGD	2025 version	31 January 2028	May 2025	30 April 2028
BLMK	MK UCS	Revaxis (DTP) vaccine PGD	6.0	04 December 2026	04 August 2024	04 December 2026
BLMK	MK UCS	Salbutamol for adults & adolescents aged 13 years and over PGD	2024 version	05 February 2027	April 2024	31 March 2027
BLMK	MK UCS	Salbutamol for bronchodilator responsiveness testing in Asthma and COPD in adults PGD 2024	2024 version	02 May 2027	April 2024	31 March 2027
BLMK	MK UCS	Salbutamol for children aged 1-2 years PGD	2024 version	25 September 2027	September 2024	31 August 2027
BLMK	MK UCS	Salbutamol for children aged 2-12 years PGD	2024 version	29 February 2024	April 2024	31 March 2027
BLMK	MK UCS	Senna for constipation PGD	2024 version	11 November 2027	February 2024	31 January 2027
BLMK	MK UCS	Sodium Cromoglicate 2% eye drops for treatment of perennial allergic conjunctivitis in adults & children and seasonal allergic conjunctivitis in children aged under 6 years PGD	2025 version	11 November 2027	January 2025	31 December 2027
BLMK	MK UCS	Tetracaine 0.5% eye drops for eye examinations and treatment PGD	2023 version	06 November 2026	February 2024	31 January 2027
BLMK	MK UCS	Trimethoprim for lower UTI in children aged 6 months - 16 years PGD	2024 version	05 February 2027	March 2024	28 February 2027
BLMK	MK UCS	Ulipristal 30mg tablets for emergency contraception PGD	2024 version	26 September 2027	March 2024	March 2026 (service is aware this has expired)