

Meeting of the Essex Integrated Care Board
Thursday, 15 October 2026 at 2.00 pm to 4.00 pm
Southend Civic Centre, Committee Room 4A, Victoria Avenue,
Southend on Sea, SS2 6ER

Part I Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
Opening Business						
1.	2.00 pm	Welcome, opening remarks and apologies for absence	Note	Verbal	Prof. M Thorne	-
2.	2.01 pm	Register of Interests / Declarations of Interest	Note	Attached	Prof. M Thorne	3
3.	2.02 pm	Questions from the Public	Note	Verbal	Prof. M Thorne	-
4.	2.12 pm	Approval of minutes of the previous Part I meeting, 16 July 2026	Approve	Attached	Prof. M Thorne	5
5.	2.13 pm	Matters arising (not on agenda)	Note	Verbal	Prof. M Thorne	-
6.	2.14 pm	Action Log	Note	No outstanding actions	Prof. M Thorne	-
7.	2.15 pm	Chief Executive's report (including update from Exec Committee and Board Seminars)	Note	Attached	T Abell	20
8.	2.25 pm	Strategic [Board] Assurance Framework	Note	Attached	T Abell	52
Shift to Neighbourhood Care & Health Inequalities						
9.	2.35 pm	Neighbourhood Health and Health Inequalities Assurance Report	Note	Attached	B Flowers	62
10.	2.45 pm	Neighbourhood Health Summary Report	Note	Attached	B Flowers	65
Access and Outcomes						
11.	2.55 pm	Access and Outcomes Assurance Report	Note	Attached	S Goldberg N Hammond B Flowers	76
12.	3.00 pm	Winter Planning	Note	Attached	S Goldberg	78
Commissioning, Quality & Resources						
13.	3.10 pm	Finance and Quality Assurance Report	Note		J Kearton N Hammond S Goldberg	196
14.	3.15 pm	Commissioning, Quality and Resource Summary Report & CQRC Escalation Report	Note	Attached	J Kearton N Hammond S Goldberg	197
15.	3.25 pm	Capital Resource Use Plan 2026/27	Note	Attached	J Kearton	213
Trusted Partner						
16.	3.35 pm	Trusted Partner Assurance Report	Note		M Watson	230
17.	3.40 pm	Report from Audit Committee	Note	Attached	M Watson	232

No	Time	Title	Action	Papers	Lead / Presenter	Page No
18.	3.45 pm	General Governance:				
		18.1 Governance Report including Revised Terms of Reference (Executive Committee) and updated Functions and Decisions Map	Approve	Attached	Prof. M Thorne	236
		18.2 New and Revised Policies	Note	Attached	Prof. M Thorne	248
Closing Administration						
19.	3.53 pm	Approved Committee minutes	Note	Attached	Prof. M Thorne	251
20.	3.55 pm	Chairs Key Issues / Escalations Report	Discuss	Verbal	Prof. M Thorne	-
21.	3.57 pm	Effectiveness of Meeting	Discuss	Verbal	Prof. M Thorne	-
22.	3.59 pm	Any Other Business	Note	Verbal	Prof. M Thorne	-
23.	4.00 pm	Date and time of next Part I Essex Integrated Care Board meeting:	Note	Verbal	Prof. M Thorne	-
		Thursday, 21 January 2027, at 2.00pm, Jubilee Suite, Hartwood Pavilion, King George's Playing Fields, Ingrave Road, Brentwood, CM13 2FD				

Essex Integrated Care Board
Register of Board Members' Interests - October 2026

First Name	Surname	Job Title / Current Position	Declared Interest (Name of the organisation and nature of business)	Financial	Non-Financial Professional Interest	Non-Financial Personal Interest	Is the interest direct or indirect?	Nature of interest	From	To	Actions taken to mitigate risk
Tom	Abell	Chief Executive Officer	Nil				Direct				
Mark	Bailham	Non-Executive ICB Board Member	Enterprise Investment Schemes in non-listed companies in tech world, including medical devices/initiatives	x			Direct	Shareholder - non-voting interest	01/07/20	Ongoing	Will declare interest during relevant meetings or any involvement with a procurement process/contract award.
Mark	Bailham	Non-Executive ICB Board Member	Mid and South Essex Foundation Trust	x			Direct	Council of Governors - Appointed Member	01/10/23	Ongoing	Will declare interest during relevant meetings or any involvement with a procurement process/contract award.
Mark	Bailham	Non-Executive ICB Board Member	Cambridgeshire and Peterborough Foundation Trust	x			Direct	Non-Executive Director	October 2025	Ongoing	Will declare interest during relevant meetings
Jo	Churchill	Non-Executive ICB Board Member	Norfolk and Waveney University Hospitals Group	x			Direct	Non Executive Director	Dec 2025	Dec 2028	To declare this interest as necessary so that appropriate arrangements can be made if required.
Jo	Churchill	Non-Executive ICB Board Member	CCRH and CH				Direct	Ambassador	Aug 2025	Ongoing	To declare this interest as necessary so that appropriate arrangements can be made if required.
Alex	Green	ICB Board Partner Member (Essex Partnership University Foundation Trust)	TBC								
Natalie	Hammond	Interim Executive Chief Nurse	AquaKare			x	Indirect	Potential interest - Spouse is business owner	2005	Ongoing	Business does not commission with NHS. Driven by insurance claims.
Mark	Harvey	ICB Board Partner Member (Southend City Council)	Southend City Council	x			Direct	Employed as Executive Director, Adults and Communities		Ongoing	Interest to be declared, if and when necessary, so that appropriate arrangements can be made to manage any conflict of interest.
Neha	Issar-Brown	Non-Executive ICB Board Member	Queen's Theatre Hornchurch (QTH)			x	Direct	Trustee - QTH often works with local volunteer sector including Healthwatch, social care sector for various community based initiatives, which may or may not stem from or be linked to NHS (more likely BHRUT than MSE).		Ongoing	Info only. No direct action required.
Neha	Issar-Brown	Non-Executive ICB Board Member	Independent Consultancy	x			Direct	Independent Consultancy contracts, including with other management consultancy firms (such as Deloitte, EY, etc.) on (predominantly international) research, innovation, early careers development, and R&D strategies. No contracts undertaken with any direct or indirect overlap with NHS/MSE/constituent Trusts/providers or consultancy firms (that I am aware are engaged with the system) to avoid conflict.	June 2023	Contract based and time limited	Info only. No direct action required.
Neha	Issar-Brown	Non-Executive ICB Board Member	British Pharmacological Society (BPS) BPS Assessments (BPSA)	x			Direct	British Pharmacological Society (BPS) - CEO & BPS Assessments (BPSA) - Managing Director The UK's primary learned society for pharmacologists, concerned with research into drugs and their mechanisms. Members work in academia, industry, regulatory agencies, and the health services, and many are medically qualified. BPSA is the learning and assessment arm of the BPS - it works to improve prescribing skills among medical and non-medical prescribers. BPSA works collaboratively in UK and globally to understand local prescribing needs and practice, to deliver tailored training.	December 2025	Ongoing	Info only. No direct action required at present.
Jennifer	Kearon	Executive Director of Finance and Commercial	Colchester Weightlifting Limited			x	Direct	Director	01/10/24	Ongoing	No conflict anticipated. To declare as appropriate.
Thomas	Lafferty	ICB Board Partner Member (Princess Alexandra Hospital Trust)	Princess Alexandra Hospital NHS Trust				Direct	Chief Executive			
Thomas	Lafferty	ICB Board Partner Member (Princess Alexandra Hospital Trust)	Passmore School Academy				Direct	Board Member			
Thomas	Lafferty	ICB Board Partner Member (Princess Alexandra Hospital Trust)	TWL Associates Limited				Direct	Director and Owner			
Sarah	Muckle	ICB Board Partner Member (Essex County Council)	Essex County Council	x			Direct	Director of Wellbeing Public Health & Communities	24/04/25	Ongoing	To declare this interest as necessary so that appropriate arrangements can be made if required.
Dr Ian	Perry	ICB Board Partner Member (Primary Care)	Maynard Court Surgery NHS	x			Direct	GP Partner	Apr-2014	Ongoing	Will declare an interest in any matter relating to the organisation and will not participate in related discussions, decision-making, procurement, or financial authorisation where a conflict exists.
Dr Ian	Perry	ICB Board Partner Member (Primary Care)	Epping Forest North PCN		x		Direct	Member	Jul-2019	Ongoing	Will declare an interest in any matter relating to the organisation and will not participate in related discussions, decision-making, procurement, or financial authorisation where a conflict exists.
Dr Ian	Perry	ICB Board Partner Member (Primary Care)	Stellar Healthcare GP Provider	x			Direct	Shareholder	Apr-2015	Ongoing	Will declare an interest in any matter relating to the organisation and will not participate in related discussions, decision-making, procurement, or financial authorisation where a conflict exists.

Essex Integrated Care Board
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Dr Ian	Perry	ICB Board Partner Member (Primary Care)	Medivys Health AI Technology	x			Direct	Shareholder	Oct-2025	Ongoing	Will declare an interest in any matter relating to the organisation and will not participate in related discussions, decision-making, procurement, or financial authorisation where a conflict exists.
Robert	Persey	ICB Board Partner Member (Thurrock Council)	Thurrock Council	x			Direct	Interim Executive Director of Adults and Health		Ongoing	To declare this interest as necessary so that appropriate arrangements can be made if required.
Adam	Sewell-Jones	ICB Board Partner Member (MSEFT)	Mid and South Essex Foundation Trust	x			Direct	Chief Executive Officer	01/06/26	Ongoing	Interest will be declared if any any time issues relevant to the organisation are discussed so that appropriate arrangements can be implemented.
Adam	Sewell-Jones	ICB Board Partner Member (MSEFT)	Fairleigh Hospice	x			Indirect	Spouse works in an admin role	01/06/26	Ongoing	Interest to be declared where any perceived conflict may arise and to be recused from the meeting.
Rex	Smith	Non-Executive Member - Audit Committee Chair	Gosfield School			x	Direct	Governor and Trustee	2022	Ongoing	None - there is unlikely to be any conflict.
Rex	Smith	Non-Executive Member - Audit Committee Chair	Helen Rollason Cancer Charity			x		Volunteer supporting charity	16/07/05	Ongoing	None - there is unlikely to be any conflict.
Trevor	Smith	ICB Board Partner Member (Essex Partnership University Foundation Trust)	Essex Partnership University NHS Foundation Trust	x			Direct	Interim Joint Chief Executive Officer	01/07/26	Ongoing	Interest to be declared as necessary so that appropriate arrangements can be implemented.
Matthew	Sweeting	Executive Medical Director	Mid and South Essex Foundation Trust	x			Direct	Part Time Consultant Geriatrician employed by MSEFT. Clinical responsibilities include consultant support to Urgent Community Response Team (UCRT) and Virtual Hospital Services, and dedicated consultant support to Colne Valley PCN. I hold no executive, managerial, budgetary, commissioning or service leadership responsibilities within these roles.	Sept 2026	Ongoing	Any actual, potential or perceived conflict relating to MSEFT, UCRT, Virtual Hospital or Colne Valley PCN will be declared in accordance with Essex ICB policy. Where required, I will withdraw from discussions and decision-making relating directly to services, contracts or funding that could benefit these organisations and delegate decision-making as appropriate.
Mike	Thorne	ICB Chair	Nil								N/A
Giles	Thorpe	Executive Chief Nursing Officer	Essex Partnership University NHS Foundation Trust	x			Indirect	Husband is the Associate Clinical Director of Psychology - part of the Care Group that includes Specialist Psychological Services, including Children and Adolescent Mental Health Services and Learning Disability Psychological Services which interact with MSE ICB.	01/02/20	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.
Giles	Thorpe	Executive Chief Nursing Officer	University of Essex		x		Direct	Honorary Professorship	2023	Ongoing	Interest will be declared as necessary so that appropriate arrangements can be made if and when required.

Minutes of the Part I Essex Integrated Care Board Meeting

Held on Thursday, 16 July 2026 at 2.00pm – 3.45pm

**Marconi Room, Civic Centre, Duke Street, Chelmsford, Essex
CM1 1JE**

Attendance

Members

- Professor Michael Thorne (MT), Chair, Essex Integrated Care Board (EICB).
- Tom Abell (TA), Chief Executive Officer, EICB.
- Jennifer Kearton (JK), Executive Director of Finance and Commercial, EICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, EICB.
- Dr Matt Sweeting (MS), Executive Medical Director, EICB.
- Mark Bailham (MB), Non-Executive Member, EICB.
- Jo Churchill (JC), Non-Executive Member, EICB.
- Rex Smith (RS), Interim Non-Executive Member, EICB.
- Thomas Lafferty (TL), Partner Member, Princess Alexandra Hospital NHS Trust (PAH).
- Adam Sewell-Jones (ASJ), Partner Member, Mid and South Essex Foundation Trust (MSEFT).
- Sarah Muckle (SM), Partner Member, Essex County Council.
- Mark Harvey (MH), Partner Member, Southend City Council.
- Ian Perry (IP), Partner Member, Primary Care.
- Ann Sheridan (AS), Executive Chief Nurse, representing Alex Green and Trevor Smith, Partner Members, Essex Partnership University NHS Foundation Trust (EPUT).
- Angela Clarke (AC), Head of Provider Services, Adult Social Care representing Robert Persey, Partner Member, Thurrock Council.

Other attendees

- Michael Watson (MW), Executive Director of Corporate Services, EICB.
- Beverley Flowers (BF), Executive Director of Neighbourhood Health, EICB.
- Lucy Wightman (LW), Chief Executive Officer, Provide Health.
- Nicola Adams (NA), Associate Director of Governance, EICB.
- Helen Chasney (HC), Governance and Risk Manager, EICB (minutes).

Apologies

- Neha Issar-Brown (NIB), Non-Executive Member, EICB.
- Alex Green (AG), Partner Member, EPUT.
- Trevor Smith (TS), Partner Member, EPUT.
- Robert Persey (RP), Partner Member, Thurrock Council.
- Samantha Goldberg (SG), Executive Director of Performance and Planning, EICB.

1. Welcome and Apologies (presented by Prof. M Thorne)

MT welcomed everyone to the Essex Integrated Care Board (EICB) meeting and reminded members of the public that this was a meeting held in public to enable transparent decision making, not a public meeting, and therefore members of the public would be unable to interact with the committee during discussions. The meeting was livestreamed to accommodate members of the public who were unable to attend the meeting, and a recording of the livestream would also be available via the ICB website after the meeting.

A round of introductions was held.

Apologies were noted as listed above.

2. Declarations of Interest (presented by Prof. M Thorne)

MT reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be appropriately managed.

No other declarations were made.

Note: The Board register of interests is available on the website.

3. Questions from the Public (presented by Prof. M Thorne)

MT advised that questions had been submitted by members of the public, as set out below, which would be addressed during the meeting.

Stuart Scrivener referred to mental health, neurodevelopmental disorders, Attention Deficit Hyperactivity Disorder (ADHD) pathways and transition from children to adult services and asked what specific improvements patients and families would see over the next 12 months, and how would the Board measure their impact on patient experience. GT advised that reducing variation in mental health and neurodiversity services was a key commitment within the ICB's Population Health Improvement Plan (PHIP). Over the next 12-18 months, patients and families should begin to see shorter waits for autism and ADHD assessments, clearer and more consistent support before and after diagnosis, the introduction of improved ADHD pathways across age groups, and better planned transitions between children's and adult mental health services.

The Board will measure success through a combination of access, quality and experience measures. This included more accurate reporting of community waiting lists and access to priority services, alongside indicators such as agreed transition protocols and feedback from patients and families on whether they feel more involved in decisions, better supported and able to access the right care at the right time. Through regular reporting, the Board will seek assurance that these improvements are delivering a meaningful difference to people's experience of care.

Colin Quarterman sought clarification over the commissioning of Musculoskeletal (MSK) services and change of provider. MS explained that prior to the introduction of the new Community MSK and Pain Service, residents across Mid and South Essex accessed different services depending on where they lived, resulting in variation in access, referral criteria and the range of support available.

The new service was commissioned to address these inconsistencies by providing a more equitable and integrated model of care across the area. The aim was to improve access to community-based assessment and treatment, deliver better patient outcomes, and ensure specialist hospital services focused on those patients with the most complex needs.

The service model was developed with input from clinicians, providers, patients and stakeholders, with public engagement helping to inform the specification and expected outcomes. The procurement process was conducted in line with NHS requirements and assessed quality, accessibility, patient outcomes and value.

As with any service redesign, some patients may experience a different care pathway than under previous arrangements, reflecting current clinical guidance and best practice. Feedback was welcomed from patients and residents as part of the ongoing monitoring and improvement of the service. Anyone wishing to share feedback could access the ICB's virtual views platform or email the ICBs enquiries inbox.

Peter Blackman referred to the independent academic report on Maldon Central, Dengie and South Woodham Ferrers: Integrated Neighbourhood Team (INT) Area and Neighbourhood Health Future and sought assurance that the ICB would work with the South Woodham Ferrers Health and Social Care Group and consider the findings of the report. BF thanked the Group for the work undertaken. Many of the recommendations aligned closely with the ambitions set out in the PHIP and the ICB's emerging Neighbourhood Health model, particularly the focus on prevention, joined-up care, reducing health inequalities, strengthening partnerships beyond the NHS, and making services easier for residents to navigate.

The report was welcomed and the findings would be reviewed carefully once published. The ICB was committed to developing neighbourhood health with local communities and partners and would be pleased to consider what lessons could be applied not only in South Woodham Ferrers, Maldon and the Dengie, but more broadly across Essex as the approach to neighbourhood-based care was developed.

There were various mechanisms to get involved and provide insight and feedback to inform the work of the ICB. Details could be found on the 'Get Involved' page on the ICBs website.

Richard Pryor sought assurance on how the ICB worked with local authorities to ensure healthcare met the changing needs of the local population. JK explained that the ICB was a statutory consultee and strategic partner in the development of Local Plans and associated infrastructure planning. The ICB engaged proactively with all Local Planning Authorities across Essex and were currently supporting the development of a number of Local Plans and Infrastructure Delivery Plans.

The response from the ICB considered proposed developments, the existing healthcare capacity serving those areas, and the likely impact of growth on health services. Where additional demand was identified, appropriate mitigation and investment in healthcare infrastructure was sought, and to be reflected within local planning frameworks.

Whilst the principle of understanding the cumulative impact of housing growth on health services was supported, Local Planning Authorities were at different stages of the planning process and therefore a single Essex position for health impact would be constantly evolving. However, the ICB would continue to work closely with planning authorities and partners to

ensure healthcare infrastructure requirements were identified as early as possible and appropriately considered as plans were developed.

4. Minutes of the Part I Essex Integrated Care Board meeting held on 23 April 2026 (presented by Prof. M Thorne)

MT referred to the draft minutes of the Part I Essex Integrated Care Board (EICB) meeting held on 23 April 2026 and asked members if they had any comments or questions.

There were no comments or amendments.

Resolved: The Board approved the minutes of the Part I Essex ICB meeting held on 23 April 2026 as an accurate record.

5. Matters Arising (presented by Prof. M Thorne)

MT advised that the five strategic objectives for the Essex ICB had been agreed and the Board agenda had been structured to reflect those strategic objectives.

There were no further matters raised.

6. Review of Action Log (presented by Prof. M Thorne)

It was noted that there were no outstanding actions on the action log.

Resolved: The Board noted that there were no outstanding actions.

7. Chief Executive's Report (presented by T Abell)

TA advised that the organisational change programme relating to the ICB transition was complete and the focus had moved to developing the new organisation and building a high performing culture.

Significant public engagement had been undertaken on ICB priorities and the PHIP. More than 2,000 written responses had been received and would be reviewed to inform the next iteration of the PHIP.

The ICB had submitted an expression of interest for the neighbourhood health centre programme. The submission included five identified anchor sites and nine additional sites proposed by partner organisations and stakeholders. Feedback from the Department of Health and Social Care and NHS England was awaited.

The findings of the Essex SEND inspection of the local area partnership was consistent with other SEND inspections, recognising strong partnership working while identifying areas for further improvement, which had been incorporated into the workplan for the coming year.

The NHS Modernisation Bill had reached committee stage, and assurance was provided that its requirements had been incorporated into the planning of the new ICB. Further developments of the Bill would be closely monitored to ensure the ICB could respond to any change requirements.

An update was provided on the National Oversight Framework (NOF). Although Essex-wide data was not yet available due to the ongoing national data aggregation for the new geography, areas of concern and planned improvement actions had been set out in Appendix B.

The building for the Hollies GP Practice would re-open on 1 August 2026 following an agreement between the caretaker practice and the landlord. Thanks were expressed to Board Members, Castle Point Council colleagues, the local MP and others who had supported the process. A review would be undertaken to capture learning and inform future commissioning approaches in similar circumstances.

The Board discussed the development of a future urgent treatment centre (UTC) model and the potential role of community-based UTC provision, particularly in areas of high deprivation. It was noted that Princess Alexandra Hospital NHS Trust (PAH) was represented on the working group and that further work was required to clarify the future UTC model and the expectations set out in neighbourhood health guidance. A consensus view was expected by the autumn, following which commissioning plans would be developed alongside the neighbourhood health centre programme.

In response to a question regarding performance reporting under the new geography, the Board was advised that NHS England was expected to provide an initial position by the end of July. Performance would be monitored through waiting list reductions and the impact of newly commissioned pathways funded through the £20 million allocation. Reporting would commence once data flows had stabilised, with a review planned after four months to assess delivery and the effectiveness of demand reduction initiatives.

MT reported that the national director for neighbourhood health had undertaken a health check of the ICB's neighbourhood health arrangements. Positive feedback had been received regarding engagement with political leaders, neighbourhood mapping, partnership working and the collaborative approach adopted across the system.

Resolved: The Board noted the Chief Executive's Report.

8. Strategic (Board) Assurance Framework (presented by T Abell)

MW advised that the report set out the proposed high-level approach for transitioning from the Board Assurance Framework to the Strategic Assurance Framework (SAF). The SAF was intended to provide the Board with concise assurance on progress against strategic objectives, the PHIP, and the nine priority strategic programmes, all linked to the ICB's risk appetite.

The SAF would include a summary risk narrative for each strategic objective, related PHIP deliverables (rated to show confidence in their delivery) and reporting through the Alert, Advise, Assure and Celebrate framework. Lead indicators and trend data would be included, once available, to provide assurance of progress. Each element of the SAF would precede its relevant agenda item at the Board meeting to enable Members to understand the risk profile and assurances on how that is being addressed in the context of the remaining Board papers being presented.

Feedback on the new approach was welcomed, and the report would continue to be refined as the wider approach of the organisation changed.

MB highlighted the importance of tracking trends over time to demonstrate whether performance was improving or deteriorating, rather than relying solely on a point-in-time assessment.

RS welcomed the report and praised those involved in its development. The Audit Committee assurance report was clear, easy to understand, and captured all relevant points.

Resolved: The Board noted the Strategic (Board) Assurance Framework report.

9. Health Inequalities Assurance Report (presented by B Flowers)

BF advised that the new report would be a useful tool for maintaining focus on activities that delivered meaningful outcomes. Narrowing health inequalities year on year remained a challenge due to their scale and ensuring the continued link back to the PHIP priorities. Future indicators would need to reflect findings from forthcoming maternity reviews and other emerging priorities. The inequalities indicators would initially focus on core PHIP measures but would be reviewed and expanded as understanding of the Essex-wide data developed.

The first meeting of the internal inequalities group had reviewed available data, priorities and areas requiring greater focus. This highlighted the need to work closely with partners, particularly through the Better Care Fund (BCF) governance structures to avoid duplication and ensure consistency in reporting and monitoring.

The report referenced the 'Work Well' programme, which focused on improving employment and economic opportunities for disadvantaged communities across Essex. Significant funding would be available over the next three years, and progress should be reported back to the Board.

BF invited feedback on any additional areas that should be considered through the inequalities lens and incorporated into future iterations of the PHIP.

MT commented that the report provided clarity and would support the Board in monitoring progress as the organisation continued to mature.

MB suggested that the report could be extended across two pages, where necessary, to include additional information and requested that changes between reporting periods were clearly highlighted.

ASJ welcomed the simplicity of the report but questioned whether linking a single risk to each strategic priority could overlook other significant risks and suggested that separate reporting on key risks within a priority area might provide greater visibility. TA advised that the organisational risk register sat beneath the SAF and that the challenge was determining the appropriate level of detail for the Board. MW explained that the highest-scoring risks had been selected to provide focus and whether the Board would prefer periodic reviews of the full risk register or more detailed discussions through Board Seminars and other sessions.

MH acknowledged that the report was supported by more detailed information and queried whether insufficient engagement with local authorities could hinder delivery, given that health inequalities were largely driven by social inequalities. Assurance was also sought on whether the Work Well programme would align with local authority employment initiatives to avoid duplication of funding. BF agreed that avoiding duplication through Work Well was essential, noting that individuals could not access multiple employment programmes within a short period. Work was underway with all three upper-tier authorities and MSEFT to align programmes and minimise duplication wherever possible.

JC suggested linking the report more clearly to the Start Well, Work Well and End Well themes to help track key trends, including those relating to maternity services. MW advised that this would be considered but emphasised that the SAF was intended to provide an overview rather than replace detailed Board reporting. Significant issues would continue to be reported through the standard governance routes, with the SAF enabling the Board to identify areas requiring further information or discussion.

Resolved: The Board noted the Health Inequalities Assurance Report.

10. Neighbourhood Health Assurance Report (presented by B Flowers)

BF advised that the delivery of several areas of neighbourhood health were also within the Strategy Directorate remit. A balance was required between establishing neighbourhood structures and delivering improvements in patient outcomes. Assurance was provided through a dedicated subcommittee and the programme board.

The recent national team visit had been highly positive regarding the ICB's neighbourhood health development approach. The organisation had subsequently been invited to share learning with regional and national colleagues. A national review of the inherited Primary Care Network (PCN) pilots had concluded positively, with Essex recognised as having some of the most advanced pilots in the country. Work was now underway to embed the effective reporting and measurement approaches developed through the pilots.

MB sought clarification on the provider market commissioning intentions. BF confirmed that a clear approach to new models of care would be required for the following year. Progress had been affected by delays to national consultation processes, but work continued on potential developments to the Directed Enhanced Service (DES), incentives for collaborative working, and piloting multi-neighbourhood approaches. Greater clarity on national requirements was still needed.

MH suggested a greater emphasis on engagement with local authorities and shared responsibilities for delivery. Assurance was sought regarding local authority readiness to respond to increased demand arising from preventative neighbourhood approaches and highlighted the need to consider wider public sector integration rather than focusing solely on clinical services. BF advised that the detailed report reflected developments in partnership-working through the BCF and there were ongoing discussions with public health leads. It was noted that the delivery of neighbourhood priorities would require strong partnership working and that leadership should not always rest with the NHS. The ICB was working to ensure that local authority and community partners were fully engaged and able to contribute confidently.

LW commented that achieving left shift towards prevention would require delegated or pooled budgets based on population need rather than organisational boundaries and queried whether national policy and contracting arrangements were developing quickly enough to support this approach. JK advised that mechanisms for pooled budgets were already available and the focus should be on making better use of existing arrangements, rather than waiting for new national policies. Work was progressing to improve understanding of population needs and outcomes-based commissioning. Future reporting would continue to evolve and could incorporate approaches such as capitated budgets, year-of-care tariffs, and neighbourhood-based funding models.

Resolved: The Board noted the Neighbourhood Health Assurance Report.

11. Neighbourhood Health Report (presented by B Flowers)

BF advised that an update would be provided on the improved Essex wide data which had been published since the report had been written.

For July 2026, dental information reported that 79% of respondents who visited an NHS-funded dentist rated their experience as 'very good' or 'fairly good', compared to the national average of 73%. During the first two months of the year, dental and orthodontic activity had exceeded 100% of commissioned levels, supported by available contract funding. Essex had

reported the fourth highest growth nationally in additional unique NHS dental attendees, equating to approximately 2,400 additional patients over 24 months. The urgent dental access service had also been extended across Essex through NHS 111. Additional orthodontic capacity had commissioned an additional 15,400 units of activity, representing one of the highest growth rates nationally. Over a three-year period, an additional £6million had been invested in orthodontic and child's dental services.

There has been an increase on GP appointments by 165,000 appointments for the year compared with the previous year. Patient satisfaction rate had risen to 72%, moving closer to the national target of 77% and demonstrated continued improvement in access.

In relation to pharmacy services, 90% of respondents to the national pharmacy survey who had received a service beyond prescription collection rated their experience as good, which was slightly above the national average and ranked Essex fifth nationally.

MT asked whether the list of additional services that pharmacies could offer would change in October 2026. BF confirmed that the range of services was expected to increase and existing services would continue, although details of the additional services had not yet been confirmed.

JC asked how patients would be informed about changing services and whether positive outcomes could be more widely promoted. BF advised that discussions were underway between Primary Care and the Communications Team regarding publicity, patient feedback and patient stories.

MS highlighted the strong performance of Essex pharmacies and noted that the October agreement would support continued delivery. It was highlighted that from September, the first cohort of pharmacists qualifying as independent prescribers would complete their training, creating opportunities to expand the role with highly trained pharmacists.

TL noted that many elements of the neighbourhood health agenda could progress locally without national direction but identified digital alignment as a key challenge and asked how neighbourhood health plan aligned with the Essex wide digital approach. MW advised that the digital strategy was being developed collaboratively across the system, with the ICB supporting the process. Recent discussions involving system partners had considered the digital requirements of neighbourhood health. While further work was required, there was greater clarity on priorities, and ongoing engagement would continue as the strategy developed. A system wide aligned approach presented a significant opportunity.

Resolved: The Board noted the Neighbourhood Health Report.

12. Access and Outcomes Assurance Report (presented by S Goldberg, Dr G Thorpe and B Flowers)

GT advised that the risk spanned all executive portfolios within the ICB and related to the organisation's ability to commission and transform services at the pace required to improve access and address inequalities across the system. Increasing demand continued to place significant pressure on providers, affecting waiting times and performance standards. Variations in service delivery also contributed to persistent health inequalities, particularly for some underrepresented groups using acute services.

GT reported that several improvement programmes were underway and highlighted areas of high confidence in the PHIP deliverables, including the agreed cancer recovery plan and increased diagnostic capacity through Community Diagnostic Centres (CDCs) and

Neighbourhood Health Centres (NHCs). This work had been supported by strong multi-agency collaboration.

Positive commissioning decisions had been made, including increasing provider capacity for ASD and ADHD diagnosis and treatment, with outcomes to be closely monitored. Improvements were also highlighted within All Age Continuing Care services following a service reorganisation, which had already improved responsiveness, strengthened compliance with statutory requirements, and enhanced partnership working across health and social care. These changes were expected to reduce delays for vulnerable individuals.

In conclusion, GT advised that the overall position remained one of moderate confidence. While good progress had been made, further work was required to sustain and build on the improvements achieved.

Resolved: The Board noted the Access and Outcomes Assurance Report.

13. Lampard Inquiry Update (presented by Dr M Sweeting)

MS presented the six-monthly update on the Lampard Inquiry, which was reviewing the deaths of mental health in-patients between 1 January 2000 and 31 December 2023. The following highlights were noted.

The governance arrangements across the three ICBs had been strengthened, with Essex ICB continuing to lead the work. All three ICBs held core participation status, enabling the sharing of information relating to historic cases.

The Inquiry hearings were expected to continue until 2027, with a final report anticipated in 2028. Positive working relationships had been maintained with the Inquiry and legal representatives, with continued efforts to support the process, including through safeguarding links. Three significant Rule 9 requests had been received, and responses were being finalised for submission by the end of July. The commissioning landscape had changed significantly over the 23-year period under review, so illustrative case studies had been used to support the Inquiry's understanding of commissioning arrangements and provider oversight. Interim recommendations were expected in October, and a further update would be provided to the Board in due course.

AS added that EPUT had also received several Rule 9 requests and that both current and former staff had provided evidence to the Inquiry, enabling themes to be identified.

Resolved: The Board noted the Lampard Inquiry Update Report.

14. Finance and Quality Assurance Report (presented by J Kearton, Dr G Thorpe and S Goldberg)

JK advised that the report articulated the risk to the long-term financial sustainability of services across Essex. Achieving a financially sustainable position without impacting quality remained challenging due to increasing demand and variation across the population. Progress depended on the pace of strategic commissioning and delivery of key PHIP priorities, including the development of neighbourhood health services. Work would continue with SG and BF to provide assurance as organisational changes and reviews progressed.

Positive developments included the establishment of Executive Resource Review meetings, improved data flows, and strengthened financial oversight across Essex. Executive Directors had received sessions to understand their finances and the contracts inherited from the three

ICBs. GT had supported the inclusion of local quality requirements within contract variations, and significant progress had been made on estates planning to support the neighbourhood health centre submission.

The overall position remained one of moderate confidence, with substantial activity underway and key areas continuing to be monitored.

GT added that the Ockenden and Amos reports had been published and a ten-point action plan was being implemented. The volume of national inquiries and directives could affect the system's capacity to deliver transformation programmes. However, as part of the Essex commissioning intentions, a quality review of perinatal services was being undertaken and engagement with provider Chief Nurses had been strong and positive. GT stressed the importance of addressing the findings of both reports, particularly concerns regarding pregnant people who feel that are not being listened to and the persistent inequalities in outcomes for Black and Asian women.

ASJ commented that there had been significant anticipation around the publication of the reports and important learning would apply across all organisations, regardless of whether they had been directly involved. It was noted that increasing complexity within maternity services continued to present challenges despite declining birth rates. TL acknowledged the pressure that heightened national scrutiny placed on maternity staff and highlighted the need to support teams working within those services.

TL also raised concerns regarding variations in commissioning decisions across ICB boundaries and the potential for inequity in service provision. JK advised that joint commissioning decisions were already taken place with East Suffolk and North East Foundation Trust (ESNEFT) and suggested that similar arrangements with neighbouring ICBs could be explored as the new organisation matured. BF added that discussions were planned with Central East locality leads to consider wider commissioning collaboration and any potential contractual approaches.

SM highlighted that she was a member of the national taskforce responsible for implementing the Ockenden and Amos recommendations and would share any relevant learning.

JC raised concern with the low confidence regarding workforce sustainability and vacancy rates, particularly given the additional staffing requirements arising from the Ockenden recommendations. GT advised that the Chief Nursing Officer for England expected all newly qualified midwives to be appointed to substantive roles, although this presented workforce challenges for provider organisations. Initial funding had been made available, and the Essex quality review would consider future workforce models to ensure they met population needs. GT expressed confidence that workforce assurance ratings would improve as providers responded to these requirements.

ASJ noted the challenge of balancing the recruitment of newly qualified midwives with the need to maintain experienced staffing levels. Further issues were highlighted relating to home births, maternity unit configuration, declining birth rates and increasing delivery complexity. Significant work remained to address both workforce and service model challenges across maternity services.

Resolved: The Board noted the Finance and Quality Assurance Report.

15. Commissioning, Quality and Resource Assurance Report (presented by J Kearton, Dr G Thorpe and S Goldberg)

JK advised that the report presented key data from month 2 and noted that, while discussions had begun to focus on trends, it was too early to draw firm conclusions. JK thanked Board members for the feedback received on the report.

At month 2, an unmitigated risk position of £14million remained, although this was expected to reduce during the year. All major contractual positions had been secured, providing greater confidence in acute, community and mental health activity, and the risk and mitigation position would be reviewed at Quarter 1. The organisation remained on track at month 2.

The importance of focusing on run rates, trends and key risks was emphasised, particularly in relation to efficiency delivery, rather than solely on forecast outturn. Data flows from North East Essex and West Essex had been incorporated into the Essex footprint, and, although further validation was required, data quality was expected to improve.

Significant progress had been made with the capital programme despite being early in the financial year. Section 106 work remained a priority, with continued collaboration with local authorities and ongoing development of neighbourhood health proposals.

Contracted activity information would be available from month 3. The ICB national oversight metrics included in the report would be used by the national team to assess the ICB alongside the other 25 ICBs across the country. The quality and depth of reporting would improve as Essex data became available.

GT advised that the National Quality Strategy had been published and would influence the future format of reporting. The strategy clarified the responsibilities of provider organisations, the ICB as strategic commissioner, and regional and national bodies. Future quality reporting would focus on health inequalities, population health outcomes and emerging system risks, rather than provider performance alone. The emphasis would be on how system pathways contributed to improving life expectancy and outcomes for Essex residents.

The System Quality Group (SQG) was established as part of the ICB's statutory responsibilities. The first deep dive would focus on the physical health needs of people with primary mental health conditions. Discussions would take a system-wide approach, involving primary care, mental health services, secondary care and acute providers, with a focus on identifying risks, sharing best practice and supporting quality improvement. The first meeting was scheduled for August.

ASJ noted that the physical health needs of people with mental health conditions extended beyond inpatient access. Compliance with routine physical health monitoring for mental health patients below the expected level and the need for secondary care physical health services to maximise opportunities to improve care and access was emphasised.

Resolved: The Board noted the Commissioning, Quality and Resource Assurance Report.

16. Trusted Partner Assurance Report (presented by M Watson)

MW advised that the report related to the fifth corporate objective and noted that the organisation had undergone significant change and was confident that the scoring would improve by the next meeting.

The ICB transition process had completed, and all staff had been informed of their future role or outcome. Most colleagues have moved into those new roles or outside of the organisation, with a small number being supported through suitable alternative employment with other ICBs. The cultural leadership and organisational development programme had been launched following a baseline staff survey. Feedback was largely positive, although opportunities for improvement had been identified. Staff briefings had been held across the ICB's key areas, to ensure an understanding of the ICB's priorities and approaches. The focus was on strengthening culture and developing strategic commissioning skills.

Good progress had been made in corporate governance, with both the formal governance framework and PHIP delivery governance arrangements established.

Significant engagement activity with stakeholders and communities was highlighted, including new approaches to funding the voluntary sector, providing greater stability and opportunities for innovation, and maintaining a strong partnership with Healthwatch to support engagement activities.

The ICB had supported NHS England's submission to the National Audit Office review of ICB mergers. Essex had been identified as an example of good practice, and the governance framework, PHIP and neighbourhood development work had been included in the submission.

In response to a request from MT for further information on the challenges of management capability and capacity, MW advised that a dedicated workstream had been included within the cultural and leadership programme. A leadership development offer was being finalised, with a focus on core management skills, including difficult conversations. Work had been undertaken to strengthen objectives, appraisals, and regular one-to-one meetings. Targeted support and potentially external expertise would be provided where staff survey and HR data identified specific areas of need.

LW welcomed the focus on staff wellbeing following the period of significant change and asked whether partner confidence should be considered as a performance metric at system level. The importance of strengthening patient and service user voice arrangements was highlighted, particularly in light of potential changes to Healthwatch, and consideration should be given to how best practice and learning could be maintained when commissioning services.

Resolved: The Board noted the Trusted Partner Assurance Report.

17. Report from Audit, Risk and Compliance Committee (presented by R Smith)

RS advised that the Audit, Risk and Compliance Committee (ARCC) had held three meetings. The approved minutes for the first two meetings were detailed later in the agenda at Item 21, and the report summarised the discussions from the meeting held on 9 June 2026.

Concerns had been raised regarding GP data sharing arrangements, noting that a proposed withdrawal by some practices may have been resolved. A report on the matter would be

presented to Executive Committee. The Population Health Management Report had identified significant variation across Essex, although progress was being made. Further work was required to improve health and safety compliance. Amendments had been made to the ARCC Terms of Reference (ToR) to include additional subgroups, strengthen oversight arrangements and clarify reporting lines. The annual report and accounts had received an unqualified audit opinion, which was considered a significant achievement.

MH requested further information on the GP data sharing issue due to its potential impact on shared care records and wider system working. MW advised that a number of GP practices had sought clarification regarding existing data sharing agreements and had raised questions about current and future arrangements. Access to data was critical to a range of approaches, including neighbourhood and population health management. Discussions with practices were ongoing to understand and address concerns and to support the continuation and development of data sharing arrangements.

IP advised that GP data sharing was a national issue rather than one specific to Essex. GP practices sought assurance that data was being used appropriately and only for agreed purposes. Practices remained committed to supporting service development through the effective use of data to meet population needs.

Resolved: The Board noted the Audit Committee Report.

18. Communications, Engagement and Involvement Strategy 2026-29 (presented by M Watson)

MW advised that the strategy would be a key component of the ICB's strategic commissioning role, to understand the views of stakeholders, communities and residents, while effectively communicating the work of the ICB and wider system to build public trust and confidence.

The strategy comprised of an overarching framework supported by three delivery plans covering internal communications, external communications and engagement with people and communities. The three-year ambition was for the ICB to become a national exemplar in community and partner engagement.

The strategy's key objectives were improving understanding of communities, strengthening trust, delivering meaningful engagement that improved outcomes and building confidence among staff and partners.

Board members were invited to provide feedback and noted that comments had been received on the need for greater detail regarding how resident views and experiences would inform pathway redesign. Delivery of the strategy would require collaboration with partners, including Healthwatch, the voluntary sector and system colleagues.

JC welcomed the focus on inclusivity and accessibility and stressed the importance of ensuring communications were effective for people with learning disabilities, mental health needs, where English was their second language, and other groups who may experience barriers to engagement. Engagement and communication approaches should form part of ongoing discussions on physical and mental health alignment.

Resolved: The Board approved the Communications, Engagement and Involvement Strategy 2026-29.

19. General Governance (presented by Prof. M Thorne)

19.1 Risk Appetite Statement

TA advised that this the ICB's risk appetite had been considered through a range of governance forums and was presented to the Board for final approval, reflecting the agreed position.

Resolved: The Board approved the risk appetite statement for the Essex ICB.

19.2 Governance Report

MT referred members to the governance report and the following revised Terms of Reference which had been updated to align with the governance model, reflect the establishment of subgroups, and had been approved by the relevant committees:

- Audit, Risk and Compliance Committee
- Executive Committee
- Neighbourhood Health Committee
- Commissioning, Quality and Resource Committee

Resolved: The Board:

- **Approved the revised terms of reference for the Audit, Risk and Compliance Committee, Executive Committee, Neighbourhood Health Committee and Commissioning, Quality and Resource Committee.**
- **Approved the updated Functions and Decisions Map.**
- **Noted the changes to the governance framework and the establishment of committee sub-groups.**

19.3 New and Revised Policies

MT referred to the new and revised policies and highlighted a correction to the report, noting that the Chair of the Commissioning, Quality and Resource Committee was Mark Bailham rather than Jo Churchill as stated.

The following policies had been approved by the relevant committees:

- Lone Worker Policy (C008)
- Security and Lockdown Policy (C011)
- Provider Accreditation Policy (F007)

Resolved: The Board noted and adopted the set of revised policies as detailed above.

19.4 Updated Scheme of Reservation and Delegation

MB advised that CQRC had fully endorsed the amendment to Section 9 of the Scheme of Reservation and Delegation, as it would reduce the number of requests requiring escalation and improve the timeliness of decision-making.

JK noted ongoing challenges with Continuing Healthcare (CHC) invoice processing, which had affected some smaller providers. The proposed actions and activity were expected to help address these issues and support valued providers in delivering services to patients.

Resolved: The Board approved the updated Scheme of Reservation and Delegation.

20. Mid and South Essex ICB Annual Report and Accounts 2025/26 and Health Inequalities Annual Report

JK presented the Mid and South Essex ICB Annual Report and Accounts for 2025/26. The Suffolk and North East Essex elements would be approved by Norfolk and Suffolk ICB, and the Hertfordshire and West Essex element by Central East.

Mid and South Essex ICB had achieved its financial targets for 2025/26. Recognition was acknowledged for the commitment and dedication of the in delivering this outcome despite the implementation of a new ledger system, organisational change, and the mobilisation of new budgets and programmes of work.

Resolved: The Board noted the Mid and South Essex ICB Annual Report and Accounts, associated audit opinion and the Health Inequalities Annual Report.

21. Approved Committee minutes

The Board received the summary report and copies of approved minutes of:

- Audit, Risk and Compliance Committee, 1 April 2026 and 22 April 2026.
- Commissioning, Quality and Resource Committee, 21 April 2026.

Resolved: The Board noted the latest approved committee minutes as detailed above.

22. Chairs Key Issues / Escalations Report

There were no chairs key issues or items of escalation.

23. Effectiveness of meeting (presented by Prof. M Thorne)

MT invited comments from members on the effectiveness of the meeting.

No comments were received.

24. Any Other Business

There were no items of any other business. MT thanked the members of the public for attending.

25. Date and Time of Next Part I Essex ICB Board meeting:

Thursday, 15 October 2026 at 2.00pm – 3.30pm in the Committee Room 4A, Southend Civic Centre, Victoria Avenue, Southend-on-Sea SS2 6ER.

Essex ICB Part I Board Meeting

15 October 2026

Agenda Item No:	7
Report Title:	Chief Executive's Report
Purpose of Report: 'Check' (x) relevant box(es).	Approval ☐ Alert ☐ Celebrate ☒ Endorsement ☐ Advise ☒ Discussion ☐ Assure ☒ Assurance Rating: Not rated, strategic update report
Confidentiality Status:	General – no additional protection
Executive Director Sponsor:	Tom Abell, Chief Executive
Report Author / Presenter:	Tom Abell, Chief Executive
Previously considered by:	Not Applicable
Subject of Report:	National reforms reinforce the direction already being taken by NHS Essex - The Health Bill has completed its Commons stages and includes the abolition of NHS England, transfer of functions to the Department of Health and Social Care and a Single Patient Record. The NHS Oversight Framework places strategic commissioning and resource shifts towards prevention and community capacity at the centre of the ICB role. Neighbourhood health remains the principal route through which Essex will deliver the three shifts - NHS England's review of neighbourhood health work in Essex recognised progress and set expectations for improving community datasets and moving towards resource shift into primary and community care through expanded proactive care. The change in local government reform alters proposed footprints, but not the strategy - Following the Government withdrawing its decision on the future local government footprint of Essex, the five multi-neighbourhood areas being developed are no longer appropriate. Revised design principles are being developed with partners. Access is improving across services, but requires ongoing focus - GP, dental and pharmacy activity has increased. Resident feedback continues to identify access and communication as concerns. Elective recovery is progressing across hospital and community services but requires continued focus into winter.

	Winter and organisational readiness - A difficult winter is expected across Essex. Assurance is being coordinated around frailty, urgent community response, discharge and mutual aid. Jennifer Kearton's departure is also prompting separation of Finance from a new Commercial, Estates and Resilience portfolio.
Recommendations:	The Board/Committee is asked to receive the report for information and note the updates provided.
Strategic Objectives: 'Check' (x) relevant box(es).	1. Health inequalities narrowing year on year ☒ 2. A decisive shift towards neighbourhood care delivery and prevention ☒ 3. Timely access and excellent outcomes across services ☒ 4. Financially and clinically sustainable services across Essex which are safe and high quality ☒ 5. An organisation that is up to the job, good to work for and good to partner with ☒
Impact Assessments (IA):	QEHIIA ☐ DPIA/DTAC ☐ Sustainability ☐ Primary care ☐ Not Applicable ☒ This is an information and assurance report and does not propose a new decision requiring an impact assessment
Financial Implications:	No direct financial implications arise from receiving this report. The report references separately governed capital investments and wider resource-shift activity.
Details of patient or public engagement or consultation:	The report includes findings from a survey of more than 2,000 Essex residents and references engagement with Maternity and Neonatal Voices Partnerships, a local voluntary sector organisation and Healthwatch Thurrock.
Conflicts of Interest:	None identified
Related risks / new risks:	The report highlights existing strategic and delivery risks relating to winter pressures, elective recovery, provider performance, neighbourhood delivery, infrastructure and organisational capacity. No new risk is proposed for addition to the Risk Register or SAF through this report.
Internal Engagement:	Finance ☐ Procurement ☐ Contracting ☐ Quality ☐ IG Team ☐ Delivery Unit ☐ Governance ☐ Comms ☐ Clinical ☐

Chief Executive's Report

1. Context and Purpose

This report provides the Board with an update on significant developments since its last meeting and summarises business considered by the ICB Executive Committee. It is presented to advise members of changes in the national and local context, provide assurance on the organisation's response and highlight matters requiring continued Board oversight.

2. Key Issues and Assurance Summary

The principal messages for the Board are set out below. The detailed evidence and supporting narrative are contained in the assessment and analysis section.

Alert	Winter pressures, elective pathway completion, provider performance and risks to the continued operation of services at Orsett Hospital require sustained system attention.
Advise	National reform, the NHS Oversight Framework and the change in the proposed local government footprint affect the operating context, while reinforcing the strategic direction towards commissioning, prevention and neighbourhood care.
Assure	Essex has coordinated winter assurance arrangements, is incorporating NHS England neighbourhood feedback into the PHIP refresh and Community Services Review, and continues to use provider, regional, national and independent sources to oversee maternity safety.
Celebrate	Primary care activity has increased, major capital developments have opened or progressed, and NHS England's neighbourhood review recognised good progress in Essex.

3. Assessment / Analysis

National Context

Health Bill and the NHS operating model

The Health Bill completed its stages in the House of Commons on 8 September and was introduced in the House of Lords on 9 September. Subject to its passage through Parliament, it provides for the abolition of NHS England and the transfer of functions to the Department of Health and Social Care, alongside measures relating to a Single Patient Record, information sharing, ICBs and foundation trusts, and wider partnership arrangements.

The national architecture will continue to evolve, but the direction is consistent with the changes already being made in Essex: a smaller and more strategic ICB; clearer provider accountability; stronger commissioning, contracting and market-shaping

capability; and deliberate movement of resources towards prevention, neighbourhood and community services.

NHS Oversight Framework

The first quarter results for 2026/27 for NHS Trusts and Foundation Trusts have been published and show a number of challenges across parts of the Essex provider landscape. Mid and South Essex NHS Foundation Trust and The Princess Alexandra Hospital NHS Trust are in segment 4; East Suffolk and North Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust are in segment 3.

ICB ratings have not yet been published by NHS England.

These results are not a substitute for rounded system judgement, but they underline the importance of our improvement work, robust contract management and alignment with our commissioning activities as part of our Population Health Improvement Plan refresh for those areas which require more fundamental redesign and recommissioning.

Thirlwall Inquiry

The Thirlwall Inquiry report, published on 15 September, found profound failures of management, governance and safeguarding at the Countess of Chester Hospital, including delayed action on clinicians' concerns and failures of candour to families.

Its 17 recommendations include an NHS-wide protocol for suspected deliberate harm, Board-level monitoring and escalation of child and baby deaths, safeguarding training for staff and Board members, and stronger managerial accountability.

We are reviewing the national response and testing the Inquiry's themes through our quality oversight and provider assurance. We regularly assess maternity safety through provider, regional and national reporting, tested against independent sources such as Care Quality Commission (CQC) findings, Maternity and Newborn Safety Investigation reports, MBRRACE-UK and the Maternity Outcomes Signal System.

The Maternity and Neonatal Voices Partnerships bring the experiences of women and families into provider safety forums. We have also commissioned a local voluntary sector organisation to understand the experiences of Black African and mixed-heritage women using perinatal services at Basildon Hospital to support this work.

As outlined in the recommendations, the bereavement care pathway we commission meets eight of the nine National Bereavement Care Pathway standards. The outstanding action is post-mortem consent training at one Trust and the soundproofing of the bereavement suite at the other. Both have plans in place, and the Essex Maternity Oversight Group will continue to review progress.

Internally, the ICB will continue to support its workforce in ensuring all staff are aware of its duty to speak up and engage on areas of safeguarding or clinical concerns, and ensure staff are updated on their mandatory training.

Essex System

Neighbourhood health

NHS England's review of neighbourhood health in Essex recognised good progress and identified the following priorities for the coming months:

- establish consistent community-service data, baselines, trajectories and performance reporting through the Community Services Review;
- confirm the baseline and implications of the planned 1% resource shift across activity, finance and workforce, and identify priority population cohorts for 2027/28;
- expand proactive care from 0.5% towards 1% of the registered population and reduce unnecessary barriers at service interfaces;
- translate pilots into commissioning intentions and mobilisation plans at scale, including agreed models in dermatology, ENT, gynaecology and urology; and
- strengthen governance through multi-neighbourhood and place partnerships, complete the Better Care Fund stocktake, and progress the VCSE convenor model.

These actions are being incorporated into the refresh of the Population Health Improvement Plan, the Community Services Review and the work of the Neighbourhood Health Committee. Together they provide a clearer route from strategy to delivery and assurance.

The full letter and one page feedback summary shared by NHS England has been included at Appendix A of this report. This and our response are explored further within the Neighbourhood Health report later on the agenda.

Annual assessments of predecessor ICBs 2025/26

NHS England has issued its statutory annual assessments for 2025/26 of the three predecessor ICBs whose footprints now form NHS Essex: Mid and South Essex, Hertfordshire and West Essex, and Suffolk and North East Essex. The assessments cover each predecessor body as it existed during 2025/26, before NHS Essex was formed. None of the three ICBs was subject to formal regulatory intervention during the year, and all three met their statutory financial duties.

NHS England has asked that the assessments are shared with the Board. The letters are included at Appendices B1 to B3, and their findings will inform the refresh of the Population Health Improvement Plan.

Local government reform

On 7 September, the Government announced that it was withdrawing its decision on local government reorganisation in Essex and reviewing its plans. Existing local government structures and partnerships will remain for now and the announcement did not change the plan for an Essex mayoral election in 2028.

For NHS Essex, this does not change our direction or immediate priorities, but the five proposed multi-neighbourhood areas aligned to the withdrawn unitary footprints are no longer appropriate. We are developing revised design principles with partners, balancing the need for coherent NHS delivery footprints with established local relationships whilst ensuring sufficient flexibility to align with any future local government changes.

Delivery

Resident experience and primary care access

More than 2,000 residents responded to our recent survey about health and care in Essex. Seventy per cent rated NHS services as fair, good or very good, while 30% rated their experience as poor or very poor.

Access and communication about access were prominent concerns and will be reflected more clearly in the Population Health Improvement Plan refresh.

However, we have continued to see encouraging signs of improvement in primary care:

- Essex general practices delivered more than 1 million appointments in July and 11.6 million over the preceding year, around 600,000 more than in the previous year;
- more than 2.6 million units of dental activity were delivered in the 12 months to May, around 200,000 more than in the previous year, with 2,400 more patients accessing NHS dentistry over two years; and
- community pharmacy use continues to grow in June, more than 20,000 residents used Pharmacy First, more than 9,000 used blood-pressure checks and nearly 5,000 used contraception services.

The test is now whether rising activity translates into a more reliable and understandable experience for residents, particularly when they are seeking timely advice or treatment.

Elective recovery and provider performance

July's waiting list position shows that despite a reduction of over 20,000 since the peak of the Essex waiting list in October 2026, elective access remains one of the system's most significant delivery challenges.

Our recent analysis indicates that despite new referral starts being slightly below plan, and 5% lower than last year, the more immediate constraint is the pace of pathway completion and removal with the requirement to see a consistent reduction of around 5,500 each month from August to March to deliver our year-end target.

Our response, working with providers is focusing on three areas: demand management, further data quality work and the release of our next tranche of funding for additional activity to support waiting list recovery.

Winter readiness

NHS England's winter planning requirements place clear responsibility on ICBs for system coordination, escalation, mutual aid, discharge and intermediate-care capacity, supported by an ICB Board assurance self-assessment. Essex is coordinating assurance across partners, with particular focus on frailty, proactive care, urgent community response, same-day emergency care, discharge and reducing avoidable hospital occupancy. This is subject to a more detailed paper being presented later to the Board.

Orsett Hospital

Board members will be aware that Mid and South Essex NHS Foundation Trust have identified risks regarding the infrastructure of Orsett Hospital in Thurrock which may affect their ability to continue to operate services from that site. The ICB is working closely with MSEFT to ensure the future safe delivery of the services which are currently provided on the site.

The ICB also announced its intention to relocate the Minor Injuries Service which is currently provided at Orsett to the Thurrock Community Hospital site, supported by £1m of additional capital funding. This change would mean that patients would benefit from better access to diagnostics through the Community Diagnostic Centre and from co-location with the existing GP out of hours service provided on the site. This change would initially involve a location change, followed by steps to expand the service to be able to support patients with a wider range of illnesses to give people in Thurrock access to better urgent care and to avoid needing to attend accident and emergency services at Basildon Hospital. We are being supported by Thurrock Healthwatch in engaging with local people on this development.

Infrastructure and service developments

The Hollies GP practice building in Hadleigh reopened in August, and the ICB is reviewing its handling of the disruption to identify learning.

Significant capital developments since my last report include the opening of Southend Hospital's £8.9 million Emergency Department extension and Braintree Community Diagnostic Centre; £6 million for Basildon Hospital's Emergency Department; support for Community Mental Health Centres in Clacton and Thurrock and £1 million of investment to develop plans to replace the ageing tower at Southend Hospital.

Organisational updates

Executive leadership

This will be the final Board meeting before Jennifer Kearton leaves the ICB to become Chief Finance Officer at Mid and South Essex NHS Foundation Trust. I thank Jen for her commitment and contribution to NHS Essex, and previously to NHS Mid and South Essex and its predecessor organisations and wish her every success in the new role. I am pleased that she will remain in Essex and that we will continue to work together.

We will separate the Finance and Commercial portfolio, establishing an Executive Director of Finance alongside a new Executive Director of Commercial, Estates and Resilience. This reflects the work ahead on payment mechanisms, contract reform, market shaping and accelerating progress on primary and community care estates development. Simon Rudkins will act as Executive Director of Finance while recruitment progresses.

Natalie Hammond is acting as Executive Chief Nurse during Giles Thorpe's parental leave which commenced in September. Emily Hough is returning from maternity leave as Executive Director of Strategy in October, and I am sure the board would join me in welcoming her back.

Executive Committee assurance

The Executive Committee has held ten meetings. The following decisions were approved by the Executive Committee:

- Review of ICB's governance and associated terms of reference, including the setup of new governance groups to support engagement and decision making across the ICB.
- Approval of the ICB's approach to engaging with the Voluntary and Community Sector through a new 'Convenor Model'.
- Review of Hospice Provision across the county.
- Approval for direct award to existing provider of Enteral Feed services across Essex.
- Review of primary care S106 estate cases.
- Review and workshop of the ICB's workforce values and mission statement.
- Review of ADHD and autism pathways across Essex.
- Approval of next steps associated with Community Services Review programme
- Approval of provision for Lung Cancer screening services across Essex, utilising existing providers.
- Approval of new Strategic Commissioning and Decision-Making Framework for the ICB.

4. Associated Risks

The report identifies ongoing risks and areas requiring oversight in relation to winter system pressure, elective recovery, provider performance, neighbourhood delivery, infrastructure and organisational capacity. These matters are managed through the relevant programme, provider assurance, committee and risk-management arrangements described in the report. The report does not identify a new risk for addition to the Risk Register or Strategic Assurance Framework.

5. Recommendations

The Board is asked to receive and note the updates and assurances provided within this report.

6. Appendices

Appendix A – NHS England Letter to NHS Essex ICB on Neighbourhood Health

Appendix B1 – Mid and South Essex ICB Annual Assessment Letter 2025/26

Appendix B2 – Hertfordshire and West Essex Annual Assessment Letter 2025/26

Appendix B3 – Suffolk and North East Essex ICB Annual Assessment Letter 2025/26

ICB Chief Executive
ICB Chair

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

17 September 2026

Dear Michael and Tom

Neighbourhood Health – Essex

Thank you to you and your team for meeting with us to discuss progress following the recent Neighbourhood Health Readiness Visit.

We appreciated the continued openness and constructive engagement from you and your colleagues. The follow – up discussion provided an opportunity to further review progress and consider the system’s trajectory as neighbourhood health continues to develop.

There are a number of strong examples of good practice across Essex.

These include:

- **North East Essex** has a long-established and successful Enhanced Service (NEEDS), supported by a mature integrator model that provides robust oversight, contract management and accountability for delivery across practices. Practices are required to deliver against a clearly defined scope, with investment following evidenced delivery and being reinvested in primary care. The model has developed over a number of years and provides demonstrable evidence of impact, including releasing GP capacity and reducing GP time required for activities that can be delivered through the wider primary care workforce.
- **Tendring PCN** is part of the national PCN pilot programme. One of their highest impact actions has been the identification of patients aged 65+ with frailty, multimorbidity or recent admissions through structured assessments, risk stratification and targeted referrals to community services. This in turn has strengthened Advanced Care Planning, increasing numbers of patients with ResPECT plans, PCC and PPD in place. 671 patients have been seen for structured assessment. Resulting in 81% A&E attendance reduction, 88% falls reduction and £335K cost reduction. 124% increase in Respect tool completion, 138% increase in PPC, 187% increase in PPD, preventing inappropriate emergency escalation

- Across **Mid and South Essex**, a Tier 2 demand-management service has been introduced to support planned-care transformation and reduce avoidable referrals into acute outpatient services. Following implementation in February 2026, dermatology referrals into MSEFT have reduced by 40%. The trauma and orthopaedics service, introduced in April 2026, has reduced referrals by 27%. This forms part of the wider trust-led decommissioning and recommissioning approach, alongside planned-care hubs and a vertically integrated subcontracting model for outpatient follow-up.
- **GP Leadership.** Over the past two to three years, Essex has developed a range of fellowship and portfolio opportunities supporting 70 GPs, including 38 through the National GP Fellowship and targeted Thurrock Scheme, 14 through the Thrive Fellowship, 10 through the First 5 Portfolio Scheme, four through Portfolio Plus and four through the Specialist Portfolio Scheme for ENT. Together, these programmes provide development, mentorship, funded CPD and portfolio career opportunities across priority clinical and leadership areas, supporting recruitment, retention, workforce development and collaboration with local partners.
- Essex's **Stewardship approach to quality improvement** empowers frontline health and care staff to collaborate across organisational boundaries, take joint responsibility for finite resources and design better solutions together. This ensures professionals who understand pathways, pressures and patient needs most lead improvement. This approach has delivered tangible improvements to patient care since its introduction in Mid and South Essex in 2020. For example, Ageing Well stewards developed and embedded the FrEDA tool, supporting a consistent and comprehensive approach to the recognition and management of frailty. Next steps include recruiting three new Essex-wide stewardship groups focused on cancer, cardiometabolic health and frailty. These groups will use the three strategic shifts as guiding principles, creating the conditions for neighbourhood partners to deliver services shaped around local need. GPEC is also being established to strengthen the general practice voice at system and place level, support better patient care and identify opportunities to expand the range of services provided through primary care
- Essex has developed a **Neighbourhoods Prioritisation Framework**, which provides a consistent, comparative view of need across neighbourhoods. It brings together data on health inequalities, service demand, access barriers and population growth to help identify where neighbourhood-based care, investment and support can have the greatest impact. It offers a high-level baseline for prioritisation and planning and can be adapted for different areas of focus, supported by local insight. This framework has been used to develop neighbourhood health centre plans and added additional information to help inform the WorkWell approach in Essex. There are plans underway to further refine the framework and to also develop a mental health and a CYP specific prioritisation framework.

Taking together the visit and follow-up process, alongside the subsequent system and Place level self – assessments, the accompanying single page summary provides an agreed reflection of the system's current position.

We would encourage you to share the agreed single page summary with your Board and system partners to support local oversight of neighbourhood health priorities, agreed next steps and future delivery.

As discussed, the key areas of focus over the coming months are to

- Establish a consistent approach across community providers to data, baselines, trajectories and performance reporting.
- Reduce unnecessary “red tape” at service interfaces and use GIRFT and local learning to spread effective practice across Essex.
- Confirm the baseline for the planned 1% resource shift in 2026/27, model the implications across activity, finance and workforce, and define the high-priority population cohorts for delivery in 2027/28.
- Proactive care is commissioned for 0.5% of the registered population, e.g. through PCN DES variation, and the system is working towards 1%.
- Translate pilots and local learning into joint commissioning intentions and mobilisation plans at scale, identifying what can be standardised across Essex and where local flexibility is required.
- By Q4, establish clear governance, accountability and escalation routes for elective care and integrated neighbourhood teams through multi-neighbourhood and place partnerships.
- Implement and evaluate the agreed models across dermatology, ENT, gynaecology and urology, with clear ownership, delivery milestones and measures to demonstrate their impact on demand, activity, access and outcomes.
- Complete a stocktake of 2026/27 BCF-funded schemes, identify those that should continue into 2027/28 and align future investment with neighbourhood priorities.
- Develop and launch a VCSE convenor model to strengthen the sector's involvement in neighbourhood planning and delivery.

Thank you again for the time and commitment shown by you and your teams throughout both the visit and follow-up process. We look forward to continuing to work with you as neighbourhood health develops across Essex.

Yours sincerely



Professor Claire Fuller MRCGP DRCOG MBBS
National Priority Programme Director – Neighbourhood Health

Annex:

Single slide summary

NHS Essex Integrated Care Board

16 September 2026

ICB at a glance			
ICB CEO	Tom Abell (substantive; prev CEO NHS Mid and South Essex ICB)		Local authorities
ICB Chair	Professor Michael Thorne CBE (substantive) CFO Jennifer Kearton (Exec Director Finance and Commercial) Medical Director Dr Matthew Sweeting (Executive Medical Director) NbH lead Beverley Flowers (Executive Director for Neighbourhood Health)	Providers	3 (Essex CC two-tier; Southend City and Thurrock unitary); 3 HWBs Acute: MSEFT, ESNEFT, PAHT. Community/MH: EPUT, NELFT (and ESNEFT, Provide CIC). Ambulance: EEAST. 8 hospices. HCRG Children's NEE&WE.
Registered population	c. 1.93 million	Trusts in regulatory action	MSEFT (RAJ, leadership inadequate; S31 on Broomfield); EPUT (R1L, Lampard Inquiry) ESNFT CQC notice S29a, Also one GP practice CQC Regulation 12 and 17 action plans
Places	5 (Mid, North East, South East, South West, West Essex); 38 neighbourhoods; 41 PCNs; 204 practices	2026/7 position	Consolidated opening position not in public domain; predecessors carried material deficits driven by MSEFT
Footprint	County of Essex; urban, rural and coastal; deprivation in Tendring, Basildon, Harlow, Southend, Thurrock, Castlepoint and Maldon	Pilots and designations	1 North East Essex Wave 1 pioneer (2 of 5 Places); 14-site NHC estates submission made (14 sites selected). Jim Mackey response Confirmed submitted (15 May): A1, J2, J4 STRONG; J1, J3 IN PROGRESS

Place level maturity score

Place (fill = maturity)	Mid Essex	Score 40	North East Essex	Score 43	South East Essex	Score 39	South West Essex	Score 41	West Essex	Score 57
Population	c.337k (5 NbHs)		c.521k (10 NbHs)		c.365k (8 NbHs)		c.374k (9 NbHs)		c.330k (6 NbHs)	
HWB sign-off	Y - agreed		Y - agreed		Y - agreed		Y - agreed		Y - agreed	
NbH footprints / PCNs	5 / c.5 PCNs		10 / c.7 PCNs		8/9 PCNs		9 / 9		6/6	
HLE (M / F)	66 / 67 (est.)		62 / 64 (est.)		62 / 64 (est.)		60 / 62 (est.)		64 / 65 (est.)	
GP federation	Predecessor federations; GPEC place board		GP Primary Choice (32 practices, CQC Good) Braintree-GPEC		Predecessor federations; GPEC place board		Predecessor federations; GPEC place board		Stellar Health (PAHT-facing); WEHCP	
MNP / integrator	Developing		Developing		Developing		Developing		Developing	

Examples of practice surfaced across Places

- North East Essex: Colchester, Tendring and Ranworth PCN test sites; Colchester ranked 1st in England for diabetic care processes; Tendring 81% A&E and 88% falls reduction for the frailty cohort, c.£355k cost avoided (visit pack).
- Mid Essex: trust-led elective decommission and recommission, taking out 40% of dermatology and 27% of MSK outpatient activity; planned-care hubs and a vertical outpatient follow-up subcontracting model (visit, 30 June 2026).
- West Essex: GP fellowship programme with 24 fellows this year, plus the Care Closer to Home Proactive Care Blueprint and six mature PCN-aligned INTs; CEO-led commitment (visit, 30 June 2026).
- System: clinical stewards model leading pathway redesign (a delivery model not seen on other visits); GPEC being established to take on unwarranted-variation work across the six place boards (visit, 30 June 2026).
- System: planned shift of 2.4% of funding into neighbourhood health over five years, with active decommission, recommission and procurement rather than additional investment alone (visit, 30 June 2026).
- North East Essex: ESNEFT GP interface team (2 facilitators since Jan 2026, agreed Principles of Care) resolved 84% of 161 queries in six months, 94% first-reply rate (PCN pilot pack, 17 June 2026).

Five Goals (RAG vs England 2.48; score inline)				
G1 Health outcomes 2.82	G2 GP access and experience 1.00	G3 Planned care 1.00	G4 Urgent and emergency care 1.89	G5 Patient and staff satisfaction 1.00
G1 read: G1 (2.82) is the only above-floor Goal, but the single score flatters and should be read with caution. It is carried by two Type 2 diabetes outcome metrics (treatment-target achievement 50.8%, rank 6 of 42; HbA1c control 68.7%, rank 8) and CVDPREVENT hypertension treated to target (rank 11). Inside the same Goal, the Cancer Faster Diagnosis Standard is 66.72% (rank 42 of 42, worst in England), and the same diabetes population scores Q4 (rank 35) on the all-eight-care-processes measure. A system genuinely strong on diabetes would not be near-bottom on process reliability for the same patients, so the Q1 outcome metrics flatter rather than reflect strong cohort delivery. The honest read is worst-in-England cancer diagnosis and an outcome-versus-process gap, not diabetes strength. The weakest Goals are G2, G3 and G5, all at the 1.00 floor; G3 RTT is rank 42 of 42 across all seven measures. All figures are the Mid and South Essex baseline.				
Enablers (Section 4)				
Enabler (fill = rating)	Key point			
Data	Three population health management tools; single Essex record and EMIS write-back not evidenced. Good practice: neighbourhood prioritisation framework using linked data.			
Workforce	Staff Survey 2025 engagement, morale, advocacy, motivation 42/42 (MSE baseline, MSEFT-driven); EPUT above England on every measure.			
Finance	Consolidated 2026/27 opening position not in public domain; MSEFT dominant risk. Good practice: c.£227.98m devolved budget in North East Essex.			
Digital	NHS App, Single Patient Record and ambient AI readiness not surfaced for the consolidated ICB.			
Estates	14-site Neighbourhood Health Centre pipeline (Core / Core+ / Core++) across five Places; NHC estates submission made, 14 sites selected (visit, 30 June 2026). St Margaret's CDC open.			

Framework readiness: Stage 1 (foundations) and Stage 2 (NbH Plan)		
Ref	Stage 1 minimum requirement (2026/27): Ref fill shows rating	Self-assessed score
S1	Reduce non-elective admissions via UCR and reablement	4
S2	Reduce variation; improve access to general practice	7
S3	Neighbourhood footprints agreed	6
S4	INTs for high-priority cohorts; devolved budgets	2
S5	Neighbourhood approach to elective pathways	0
S6	18-week community waits; eliminate 52-week waits	1
S7	BCF pooled funding plans confirmed with LAs	5
S8	Primary / secondary care interface (RTC)	5
S9	Organisational ownership of planned deliverables	3
S10	Data-sharing arrangements for patient identification	3
Stage 1 overall:		36
Ref	Stage 2 NbH Plan step (2027/28): Ref fill shows rating	
1	National objectives via the three reform agendas	
2	Support wider local goals and public service reform	
3	Local objectives informed by JSNA	
4	Confirm final geographies	
5	Confirm organisational delivery responsibilities	
6	Confirm governance and operational arrangements	
7	Align other initiatives (Family Hubs, Pride in Place, MH hubs, employment)	
Stage 2 overall		

Forward look - Key actions over next 6-12 months:					Forward look – Key actions over next 12-18 months				
1.	Establish a consistent approach across community providers to data, baselines, trajectories and performance reporting.				1.	Put in place the necessary data-sharing arrangements and address gaps across the wider primary care family, community services, local government and the VCSE sector.			
2.	Reduce unnecessary 'red tape' at service interfaces and use GIRFT and local learning to spread effective practice across Essex.				2.	Mobilise commissioning plans at scale, with delivery aligned to local goals, neighbourhood priorities and population health needs.			
3.	Confirm the baseline for the planned 1% resource shift in 2026/27, model the implications across activity, finance and workforce, and define the high-priority population cohorts for delivery in 2027/28.				3.	Embed shared outcomes and measures that demonstrate impact on access, inequalities, prevention, avoidable demand and resident outcomes.			
4.	Proactive care is commissioned for 0.5% of the registered population, e.g. through PCN DES variation, and the system is working towards 1%.								
5.	Translate pilots and local learning into joint commissioning intentions and mobilisation plans at scale, identifying what can be standardised across Essex and where local flexibility is required.								
6.	By Q4, establish clear governance, accountability and escalation routes for elective care and integrated neighbourhood teams through multi-neighbourhood and place partnerships.								
7.	Implement and evaluate the agreed models across dermatology, ENT, gynaecology and urology, with clear ownership, delivery milestones and measures to demonstrate their impact on demand, activity, access and outcomes.								
8.	Complete a stocktake of 2026/27 BCF-funded schemes, identify those that should continue into 2027/28 and align future investment with neighbourhood priorities.								
9.	Develop and launch a VCSE convenor model to strengthen the sector's involvement in neighbourhood planning and delivery.								

Professor Michael Thorne
Chair
Essex ICB

NHS England – East of England
Victoria House
Camlife
Fulbourn
Cambridge
CB21 5XB

31 July 2026

Dear Mike,

Annual assessment of Mid and South Essex (MSE) Integrated Care Board's (ICB) performance in 2025-26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB).

This has been a particularly challenging year for ICBs, marked by significant system-wide pressures and organisational change. In parallel, ICBs have been required to adapt to an evolving operating model while maintaining a clear focus on statutory duties, system leadership and delivery for local populations. In the East of England, this has included the additional complexity of managing the merger of all six predecessor ICBs in-year.

Against this backdrop, I recognise the complexity of the task facing your organisation and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. I also acknowledge the additional burden of maintaining stability, continuity and delivery through a period of significant structural transition.

In reaching this assessment, I have considered evidence from the ICB's annual report and accounts, available performance and assurance data, feedback from partners where received, and the discussions my team and I have held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, I have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

I remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

I would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. My team and I look forward to continuing to work with you in the year ahead.

Yours sincerely,

A handwritten signature in dark ink, appearing to read 'Clare Panniker', followed by a small dot.

Clare Panniker
Regional Director
NHS England - East of England

Cc Tom Abell, Chief Executive Officer, Essex ICB
Simon Wood, Executive System Lead & Regional Director of Strategy
and Integration, NHS England - East of England

Section 1: ICB performance assessment

During 2025/26, MSE ICB operated in a period of significant organisational change, maintaining a clear focus on its statutory duties, system leadership and delivery for its population. This assessment reflects performance against these duties, including reducing inequalities, improving quality, meeting financial requirements, supporting research, and aligning with local strategies. It also considers the wider effect of decisions across the system, consistent with the triple aim of improving population health, quality of care and value for money, and supporting the long-term sustainability of services for local communities.

Population Health and Inequalities

MSE ICB's performance on population health and inequalities was mixed during 2025/26, with some clear areas of progress but also several continuing concerns. The most notable strengths were in annual physical health checks for people with serious mental illness, which reached 65% and exceeded the national target, alongside strong improvement in learning disability health checks over the year. There was also evidence of continued strategic focus through Core20PLUS5, population health management and targeted prevention activity, indicating a strengthening approach to address inequalities.

However, the broader picture points to the need for sustained action. Childhood measles, mumps and rubella (MMR) coverage before age 5 remained below the 95% ambition throughout the year and at 87% for quarter four, and screening performance remained below expected levels across key programmes, including bowel and breast screening.

Performance also deteriorated in important areas of long-term condition management, including delivery of all eight diabetes care processes. There were also continuing inequality gradients in outcomes, including cancer stage at diagnosis and pre-term births by deprivation and ethnicity. Taken together, these indicators suggest that although the ICB has strengthened its strategic focus on inequalities, measurable improvement in outcomes remains uneven and challenges persist.

Quality and Safety of Services

During 2025/26, the ICB maintained focus on quality oversight and system working, but the quality and safety picture remained challenging. While there was some improvement in neonatal deaths and stillbirths and reductions in inappropriate out-of-area adult acute mental health bed days, wider provider concerns remained significant. In particular, Mid and South Essex NHS Foundation Trust (MSEFT) continued to present substantial quality, governance and assurance concerns, with the need for clearer accountability across sites.

Whilst the ICB strengthened quality oversight during the year, including clearer dashboards, quality assurance activity and implementation of patient safety learning arrangements, a number of safety concerns remained. Regional reviews identified ongoing concerns in maternity and paediatric services at MSEFT, alongside the need for a strengthened quality governance framework and clearer risk ownership. Continuing system concerns were also highlighted in relation to maternity and women's services, inconsistent audit findings, paediatric scrutiny and the need for enhanced oversight where assurance was insufficient. Overall, safety performance remained in the lowest performing quartile, reinforcing the importance of sustained focus on provider quality, stronger governance and effective escalation arrangements.

Access and Experience

Access to core services remained a significant challenge for the MSE population throughout 2025/26, with performance in the lowest performing quartile overall. Accident and emergency four-hour performance was 66.20%, 18-week referral to treatment (RTT) performance was

53.10% and cancer 62-day performance was 53.42%. All three measures remained below the national standards, although RTT and 62-day cancer performance showed some improvement on the previous year. Taken together, these indicators point to sustained operational pressure across urgent and elective care and should be seen as material areas of underperformance.

The wider provider context reinforces this position. MSEFT remained very challenged, with Tier 1 access pressures, rising long waits, cancer performance off plan and support required through Getting it Right First Time (GIRFT), Essex System Executive Oversight Committee (ESEOC) and National Performance Improvement Programme (NPIP) arrangements. Quarterly review discussions also consistently identified MSEFT as the key system risk, with concerns across multiple performance metrics and the need for a two-year recovery plan focused on finance and elective performance. This indicates that the performance pressures across the ICB reflect deeper and more sustained delivery challenges across core acute pathways.

The picture on experience is somewhat more mixed, but still not consistently strong. GP satisfaction improved to 71.77%, although it remained below the national average, and there was an improvement in the proportion of patients able to see their preferred general practice professional. However, this more positive movement sits alongside continuing access pressures across urgent, elective and cancer pathways, meaning that the overall experience for patients is likely to have remained uneven. On balance, there is evidence of some localised improvement, but not at a scale sufficient to offset wider system pressures.

Financial Duties

During 2025/26, financial performance was mixed. MSE ICB delivered a small year-end surplus, had an agreed plan to breakeven, remained within its running cost limits and achieved the Mental Health Investment Standard. This indicates that the ICB met its core statutory financial duties during the year and performed strongly against the NHS Oversight Framework finance domain.

However, the wider financial context remained challenging. While the ICB reported a surplus position, the overall system reported a deficit and was significantly adverse to plan, reflecting continued provider and system pressure. This contrast reflects the difference between the ICB's statutory financial position and the wider system financial position in which it operated. This should also be viewed in the context of ongoing year-end adjustments and residual financial risk associated with the merger and boundary changes, with a three-year plan in place to support a return to a sustainable break-even position.

There were also significant provider-side pressures affecting the financial context. MSEFT remained a major source of risk, with a substantial deficit against plan, insufficient recurrent savings and the need for a stronger multi-year recovery approach linked to workforce and productivity. Successor arrangements also set out a three-year plan towards financial recovery, although this remained dependent on further efficiencies and the management of residual risk. Overall, while the ICB met its statutory financial duties, wider system financial sustainability remained a material concern.

Research and Local Strategies

The ICB remained engaged in strategic development during 2025/26 despite the operational and financial pressures described above. There was continuing work on neighbourhood health, community services, procurement reform and wider system strategy development, indicating continued focus on longer-term service transformation and alignment with local priorities. The ICB also contributed to the wider social and economic fabric of the system

through partnership-based approaches to prevention, service development and strategic alignment. It also recognised its duties in relation to climate change, with system oversight of the ICS Green Plan and action during the year including sustainability impact assessments in commissioning, greener prescribing initiatives and wider Greener NHS measures linked to estates, workforce and service models.

Section 2: ICB Capability assessment

During 2025/26, MSE ICB demonstrated organisational capability during a period of significant transition, while continuing to discharge its commissioning, governance and partnership responsibilities. This assessment considers the ICB's ability to commission services, obtain appropriate advice, maintain effective governance and leadership, and involve the public, alongside its capacity to sustain delivery through organisational change.

Commissioning and Delegated Services

MSE ICB maintained its commissioning responsibilities across delegated and directly commissioned services in a challenging operating environment. This included continued work across primary care, community services, mental health and wider system transformation, alongside increasing emphasis on neighbourhood health and more strategic commissioning approaches.

The ICB continued to develop its commissioning role through work on neighbourhood models, community services and pathway reform. However, the effectiveness of commissioning was significantly constrained by the scale of provider challenge across the system, particularly in relation to MSEFT, which remained the key system risk across finance, performance and governance. This included increasing demand pressures and challenges in community-based pathways, including rising numbers of inpatients with autism and learning disability, reinforcing the extent to which commissioning effectiveness remained constrained by system delivery.

The period under review also highlighted the importance of maintaining sufficient commissioning capacity and clarity of role through organisational change, particularly as oversight responsibilities evolved between the ICB and NHS England. Overall, MSE ICB maintained its core commissioning functions during a demanding year, but the period under review also demonstrated the extent to which commissioning effectiveness remained dependent on provider recovery, organisational capacity and clear system governance arrangements.

Governance and Decision-Making

Core governance arrangements were maintained during 2025/26, with board and committee structures supporting oversight of quality, performance, finance and risk through a period of significant organisational change. Transitional arrangements were also put in place as the system moved towards the new Essex ICB.

The period under review nevertheless highlighted the importance of clear accountability, particularly in relation to provider oversight and the interface between the ICB and NHS England as responsibilities evolved. Review discussions pointed to the need for continued clarity of roles, effective escalation routes and sufficiently strong governance to manage major system risks, particularly in relation to the scale and persistence of provider risk within the system.

Overall, the ICB maintained governance and decision-making arrangements through a demanding year, but the period under review also demonstrated the need for continued focus on accountability, oversight and organisational grip through transition.

Workforce and Culture

The ICB managed its workforce through a demanding period of organisational change, including transition to the new Essex ICB, while maintaining delivery in a pressured system context. There was active staff engagement through regular briefings, consultation and staff networks during the change process, which helped support organisational continuity through transition. However, workforce pressures remained evident, including increasing GP leaver rates and sustained levels of sickness absence, indicating ongoing challenges in workforce stability and capacity

Review discussions identified the need to build organisational capacity in relation to strategic commissioning, data and analytics, and finance, as the ICB moves its focus to strategic commissioning. In other areas, such as digital and IT, sufficient capacity would need to be retained in the new operating model to reflect the ICB's changed but ongoing role.

Public Involvement and Consultation

The ICB continued to engage with residents, partners and wider stakeholders during 2025/26 through established governance, engagement and partnership arrangements. This included ongoing engagement with Health and Wellbeing Boards (HWBs) and wider system partners in the development of local priorities and strategic plans, alongside wider community engagement through the Research Engagement Network and Virtual Views platform.

There was also evidence of active participation in all three HWBs, with positive feedback from local authority partners on collaborative working. Feedback from the Southend-on-Sea HWB described the ICB as a constructive and collaborative system partner, with positive engagement in relation to prevention, neighbourhood working and alignment with locally agreed outcomes. Overall, public involvement and partnership working remained active through the year, although continued focus will be required as arrangements embed within the new Essex ICB structure.

Section 3: Support and intervention

This section considers the nature of oversight during the year, progress against improvement priorities, and the ICB's capacity to sustain improvement.

Support and Oversight

During 2025/26, MSE ICB was not subject to formal regulatory intervention. The ICB did, however, operate within a context of close regional oversight, particularly in relation to financial sustainability, provider performance, quality and major system risks. This included structured engagement through quarterly review arrangements and wider oversight of provider recovery and transition. This reflected sustained concerns across core domains, including access, safety and system financial performance, which remained in the lowest performing quartile or below plan. The ICB continued to monitor MSEFT's delivery of its enforcement undertakings, with oversight and assurance arrangements in place to track progress against agreed milestones.

Progress Against Improvement Objectives

Over the course of the year, the ICB made progress in several strategic areas, including neighbourhood development, commissioning reform, public engagement and aspects of financial and organisational planning. However, headline performance against several core standards remained below expectation, and provider performance continued to present the most significant challenge. In particular, MSEFT remained the key system risk across finance, access, governance and quality, while wider system pressures also continued in relation to mental health and provider resilience. These issues required sustained oversight and

coordinated action across partners and highlight the extent to which system improvement remained dependent on provider recovery.

Capacity to Sustain Improvement

The ICB maintained organisational grip through a demanding year and demonstrated the ability to maintain organisational continuity through significant change. However, the period under review also highlighted the extent to which sustained improvement remained dependent on provider recovery, clear accountability and the preservation of sufficient commissioning and leadership capacity through transition. On balance, the ICB demonstrated the ability to support improvement in a challenging context, but continued focus will be required as these responsibilities transfer into the new Essex ICB.

Conclusion

In forming this assessment, I have taken a balanced and proportionate view of your performance in a complex operating environment. I recognise the progress made towards more mature, integrated care shaped by the needs of local people and communities.

This assessment reflects the statutory body in place during the period assessed (2025/26). NHS England remains committed to supporting continuity, learning and improvement as the new ICB embeds its responsibilities.

Please share this assessment with your board and senior leadership team and consider publishing it alongside your annual report at a public meeting. NHS England will also publish a summary of all ICB annual assessment outcomes.

Robin Porter
Chair
Central East ICB

NHS England – East of England
Victoria House
Camlife
Fulbourn
Cambridge
CB21 5XB

31 July 2026

Dear Robin,

Annual assessment of Hertfordshire and West Essex (HWE) Integrated Care Board's (ICB) performance in 2025-26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB).

This has been a particularly challenging year for ICBs, marked by significant system-wide pressures and organisational change. In parallel, ICBs have been required to adapt to an evolving operating model while maintaining a clear focus on statutory duties, system leadership and delivery for local populations. In the East of England, this has included the additional complexity of managing the merger of all six predecessor ICBs in-year.

Against this backdrop, I recognise the complexity of the task facing your organisation and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. I also acknowledge the additional burden of maintaining stability, continuity and delivery through a period of significant structural transition.

In reaching this assessment, I have considered evidence from the ICB's annual report and accounts, available performance and assurance data, feedback from partners where received, and the discussions my team and I have held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, I have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

I remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

I would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. My team and I look forward to continuing to work with you in the year ahead.

Yours sincerely,

A handwritten signature in dark ink, appearing to read 'Clare Panniker', followed by a small dot.

Clare Panniker

Regional Director

NHS England - East of England

Cc Jan Thomas, Chief Executive Officer, Central East ICB
Tom Abell, Chief Executive Officer, Essex ICB
Adam Cayley, Executive System Lead & Chief Operating Officer, NHS England - East of England
Simon Wood, Executive System Lead & Regional Director of Strategy and Integration, NHS England - East of England

Section 1: ICB performance assessment

During 2025/26, Hertfordshire and West Essex (HWE) ICB operated through a period of significant organisational change, maintaining focus on its statutory duties, system leadership and delivery for its population. This assessment reflects performance against these duties, including reducing inequalities, improving quality, meeting financial requirements, supporting research, and having regard to local strategies. It also considers the wider effect of decisions across the system, consistent with the triple aim of improving population health, quality of care and value for money, and supporting the long-term sustainability of services for local communities.

Population Health and Inequalities

HWE ICB demonstrated strong system performance in population health overall, with the National Oversight Framework (NOF) domain assessed within the highest performing quartile. This reflects continued focus on Core20PLUS5 priorities, partnership working with local authorities and voluntary, community and social enterprise (VCSE) partners, and development of neighbourhood-based approaches to population health management.

However, a number of key prevention indicators remain below national ambition. Childhood immunisation uptake remained below ambition, with measles, mumps and rubella (MMR) coverage before age 5 below the 95% ambition throughout the year and at 87.5% in quarter four. Serious mental illness (SMI) health check coverage remains low at 53%. Activity in obesity-related interventions also reduced, with declining referrals to digital weight management services and the Diabetes Prevention Programme. Screening coverage is comparatively stronger, although still below optimal levels.

In addition, variation in long-term condition management remains evident, with hypertension control averaging at approximately 68.5% and cholesterol management at 47.6%.

Taken together, this indicates that while the ICB has strong strategic foundations and relative strength in some population health measures, further system-wide effort is required to improve prevention delivery, strengthen long-term condition management and reduce unwarranted inequalities.

Quality and Safety of Services

During 2025/26, the ICB maintained a clear focus on quality, safety, safeguarding and system oversight, supported by collaborative working across providers and partners, with established governance arrangements and implementation of the Patient Safety Incident Response Framework (PSIRF), alongside system learning activity.

However, a number of safety challenges remain. The safety domain was assessed as below average, reflecting variation in outcomes and ongoing system pressures. Outcomes in maternity and neonatal services require continued focus. While antibiotic prescribing in children improved over the year, broader variation in safety outcomes remain. System oversight discussions during the year also identified areas of provider fragility and service-specific pressures requiring continued attention.

Access and Experience

Throughout 2025/26, the ICB operated under sustained demand and capacity pressures, with access performance remaining below national standards across key pathways despite improvement over the course of the year. Referral to treatment performance was 67.39% at year-end, and cancer 62-day performance was 75.74%, both improving on the previous year. Overall access performance is assessed as above average, reflecting improvement across key pathways.

Accident and emergency four-hour performance was above the national target and improved on the previous year, at 79.80% at year-end. Primary care activity remained strong, with GP satisfaction at 75.08%, showing improvement from 2024, although still below the national average.

The wider experience and effectiveness picture remains mixed. While some indicators have improved, variation persists across patient experience and access to services, alongside ongoing challenges in urgent and emergency care, and continued pressure in elective and cancer pathways. In addition, there are ongoing challenges in mental health pathways, including increases in inappropriate out-of-area placements and variation in outcomes for people with a learning disability or autism.

Financial Duties

At the end of the 2025/26 financial year, HWE ICB met its statutory financial duties, delivering a compliant financial position. The ICB also demonstrated strong financial governance, with the finance domain assessed within the highest performing quartile.

However, underlying system pressures remain, including provider financial fragility and the need to deliver sustained productivity improvements. Nevertheless, the ICB maintained compliance with its statutory responsibilities and demonstrated continued focus on productivity and value for money. Sustaining this position, while addressing underlying provider fragility, will remain important for the new ICB.

Research and Local Strategies

During 2025/26, the ICB continued to have regard to relevant local strategies, including the Joint Forward Plan, Medium Term Plan and wider system strategies, working in partnership with local authorities, NHS providers and the VCSE sector. These strategies set out a clear direction for service transformation, including strengthening prevention, improving access and delivering more care closer to home.

Delivery activity aligned to these strategies included development of Integrated Neighbourhood Teams, expansion of community-based diagnostic capacity and targeted prevention programmes, supporting earlier intervention and more integrated care delivery.

The ICB also supported research and innovation activity, including work to improve research participation among underserved communities and strengthen links between research, service delivery and population health outcomes. It also recognised its duties in relation to climate change and has developed a system-wide Green Plan, setting out an approach to reducing emissions and embedding sustainability across commissioning and delivery. Progress has included strengthening governance arrangements and delivering targeted initiatives; however, further work is required in relation to the Greener NHS programme, to embed delivery and strengthen measurable impact across the system.

Section 2: ICB Capability assessment

During 2025/26, HWE ICB demonstrated organisational capability during a period of significant transition, while continuing to discharge its commissioning, governance and partnership responsibilities. This assessment considers the ICBs ability to commission services, obtain appropriate advice, maintain effective governance and leadership, and involve the public, alongside its capacity to sustain delivery through organisational change.

Commissioning and Delegated Services

The ICB maintained its commissioning responsibilities across delegated and directly commissioned services, including primary care, community services and specialised delegated functions. Commissioning activity remained aligned to system priorities, including improving access, reducing variation and strengthening neighbourhood-based delivery. This included improvements in delivery of targeted programmes to support earlier diagnosis, community-based care and improved access, such as expansion of community diagnostic centres and development of new elective and surgical capacity.

The ICB also demonstrated continued focus on population need and inequalities, including targeted cardiovascular prevention programmes and partnership working with local authorities and VCSE partners to improve outreach and engagement in underserved communities. While commissioning responsibilities were maintained during a period of transition and organisational change, sustaining capacity, analytical capability and strategic commissioning focus will remain important as new arrangements are embedded.

Governance and Decision-Making

Core governance arrangements were maintained throughout 2025/26, with board and committee structures providing oversight of quality, performance, finance and risk. These arrangements were strengthened through the use of integrated performance reporting, risk management processes and regular oversight of the Board Assurance Framework and corporate risk register.

During the year, transitional governance arrangements were established to support the move towards new ICB structures, including joint committees operating across partner organisations and revised decision-making arrangements. Governance processes enabled continued oversight of key risks, including access performance, quality, workforce and system resilience, alongside effective management of organisational risks during a period of significant change. Internal audit findings indicated that governance, risk management and internal control arrangements were overall adequate and effective, with further enhancement required in some areas.

Workforce and Culture

The ICB managed its workforce through a demanding period characterised by organisational change, leadership transition and preparation for new system arrangements. Workforce performance was comparatively strong overall, with the workforce domain assessed within the highest performing quartile. Staff engagement and development were supported through a range of initiatives, including leadership development, workforce engagement programmes and system-wide collaboration through workforce forums and partnership arrangements.

However, there are ongoing workforce risks, including GP retention pressures, with leaver rates of approximately 6%, and operational pressures in specific services where vacancy levels remain high. Organisational feedback also highlights opportunities to strengthen engagement, organisational learning and culture, particularly in the new system arrangements.

Public Involvement and Consultation

The ICB continued to engage with residents and partners during 2025/26 through established mechanisms, including public board meetings and engagement activity linked to service change and strategic programmes. There was continued collaboration with Health and Wellbeing Boards (HWBs), local authorities and VCSE partners. This included engagement supporting service change and system transformation programmes, as well as targeted work

to improve inclusion and reach within underserved communities. For example, community-based engagement and partnership working supported prevention initiatives and improved access to services for higher-risk groups.

Feedback from HWB partners indicates positive and collaborative joint working, with strengthened integration across pathways, particularly in adult social care, community services and mental health, alongside a continued focus on prevention and reducing health inequalities. Looking ahead, there are opportunities to further strengthen engagement, including embedding neighbourhood working more consistently, improving the use of shared data and intelligence, and deepening co-production with residents, particularly those experiencing the greatest inequalities.

Section 3: Support and intervention

This section considers the nature of oversight during the year, progress against improvement priorities, and the ICB's capacity to sustain improvement.

Support and Oversight

During 2025/26, HWE ICB was not subject to formal regulatory intervention but operated within a context of enhanced regional oversight across a number of priority areas. This reflected sustained performance pressures in key areas, including urgent and emergency care and prevention, alongside system risks linked to provider capacity and service sustainability.

Oversight activity included structured engagement with NHS England and system partners, alongside targeted support in relation to elective recovery, cancer performance and urgent and emergency care. In addition, provider-level issues within the HWE system, including challenges in estates, workforce stability and governance at specific providers, required continued regional attention and system coordination.

These arrangements provided an appropriate level of support and challenge during a period of sustained operational pressure and organisational transition.

Progress Against Improvement Objectives

Over the course of the year, the ICB made progress in a number of areas, including improvement in access performance across elective and cancer pathways, alongside maintaining financial control within plan. There was also continued development of system-wide approaches to neighbourhood-based care and prevention.

However, performance against several core standards remained below national expectations, particularly in prevention indicators. Progress in these areas continues to be constrained by underlying provider capacity, workforce and infrastructure challenges across the system.

Sustained, coordinated system action will be required to deliver further improvement, particularly in addressing variation and supporting recovery in access and prevention outcomes.

Capacity to Sustain Improvement

The ICB demonstrated organisational grip over the course of the year, supported by strong financial management, governance arrangements and system working. It has shown the ability to manage risk and respond to areas of performance pressure.

However, the transition to new ICB arrangements introduces additional complexity, particularly in maintaining capacity, continuity and focus. This is alongside ongoing provider-level risks

within the system, including organisational change, workforce pressures and infrastructure challenges, which may affect the pace and sustainability of improvement.

On balance, the ICB is considered capable of sustaining improvement, provided that governance, leadership capacity and system collaboration continue to be strengthened, and that targeted support remains in place to address both system and provider-level risks.

Conclusion

In forming this assessment, I have taken a balanced and proportionate view of your performance in a complex operating environment. I am encouraged by progress towards more mature, integrated care shaped by the needs of local people and communities.

This assessment reflects the statutory body in place during the period assessed (2025/26). NHS England remains committed to supporting continuity, learning and improvement as the new ICB embeds its responsibilities.

Please share this assessment with your board and senior leadership team and consider publishing it alongside your annual report at a public meeting. NHS England will also publish a summary of all ICB annual assessment outcomes.

Professor Will Pope
Chair
Norfolk and Suffolk ICB

NHS England – East of England
Victoria House
Camlife
Fulbourn
Cambridge
CB21 5XB

31 July 2026

Dear Will,

Annual assessment of Suffolk and North East Essex (SNEE) Integrated Care Board's (ICB) performance in 2025-26

I am writing under section 14Z59 of the NHS Act 2006, as amended by the Health and Care Act 2022, which requires NHS England to conduct an annual performance assessment of each Integrated Care Board (ICB).

This has been a particularly challenging year for ICBs, marked by significant system-wide pressures and organisational change. In parallel, ICBs have been required to adapt to an evolving operating model while maintaining a clear focus on statutory duties, system leadership and delivery for local populations. In the East of England, this has included the additional complexity of managing the merger of all six predecessor ICBs in-year.

Against this backdrop, I recognise the complexity of the task facing your organisation and the sustained effort required to balance immediate operational pressures with longer-term strategic priorities. I also acknowledge the additional burden of maintaining stability, continuity and delivery through a period of significant structural transition.

In reaching this assessment, I have considered evidence from the ICB's annual report and accounts, available performance and assurance data, feedback from partners where received, and the discussions my team and I have held with ICB colleagues over the course of the year.

While this annual assessment is a statutory requirement, I have sought to ensure that it is balanced and proportionate, recognising both the need to assess performance against statutory responsibilities and the realities of the organisational change that has taken place during the year.

I remain committed to working constructively with you, building on learning from the year, and supporting ICBs as roles, responsibilities and arrangements continue to evolve.

I would like to thank you, your Board and your wider team for your leadership and continued commitment during a demanding period of change. My team and I look forward to continuing to work with you in the year ahead.

Yours sincerely,

A handwritten signature in dark ink, appearing to read 'Clare Panniker', followed by a small dot.

Clare Panniker

Regional Director

NHS England - East of England

Cc Ed Garratt, Chief Executive Officer, Norfolk and Suffolk ICB
Tom Abell, Chief Executive Officer, Essex ICB
Adam Cayley, Executive System Lead & Chief Operating Officer, NHS England – East of England
Simon Wood, Executive System Lead & Regional Director of Strategy and Integration, NHS England – East of England

Section 1: ICB performance assessment

During 2025/26, Suffolk and North East Essex (SNEE) ICB operated through a period of significant organisational change, maintaining focus on its statutory duties, system leadership and delivery for its population. This assessment reflects performance against these duties, including reducing inequalities, improving quality, meeting financial requirements, supporting research, and having regard to local strategies. It also considers the wider effect of decisions across the system, consistent with the triple aim of improving population health, quality of care and value for money, and supporting the long-term sustainability of services for local communities.

Population Health and Inequalities

The ICB demonstrated strong performance in population health and prevention during 2025/26, with the system in the highest performing quartile for population health. There was particularly strong performance in serious mental illness health checks, alongside evidence of well-developed prevention and inequalities programmes. This includes neighbourhood health implementation, cardiovascular prevention, vaccinations, integrated weight management, social prescribing, targeted dental access and partnership-based work to address inequalities in coastal and more deprived communities.

While overall performance in population health is strong, there remain areas where outcomes and access vary across the SNEE population. This includes variation in elective waits, emergency admissions for children, Mental Health Act detentions and early cancer diagnosis. These patterns indicate that, alongside strong system-wide performance, further sustained action will be required to reduce unwarranted variation and improve outcomes for specific population groups.

Quality and Safety of Services

The ICB maintained active oversight of quality and safety during the year, supported by strengthened governance arrangements, system quality forums and responsive review processes. SNEE ICB performed above average for safety and demonstrated a mature approach to quality management, collaborative oversight and proactive intervention where risks emerged.

However, the quality picture remained mixed across the provider landscape. In particular, there were concerns at East Suffolk and North Essex NHS Foundation Trust during the year, including regulatory findings, operational pressures and variation in delivery. While the ICB remained engaged and responsive, these provider-level risks persisted and required ongoing system oversight and improvement.

Access and Experience

Performance on access and experience was comparatively strong over the course of 2025/26, with the ICB performing above average overall. There was particularly positive performance in primary care experience, including GP satisfaction, alongside continued delivery in areas such as pharmacy first and community-based alternatives to hospital care.

However, despite this relative strength, delivery against key constitutional standards remained below national ambition in a number of areas, including urgent and emergency care, elective care and the 62-day cancer standard, with both accident and emergency four-hour performance and 62-day cancer performance showing a deterioration on the previous year. In addition, there were ongoing pressures in flow and discharge, and in some community-based pathways, contributing to variation in experience across the system. As a result, while the system demonstrates comparative strength in access and experience overall, residents

continue to experience pressure and variation across core services, and further coordinated action will be required to deliver sustained improvement.

Financial Duties

SNEE ICB met its statutory financial duties in 2025/26 and demonstrated strong financial control in a challenging environment. The ICB was in the highest performing quartile for system finance, delivered a surplus position, and played a key role in enabling the wider system to achieve financial balance and meet its statutory financial duties.

This position was achieved despite continued provider fragility and underlying financial risk within parts of the system, and without any external support. The ICB took a proactive approach, including effective use of the Commissioning Management System, targeted review of diagnostics activity and robust system level financial oversight and scrutiny. While the financial performance in 2025/26 was strong, ongoing challenges remain in relation to efficiency, productivity and the delivery of recurrent financial sustainability.

Research and Local Strategies

During 2025/26, the ICB continued to have regard to relevant local strategies, including the Joint Forward Plan and wider system strategies structured around the Live Well framework. There is strong evidence that SNEE maintained a strategic focus on neighbourhood health, prevention, integration and partnership working, while also supporting research, innovation, sustainability and wider social value. This included development of the Research Engagement Network, extensive community and co-production infrastructure, work with anchor institutions, and a broad range of initiatives linking health improvement with employment, housing, digital inclusion and environmental sustainability. The ICB's three-year Green Plan sets out strategic objectives and key activities across the system. Progress includes reductions in carbon emissions, sustainable commissioning, and partnership work supporting the Greener NHS programme

It is evident that the ICB not only maintained strategic direction during a difficult year but also continued to contribute to the wider social and economic fabric of its system. The breadth of partnership and co-production work is a notable strength and provides a strong foundation for future strategic commissioning and neighbourhood-based delivery.

Section 2: ICB Capability assessment

During 2025/26, SNEE ICB demonstrated effective organisational capability through a demanding period of transition, while continuing to discharge its commissioning, governance and partnership responsibilities. This assessment considers the ICBs ability to commission services, obtain appropriate advice, maintain effective governance and leadership, and involve the public, alongside its capacity to sustain delivery through organisational change.

Commissioning and Delegated Services

The ICB maintained its commissioning responsibilities across a broad range of services, including delegated primary care, community, dental, pharmacy, specialised and strategic commissioning functions. There is evidence of increasingly mature commissioning arrangements across areas such as dentistry, community services redesign, urgent care, neighbourhood delivery and strategic transformation programmes. Delegated services were commissioned in line with national requirements and the ICB was able to evidence compliance with delegation arrangements.

Governance and Decision-Making

The ICB maintained effective governance and decision-making arrangements throughout the year, with clear board and committee structures supporting oversight of finance, performance, quality, risk and transformation. The ICB demonstrated well-developed governance arrangements, active board assurance processes and strong committee architecture. Review discussions during the year also reflected confidence in the board's leadership, governance discipline and ability to maintain strategic oversight while progressing operational priorities.

Given the scale of organisational change, governance will remain an area requiring continued focus in the successor arrangements, however, SNEE retained sufficient governance oversight and decision-making maturity during the period assessed.

Workforce and Culture

SNEE ICB demonstrated a strong workforce position during 2025/26, with performance in the highest quartile and a positive picture in relation to staff engagement, inclusion and organisational wellbeing. Staff experience indicators were strong overall, reflecting a resilient workforce and a positive internal culture through a demanding period of change.

However, as with all organisations undergoing major transition, there are risks relating to capacity, retention and the continuity of specialist expertise. Maintaining workforce stability and sufficient capability to support strategic commissioning, planning, intelligence and improvement will therefore remain important as the successor organisation embeds its operating model.

Public Involvement and Consultation

This is a clear area of strength for SNEE. The ICB demonstrated mature and meaningful public involvement and partnership working, including structured engagement with Healthwatch, the voluntary sector and wider community groups, alongside effective mechanisms for incorporating insight into planning and commissioning decisions. There is clear evidence of involvement of people and communities in service redesign and strategic development, providing a strong foundation for future neighbourhood health and strategic commissioning work.

Section 3: Support and intervention

This section considers the nature of oversight during the year, progress against improvement priorities, and the ICB's capacity to sustain improvement.

Support and Oversight

During 2025/26, SNEE ICB was not subject to formal regulatory intervention. However, the ICB did operate under regular and, in some areas, close regional oversight during the year. This included formal review meetings, performance discussions and targeted regional engagement in response to provider-level quality, operational and financial risks. In particular, there was sustained oversight in relation to ESNEFT, mental health flow, urgent and emergency care, and provider financial delivery. Whilst proportionate and constructive, these arrangements reflect material and continuing pressures within parts of the system.

Progress Against Improvement Objectives

Over the course of the year, the ICB demonstrated progress across a number of priority areas including financial control, prevention, primary care and dental access, neighbourhood development and aspects of access and experience. This included supporting improvement trajectories at West Suffolk NHS Foundation Trust, progress in addressing challenges across ambulance and mental health services, and delivering a significant expansion in access to

NHS dentistry. There was evidence of increasing strategic maturity and several areas of strong delivery, particularly in population health, workforce and financial management.

Nevertheless, progress was variable. While overall performance improved and the ICB performed comparatively strongly in several domains, delivery against key constitutional standards in urgent care, elective care and cancer remained below national ambition. In addition, provider fragility, particularly in relation to ESNEFT and aspects of mental health flow and operational delivery, continued to constrain overall system performance. These areas will require continued focus and coordinated action.

Capacity to Sustain Improvement

On balance, SNEE enters the next phase with a number of significant strengths that should support continued improvement. These include strong strategic leadership, good financial grip, a resilient workforce, comparatively mature public and partnership infrastructure, and well-established prevention and neighbourhood programmes.

However, the capacity to sustain improvement will depend on how effectively successor arrangements maintain grip on access recovery, provider quality and operational resilience, while preserving strategic commissioning capability and organisational stability during transition. Continued focus on governance, workforce capability, commissioning maturity and system collaboration will be essential.

Conclusion

In forming this assessment, I have taken a balanced and proportionate view of your performance in a complex operating environment. I am encouraged by progress towards more mature, integrated care shaped by the needs of local people and communities.

This assessment reflects the statutory body in place during the period assessed (2025/26). NHS England remains committed to supporting continuity, learning and improvement as the new ICB embeds its responsibilities.

Please share this assessment with your board and senior leadership team and consider publishing it alongside your annual report at a public meeting. NHS England will also publish a summary of all ICB annual assessment outcomes.

Essex ICB Part I Board Meeting

15 October 2026

Agenda Item No:	8
Report Title:	Strategic Assurance Framework Overview Report
Purpose of Report: 'Check' (x) relevant box(es).	Approval ☐ Endorsement ☐ Discussion ☒ Alert ☒ Advise ☒ Assure ☒ Celebrate ☒ Assurance Rating: ● Moderate
Confidentiality Status:	General – no additional protection
Executive Director Sponsor:	Michael Watson – Executive Director of Corporate Services
Report Author / Presenter:	Nicola Adams – Associate Director of Governance
Previously considered by:	Executive Team. Associated risks have also been considered by the Commissioning, Quality and Resources Committee, Neighbourhood Health Committee and Executive Committee.
Subject of Report:	This report presents the October 2026 Strategic Assurance Framework (SAF), explains movement since the July baseline and triangulates the SAF assessments with the directorate risk register and other reports on the 15 October Board agenda. Overall assurance remains moderate. Delivery evidence has strengthened for health inequalities, neighbourhood health, sustainable services and organisational capability, but this has not consistently translated into reduced strategic exposure. Timely access, provider quality, financial sustainability and neighbourhood resource shift remain key areas for continued oversight. Risk analysis heat maps show the correlating risks to the SAF objectives where mitigating activity is delivered principally through the associated PHIP projects, with detailed risk controls and assurance considered through the relevant committees.

Recommendations:	The Board/Committee is asked to: • Note the development of the SAF and the movement since July 2026. • Discuss whether the stated delivery confidence, assurance and risk trends are reasonable when read with the other Board reports. • Seek further assurance where evidence remains incomplete or risks remain outside appetite.
Strategic Objectives: 'Check' (x) relevant box(es).	1. Health inequalities narrowing year on year ☒ 2. A decisive shift towards neighbourhood care delivery and prevention ☒ 3. Timely access and excellent outcomes across services ☒ 4. Financially and clinically sustainable services across Essex which are safe and high quality ☒ 5. An organisation that is up to the job, good to work for and good to partner with ☒
Impact Assessments (IA):	QEHIIA ☐ DPIA/DTAC ☐ Sustainability ☐ Primary care ☐ Not Applicable ☒ <i>This is an assurance report collating insight from Board reports.</i>
Financial Implications:	There are no direct financial implications arising from this report.
Details of patient or public engagement or consultation:	No separate engagement was undertaken for this report, although Patient and public intelligence reported in the Board pack has been used as an assurance source, including the Essex resident survey and engagement described in the Chief Executive's report.
Conflicts of Interest:	None identified.
Related risks / new risks:	Directorate Datix risks are listed within the heatmaps and mapped against each SAF objective. No new risks are proposed. All five SAF objective-level risks remain outside appetite.
Internal Engagement:	Finance ☒ Procurement ☐ Contracting ☐ Quality ☒ IG Team ☐ Delivery Unit ☒ Governance ☒ Comms ☐ Clinical ☒

Strategic Assurance Framework Overview Report

1. Context and Purpose

The Strategic Assurance Framework provides the Board with a single line of sight between the five corporate objectives, PHIP delivery, directorate risks, risk appetite and the evidence presented through Board and committee reporting. It is designed to support Board judgement rather than replace the underlying reports or detailed committee scrutiny.

This second substantive iteration explains movement from the July baseline. It tests the October assessments against the directorate risk register and other papers on the 15 October agenda so that changes in delivery confidence, assurance and risk are supported by a broader evidence base. Directorate risks only are included in the risk references and heat maps. Team and service-level risks remain subject to operational and committee oversight but have been excluded from this strategic view.

The framework is outcomes-focused and asks whether the organisation is on track to achieve each objective, rather than simply describing activity. Delivery confidence assesses whether the relevant programmes and actions are progressing as expected at this point in the delivery cycle.

The mitigating actions for the SAF risks are principally the delivery actions and milestones contained within the associated PHIP projects. This avoids creating a parallel action plan: programme delivery, benefits realisation and exception reporting should demonstrate whether strategic risk is reducing, supported by the controls and assurance recorded in Datix.

Overall assurance assesses the strength of evidence that the objective itself will be achieved. A programme can therefore be on track while evidence of the eventual population outcome remains emergent.

The Alert, Advise, Assure and Celebrate (AAAC) section direct Board attention to the most material matters and are not intended to be an exhaustive record of all operational issues.

Trend is now assessed separately for deliver, assurance and risk, enabling the Board to distinguish progress in programme implementation from changes in evidence or exposure.

Each relevant page of the SAF is included throughout the Board agenda at the start of each section to which it relates, this report provides an overview of all SAF pages and collates insight from the Board reports to better engage the Board in preparation for its meeting and discussions.

2. Key Issues and Assurance Summary

Risk Governance and Committee Assurance

Risk reports have continued to be presented to the respective committees in accordance with their remits. This provides detailed oversight of individual risks, controls and actions closer to the source of assurance. The SAF does not replace that committee scrutiny. It draws together the risks that could materially affect each corporate objective and presents them in the context of PHIP delivery, overall assurance and the Board's risk appetite.

The risk references on each SAF objective should therefore be read as a cross-reference to the underlying Datix records and committee risk reports. Several risks contribute to more than one objective, reflecting the interdependence of the strategy. In particular, data and analytics, engagement, workforce, finance and commissioning capability are enabling risks with consequences across several objectives.

The mitigating actions shown through the SAF are primarily the actions and milestones contained within the associated PHIP projects. This is deliberate: the strategic risk is mitigated through delivery of the agreed transformation, commissioning and organisational development programmes, supported by the specific controls recorded in Datix. Progress against PHIP delivery should therefore be the principal evidence that risk exposure is reducing, rather than creating a separate parallel action plan within the SAF.

The following table summarises the key messages to the Board.

Alert	Timely access, provider quality and financial or clinical sustainability remain the most significant areas of exposure. Directorate risk profiles for objectives 3 and 4 retain red-rated risks and the wider Board pack identifies continuing elective, provider, continuing healthcare, mental health and efficiency pressures.
Advise	Improving delivery confidence does not necessarily mean that the long-term objective is secured. Neighbourhood delivery, resource shift and measurable improvement in outcomes remain dependent on completing baselines, trajectories, scaled commissioning models and benefits evidence.
Assure	Risk reports continue through the relevant committees; the October SAF now identifies directorate Datix references and separates delivery, assurance and risk trends. Other Board reports provide corroborating evidence of stronger programme governance, contracting, financial controls, PHIP delivery and organisational arrangements.
Celebrate	The October position shows stronger evidence than July: health inequalities and organisational principal risk ratings have reduced from 16 to 12; neighbourhood delivery confidence has improved; primary care activity and organisational governance arrangements have progressed.

3. Assessment / Analysis and Associated Risks

The October SAF is more developed than the July baseline. It introduces separate trends for delivery, assurance and risk; names the relevant directorate Datix risks; and replaces several placeholder indicators with measurable evidence. The overall position remains moderate assurance across the objectives. The principal distinction is that evidence of programme activity and stronger controls has improved more quickly than evidence that the long-term strategic outcomes have been achieved.

Risk reports have been presented to the respective committees, enabling more detailed scrutiny of risk causes, controls and actions. The Board-level SAF therefore focuses on the aggregated strategic position and the sufficiency of assurance, while relying on committee reporting and the other Board papers for supporting evidence.

The following table summarises the updates for the SAF for October, shows where confidence in delivery of the relevant Population Health Improvement Plan (PHIP) programmes has changed, as well as showing any changes in the overall assurance level and risk rating for each of the corporate objectives. A summary of the key 'alert' messages for the Board are also included.

Corporate Objective	Delivery confidence	Delivery Trend	Overall Assurance	Assurance Trend	Principle Risk Rating	Risk Rating Trend	Board Attention (AAAC)
1. Health inequalities narrowing year on year	MC	▲ I	M	▲ I	4 x 3 = 12	▼ D	• There were no matters to bring to the attention of the Board
2. A decisive shift towards neighbourhood care delivery and prevention	MC	▲ I	M	► S	4 x 4 = 16	► S	• Withdrawal of LGR plans requires revised planning assumptions; principles developed around the 38 neighbourhoods, with multi-neighbourhood footprints and governance to be agreed. • National neighbourhood priorities and approach may change following Claire Fuller's departure.
3. Timely access and excellent outcomes across services	MC	► S	M	► S	4 x 4 = 16	► S	• Working with providers to meet demand growth that continues to place pressure on waiting times and service standards at pace. • Identifying where long waits increases risk to patient outcomes and experience.
4. Financially and clinically sustainability services across Essex which are safe and high quality	MC	▲ I (improvement in leading indicators)	M	► S	4 x 4 = 16	► S	• Remaining risks to the financial position, sit across All Age Continuing Health Care and specific areas of Mental Health spend. Plans are in place to mitigate and remediate. • Expected imminently National Quality of Care Dashboard for all providers, data driven and metric focused which will provide indicators for ICB oversight in Quality & Safety
5. An organisation that is up to the job, good to work for and good to partner with	HC	▲ I (improvement in leading indicators)	M / H	► S	4 x 3 = 12	▼ D	• Need to continue to assess whether the structures during the change process provide sufficient resource in key areas, and whether the organisations workforce has the right skills and capabilities to deliver its objectives. • Whilst progress has been made on establishing the ICBs internal Population Health Management (PHM) and Business Intelligence (BI) function (see assure), challenges remain in establishing a single data architecture across the Essex system.

Health inequalities narrowing year on year

Programme ratings have improved and measurable indicators are now included. The wider evidence adds positive delivery signals, such as the additional evidence available through the WorkWell, unpaid carers support and planned inequalities deep-dives. Long-term outcomes evidence remains dependent on sustained system action and current resident experience feedback and outcome gaps mean that the rating of moderate assurance remains appropriate.

The Datix risks associated with this objective are showing in the table below, grouped by their overall risk rating (scores in brackets).

Green (1-3)	Yellow (4-6)	Amber (8-12)	Red (15-25)
0	0	4	0

All four linked risks are amber. The position is therefore broad but not concentrated in the highest band. The most material dependencies concern access to primary care

data, antimicrobial stewardship, drugs of dependence and the statutory duty to engage. These risks reinforce the October assessment that delivery is improving but that measurable narrowing of inequalities remains a longer-term outcome.

Neighbourhood care and prevention

Programme delivery has become more consistent and same-day access/secondary prevention indicators provide positive evidence. However, local government reorganisation assumptions, national policy uncertainty, transfer of activity and investment, and provider readiness mean strategic exposure has not reduced.

National review feedback recognised progress but requires stronger community baselines, confirmation of resource shift, expansion of proactive care and conversion of pilots into scaled commissioning models. Delivery is strengthening, but outcome assurance and exposure have not yet reduced.

The Datix risks associated with this objective are showing in the table below, grouped by their overall risk rating (scores in brackets).

Green (1-3)	Yellow (4-6)	Amber (8-12)	Red (15-25)
0	2	8	1

The directorate profile contains one red, eight amber and two yellow risks. The red risk concerns analytics and population health intelligence capacity. NHS England recognised progress in Essex but identified specific next steps on community datasets, the planned 1% resource shift, proactive care, scaled commissioning models and governance. These findings explain why delivery confidence is improving but assurance and the principal risk remain stable.

Timely access and outcomes

The central risk position is unchanged. Additional investment in areas such as the new Community Diagnostic Centre and efforts to improve cancer waiting times, alongside strengthening contract controls (via the Quality, Contracting Performance Review Meetings) strengthen controls, but longer-term delivery and persistent long waits, provider variation and capacity contribute to the risk score and moderate assurance remaining unchanged.

Access and communication remain resident concerns (in current engagement feedback); elective pathway completion, provider quality and capacity pressures continue to constrain assurance.

The Datix risks associated with this objective are showing in the table below, grouped by their overall risk rating (scores in brackets).

Green (1-3)	Yellow (4-6)	Amber (8-12)	Red (15-25)
0	1	6	2

The directorate profile contains two red, six amber and one yellow risk. GP, dental and pharmacy activity has increased, but resident feedback continues to identify access and communication concerns. Elective recovery remains a significant challenge and

requires sustained monthly pathway reduction. The balance of evidence supports stable moderate assurance and continued risk outside appetite.

Sustainable, Safe and High-Quality Services

Improved financial-plan and programme indicators support a more positive delivery trend, but continuing All Age Continuing Care (AACC) and mental health cost pressures, productivity requirements and uncertain quality risks mean the principal exposure remains high.

The ICB continues to forecast breakeven, contracts are increasingly agreed and the efficiency gap has reduced. Continuing healthcare, mental health demand, provider quality and the remaining efficiency gap retain some potential exposure.

The Datix risks associated with this objective are showing in the table below, grouped by their overall risk rating (scores in brackets).

Green (1-3)	Yellow (4-6)	Amber (8-12)	Red (15-25)
0	1	11	5

The directorate profile contains five red, eleven amber and one yellow risk, the largest and highest-exposure portfolio. Positive evidence includes the forecast breakeven position, increased contract agreement and a reduction in the unidentified efficiency gap. However, continuing healthcare, mental health out-of-area placements, autism and ADHD demand, provider quality and the residual efficiency gap remain material. Improving delivery indicators have therefore not yet reduced strategic exposure.

Trusted Partner

This area has the strongest movement. Governance, organisational establishment, partnerships, digital governance and workforce stability provide stronger evidence of delivery. Remaining concerns relate to capability in key areas, strategic commissioning maturity and a single Essex data architecture.

Governance, organisational establishment, partnerships and delivery oversight have strengthened. The proposed portfolio changes and establishment of the Delivery Coordination and Risk Oversight Group (DCROG) arrangements add capacity and accountability, while strategic commissioning capability and data architecture remain developing areas.

The Datix risks associated with this objective are showing in the table below, grouped by their overall risk rating (scores in brackets).

Green (1-3)	Yellow (4-6)	Amber (8-12)	Red (15-25)
0	0	10	3

The directorate profile contains three red and ten amber risks. The risk reduction from 16 to 12 is supported by stronger governance, Executive Committee decisions, the Strategic Commissioning and Decision-Making Framework, maturing PHM/BI arrangements and revised delivery oversight. Governance changes also strengthen leadership for finance, commercial, estates and resilience. Continued attention is required on strategic commissioning capability, organisational capacity and system

data architecture requiring continued committee oversight, which is happening through the Executive Committee.

Conclusion

The October SAF iteration provides clearer trend information, stronger linkage to Datix risks, more specific leading indicators and a more disciplined distinction between delivery confidence and overall assurance a stronger and more evidence-based view than the July baseline. It demonstrates improvement in delivery confidence for several objectives and a reduction in the principal risk assessment for objectives 1 and 5. Triangulation with the wider Board pack supports those movements, while also showing why moderate assurance remains appropriate. In particular, neighbourhood transformation requires firmer baselines and scaled delivery; access and provider quality pressures remain material; and financial or clinical sustainability continues to carry the largest concentration of red directorate risks.

The Board should therefore read the positive delivery trends as evidence that the agreed mitigations are progressing, not as evidence that all outcomes have been secured. PHIP delivery, benefits realisation, directorate risk reporting and committee assurance should continue to be brought together in future SAF iterations.

4. Recommendations

The Board/Committee is asked to:

1. Note the development of the SAF and the movement since July 2026.
2. Discuss whether the stated delivery confidence, assurance and risk trends are reasonable when read with the other Board reports.
3. Seek further assurance where evidence remains incomplete or risks remain outside appetite.

Interpreting this report

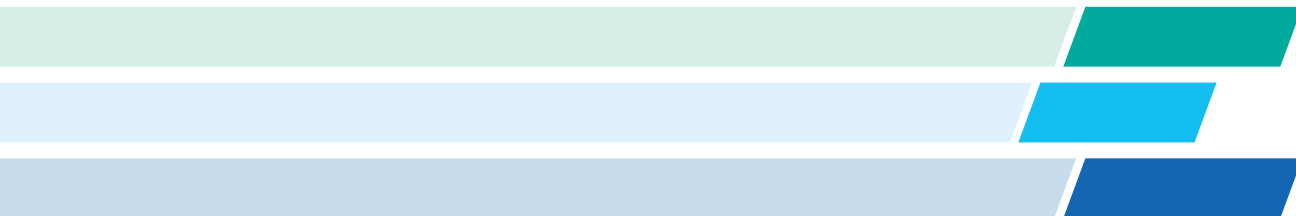
Section	Definition
Assurance Assessment	Describes overall assurance level, the trend (movement from the previous meeting), and whether the risk is within or outside the Board risk appetite.
PHIP Deliverables	3-5 delivery programmes linked to the achievement of the objective (as outlined within PHIP and of the nine strategic priorities).
Alert	Action statements describing strategic issues requiring intervention / key threats to delivery of the objective.
Advise	Emerging risks or issues, dependencies or decisions that the Board should be aware of.
Assure	Evidence that controls, governance and delivery arrangements are working.
Celebrate	Notable achievements or milestones
Leading Indicators	3-5 metrics only to track delivery of the objective.
Assurance Narrative	A short paragraph describing the rationale for the assurance rating.

Delivery Rating	RAG	Definition	Typical Characteristics
High Confidence	 H	The objective is highly likely to be achieved within planned timescales and resources	Delivery milestones are on track; performance indicators are favourable; risks are controlled and within appetite; dependencies are being effectively managed
Moderate Confidence	 M	The objective remains achievable , but there are material risks, issues or dependencies that require active management	Some milestones are delayed or under pressure; performance is mixed; certain risks remain outside appetite; corrective actions are in place
Low Confidence	 L	Significant concerns exist regarding achievement of the objective and substantial intervention may be required	Multiple milestones are off track; performance is deteriorating; major risks or dependencies threaten delivery; existing mitigations may be insufficient
Very Low Confidence	 VL	The objective is unlikely to be achieved in its current form without fundamental change, additional resource, or Board intervention	Major delivery failure risk; significant programme slippage; key dependences unresolved; objectives, scope or timescales may need to be reconsidered

Assurance Level	RAG	Definition	Board Interpretation
High Assurance	 H	Strong evidence that the objective will be achieved . Risks are controlled and assurance sources are consistent	Board can be confident delivery is on track
Moderate Assurance	 M	Reasonable confidence , but some significant risks, gaps or dependencies require management attention	Objective remains deliverable but needs monitoring.
Limited Assurance	 L	Significant concerns regarding delivery, controls, performance or assurance	Board intervention or additional oversight may be required.
No Assurance	 N	Insufficient evidence to conclude the objective is likely to be achieved	Immediate action required

Strategic Assurance Framework Report

15 October 2026



1. Health inequalities narrowing year on year

Risk Narrative:

Datix Risk Ref:
160, 165, 167, 178

Risk Owner/Lead:

Beverley Flowers, Executive Director of Neighbourhood Health
Dr Matthew Sweeting, Executive Medical Director
Cross cutting objective applies to all Executive Directors

PHIP Deliverables and RAG Status:

Integrated neighbourhood team support to priority cohorts ● MC▲
Improve secondary prevention measures, e.g. Cardiometabolic ● MC▲
'Workwell' approach across Essex ● HC▲
Earlier diagnosis of cancers ● MC►
Improved community Mental Health services ● MC►

Link to:

5. Convener Model
2. INT development

**Current Risk Score:
(impact x likelihood)**

Target Score

Risk Appetite Category

4 x 3 = 12 (Amber) ● ▼ D

4 x 2 = 8 (Amber)

Quality: 4 (Seek)
Regulatory: 3 (Open)

Directorate:

Board Committee:

Neighbourhood Health (NH).
NH Committee / Health Inequalities Group

Overall Assurance Level:

Trend:

Risk Appetite Position:

Assessment:

● M

● ▲ I

Outside Appetite

Alert (Strategic issues or external factors)

There are no areas to 'alert' to the Board

Advise (Gaps in control or assurance)

- Health outcome gaps remain stubborn in our most deprived communities.
- Delivery remains dependent on system partners and wider determinants beyond direct ICB control.
- Need to ensure patient voice, VCSFE, complaints, lived experience and population intelligence are effectively triangulated.

Assure (Controls and Assurance)

- PHIP includes dedicated inequalities outcomes and Core20PLUS5 priorities..
- Governance arrangements through the NH Committee and PHIP programme structures are strengthening, learning and training opportunities ICB identified and plan being developed
- Cardiometabolic programme which incorporated core element of health inequalities being developed, first workshop 8th October.

Celebrate (Controls and Assurance)

- Secured funding for the Workwell programme £6m delivery over next three years, commencing November 2026.
- Selected as one of 15 national sites to improve support for unpaid carers, helping reduce inequalities through earlier identification and support
- Partnership with Healthwatch established for inequalities-focused deep dives into frailty in year one and cardiometabolic health in year two.

Leading Indicators	Target	RAG	Assurance
Eligible population supported by obesity prevention programme (per 1,000 eligible people. Average score of 2.57 for Q1 2026/27)	2.57	● MC	Moderate assurance is provided through established governance arrangements, PHIP delivery programmes and emerging population health intelligence. While programmes are in place, achievement of long-term measurable reductions in inequalities remains dependent on long-term system action and broader social determinants.
Higher risk AF patients receiving anticoagulation	90%	● HC	
People starting Diabetes Prevention Programme Rate (per 1,00 eligible people. 13.5 is national average)	13.5	● MC	
Learning disability annual health check	75%	● HC	

2. A decisive shift towards neighbourhood care delivery and prevention

Risk Narrative: Datix Risk Ref: 157, 159, 160, 167, 178, 185, 189, 190, 192, 193, 195		There is a risk that the ICB does not achieve a decisive shift towards neighbourhood care delivery and prevention. This is caused by the scale of service transformation required, competing operational pressures, workforce and financial constraints, and an inability to move activity, resource and investment from reactive hospital-based care into proactive neighbourhood and preventative services. This could lead to missed opportunity on improving population health outcomes, continued growth in demand for acute services, reduced financial sustainability, and failure to deliver the intended benefits of the PHIP.		Current Risk Score: (impact x likelihood) Target Score Risk Appetite Category		4 x 4 = 16 (Red)  ► S 4 x 3 = 12 (Amber) Quality: 4 (Seek)	
Risk Owner/Lead:		Beverley Flowers, Executive Director of Neighbourhood Health		Directorate: Board Committee:		Neighbourhood Health (NH). NH Committee / NH Programme Board	
PHIP Deliverables and RAG Status:		Develop Essex-wide Frailty case management approach  MC ► Develop Neighbourhood Health service model  MC ▲ Community Commissioning Review  MC ▲ Strengthen access and capacity in Primary Care and access to dentistry  MC ► Outpatient left shift plan for agreed specialties  MC ▲ Increase capacity for community urgent care services  MC ►		Overall Assurance Level: Trend: Risk Appetite Position:		Assessment:  M  ► S Outside Appetite	
Alert (Strategic issues or external factors)		Advise (Gaps in control or assurance)		Assure (Controls and Assurance)		Celebrate (Controls and Assurance)	
- Withdrawal of LGR plans requires revised planning assumptions; principles developed around the 38 neighbourhoods, with multi-neighbourhood footprints and governance to be agreed. - National neighbourhood priorities and approach may change following Claire Fuller's departure.		- Provider capacity and capability to deliver new neighbourhood models not yet fully assessed. - Initial left-shift opportunities identified; delivery plans, trajectories and measures require development. - Community Commissioning Review underway, with key dependencies requiring continued coordination across related workstreams.		- Same day access to general practice in line with trajectories - Integrated Neighbourhood Team development is progressing across Essex, informed by learning and best practice from the National Neighbourhood Health Implementation Programme (NNHIP) - Essex wide review of Better Care Fund (BCF) underway to align investment with neighbourhood priorities and improve outcomes.		- Essex neighbourhood best practice gaining national recognition: Central Basildon shortlisted for PCN of the Year and West Essex NNHIP invited to contribute to two national case studies. - ECF proof of concept for a VCSE convenor model focused on improving vaccine uptake across priority cohorts is progressing to sign-off. - Essex ICB is currently tracking "green" across 3 domains of dental reform.	
Leading Indicators		Perform (Target)	RAG	Assurance			
% of patients with urgent need seen on the same day (General Practice).		90%	 MC	Moderate assurance is provided through clear strategic intent, active programme delivery and improving governance arrangements. However, realisation of benefits remains dependent on transformational change, readiness of Providers, workforce availability and successful transfer of activity and investment from traditional models of care.			
CVD patients receiving Lipid lowering therapy		86%	 HC				
Level of growth in community care contracts (%)		3%	 HC				
Hypertension controlled to the age-appropriate threshold		80%	 HC				

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Essex ICB Part I Board Meeting

15 October 2026

Agenda Item No:	10
Report Title:	Neighbourhood Health Report
Purpose of Report: 'Check' (x) relevant box(es).	Approval ☐ Endorsement ☐ Discussion ☐ Alert ☐ Advise ☐ Assure ☒ Celebrate ☐ Assurance Rating: ● M
Confidentiality Status:	General – no additional protection
Executive Director Sponsor:	Beverley Flowers, Executive Director of Neighbourhood Health
Report Author / Presenter:	Karen Wesson, Associate Director of Neighbourhood Health. Lynn Stimson, Associate Director of Neighbourhood Health. Jenni Speller, Associate Director of Neighbourhood Health. Amy Jackson, Associate Director of Community and Neighbourhood Development. Charlotte Stone, Director of Commissioning Neighbourhoods and Community William Guy, Director of Commissioning for Primary Care
Previously considered by:	The Neighbourhood Health Committee is responsible for oversight of the issues covered in this report.
Subject of Report:	This report seeks to provide assurance to the Board on the progress in delivering the neighbourhood health strategic objectives and associated commitments within the Population Health Improvement Programme (PHIP), Operational Plan and National Oversight Framework.
Recommendations:	The Board is asked to note the assurance provided in this report regarding progress in delivering the neighbourhood health strategic objectives and associated PHIP programmes.
Strategic Objectives: 'Check' (x) relevant box(es).	1. Health inequalities narrowing year on year ☒ 2. A decisive shift towards neighbourhood care delivery and prevention ☒ 3. Timely access and excellent outcomes across services ☒ 4. Financially and clinically sustainable services across Essex which are safe and high quality ☒ 5. An organisation that is up to the job, good to work for and good to partner with ☒
Impact Assessments (IA):	QEHIIA ☐ DPIA/DTAC ☐ Sustainability ☐ Primary care ☐ Not Applicable ☒

Financial Implications:	There are no specific financial implications associated with this paper.					
Details of patient or public engagement or consultation:	Not applicable					
Conflicts of Interest:	None identified.					
Related risks / new risks:	1. Health inequalities narrowing year on year 2. A decisive shift towards neighbourhood care delivery and prevention					
Internal Engagement:	Finance	☐	Procurement	☐	Contracting	☐
	Quality	☐	IG Team	☐	Delivery Unit	☐
	Governance	☐	Comms	☐	Clinical	☐

Neighbourhood Health Report

1. Context and Purpose

The purpose of this report is to provide assurance to the Board regarding the progress in delivering the Board's strategic objective of a decisive shift towards neighbourhood care delivery and prevention. It describes progress against key commitments within the NHS Essex Operational Plan and the development of programmes intended to improve performance against relevant National Oversight Framework (NOF) measures and population health outcomes.

The report is intended to provide assurance that appropriate arrangements are in place to support delivery of the neighbourhood health objective, that programmes remain aligned to the Population Health Improvement Plan (PHIP), Operational Plan and wider organisational priorities, and that progress is being made towards achieving improved outcomes, reducing health inequalities and delivering more integrated care closer to home for the people and communities of Essex.

The following PHIP projects/programmes are relevant to this report.

Ref	PHIP Deliverable	Delivery Rating
NbH-A	Implement agreed neighbourhood footprints across all places in Essex.	● HC
	Begin to develop joint working arrangements between partners across NbH footprints, including new governance arrangements	● LC
NbH-B	Work with partners for full implementation of plans	● LC
	Develop PHM approach to supporting agreed priority cohorts for 27/28	● MC
NbH-C	Improve relationships and performance across primary and secondary care interface, implementing the recommendations from the Red Tape Challenge (RTC) locally.	● HC
NbH-D	Develop plans for the delivery of Neighbourhood Health Centres (once guidance is published)	● MC
NbH-E	Work with Local Authorities and providers to implement schemes identified for 2026/27	● MC
	Work with Local Authorities to review services commissioned through the Better Care Fund across Essex	● MC
6.1.2 A	Strengthen access and capacity in general practice. Improving access, tackling unwarranted variation across general practice and improving patient experience	● HC
6.1.2 B	Develop and commission an Essex-wide approach to Enhanced Primary Care Services (Local and Direct), drawing on best practice from across Essex to help move towards neighbourhood models	● HC

Ref	PHIP Deliverable	Delivery Rating
6.1.2 C	Improve access to dental services	● HC
6.1.2 D	Improve access to pharmacy services	● HC
6.1.2 E	Improve access to optometry services	● HC
6.1.3 A	Community Commissioning Review - Interim Progress Report approved by Exec, commencing design phase.	● HC
	Hospice Services Review - Baseline assessment underway	● HC
	Wheelchair Services Review - Review commenced	● HC
	Tissue Viability and Wound Care Review - Scoping completed	● HC
6.1.3 D	Community Equipment Review - Provider engagement completed	● HC
	CHC Therapy Provision Review - Analysis underway	● HC
6.1.4 A	Weight Management - Tirzepatide pathway implemented	● HC
	Cardiometabolic Programme - October workshop planning underway	● HC
6.1.4 C	Lipid Optimisation - Programme rolling out across Essex	● HC
6.1.4 D	Diabetes Care: 8 Care Processes. Business case approved by the Executive Committee and mobilisation is underway.	● HC
6.1.1 F	WorkWell Programme - Procurement launched	● HC

2. Key Issues and Assurance Summary

Neighbourhood Health Readiness

Following the NHS England Neighbourhood Health Readiness Visit on 30 June 2026, the ICB has worked with NHS England to review progress and agree the system's current position. This is reflected in the NHS England letter dated 17 September 2026 and the accompanying single-page summary [Appendices A and B].

NHS England identified strong practice across three broad areas:

- Developing and scaling neighbourhood models: including the established North East Essex Enhanced Service and integrator model, the impact of the Tendring PCN pilot, and emerging Tier 2 demand-management models in Mid and South Essex.
- Clinical leadership and improvement: including Essex's investment in GP leadership and fellowship opportunities, alongside the stewardship approach to quality improvement and pathway redesign.

- Population health intelligence: including the Neighbourhood Prioritisation Framework, which brings together data on inequalities, demand, access and population growth to support planning and investment decisions.

The agreed priorities for the next six to twelve months can be grouped into four areas:

- Data, outcomes and evidence: establish consistent baselines, trajectories and performance reporting; strengthen shared measures; and address variation in proactive care.
- Commissioning and care redesign: translate effective pilots into commissioning and mobilisation plans at scale, spread GIRFT and local learning, and progress care closer to home models across priority elective pathways.
- Resources and accountability: establish the baseline and implications of the planned 1% resource shift, identify priority population cohorts, and strengthen governance, ownership and escalation arrangements.
- Community capacity and partnerships: align Better Care Fund investment with neighbourhood priorities and develop the VCSE convenor model to support meaningful involvement in planning and delivery.

The next phase will focus on converting these agreed priorities into a coordinated delivery plan, with clear ownership, milestones and measures of impact. The attached letter and single-page summary provide the supporting detail and the wider 12 to 18-month direction.

Community and Neighbourhood Development

WorkWell

The Essex WorkWell programme continues to progress through procurement, with mobilisation planned for 1 November 2026. Work has focused on maintaining programme governance, supporting procurement activity and preparing for implementation, including engagement with system partners to maximise alignment with neighbourhood health, prevention and employment support objectives. The programme represents a key opportunity to strengthen the integration of health and employment support for Essex residents and to contribute to wider prevention and health inequalities priorities.

Health Inequalities and Prevention

The Health Inequalities, Long-Term Conditions and Prevention programme is delivering several priority-workstreams to improve population health outcomes and reduce unwarranted variation across Essex.

- **Diabetes Care Processes:** The Diabetes 8 Care Processes programme has received Executive Committee approval and has progressed into mobilisation. Stakeholder engagement, operational planning and training development are underway.

- **Cardiometabolic Prevention:** The Cardiometabolic Programme is progressing through evidence review, population needs assessment and the development of a countywide prevention approach to support improved cardiovascular and metabolic health outcomes.
- **Lipid Optimisation:** The Lipid Initiate and Optimise programme continues to expand, with 67% of Mid and South Essex Primary Care Networks now participating and early performance reporting arrangements in place.

Community Commissioning

The Community Commissioning Review (CCR) has continued to progress following approval of the Interim Progress Report by Executive Committee. The programme has now entered the design phase. Current activity is focused on developing a robust understanding of community services across Essex, including analysis of activity, outcomes, demand and variation, to support future strategic planning. Early work is identifying opportunities to reduce unwarranted variation and improve consistency of approach across Essex, while maintaining alignment with neighbourhood health priorities and wider transformation programmes. Several service-specific reviews continue in parallel, including community equipment, wheelchair services, tissue viability and hospice services.

Neighbourhood Programme Development

Since the NHS England readiness visit and subsequent self-assessment, the focus has moved from assessing readiness to translating the findings into a coordinated programme of delivery. The programme is building on strong local practice while developing a more consistent Essex-wide framework, applied at the appropriate neighbourhood, multi-neighbourhood and system scale.

Current activity is focused on three connected areas:

- **Neighbourhood capability:** establishing Integrated Neighbourhood Team baselines and assessing maturity across primary care networks to provide a clearer understanding of current capability, variation and development needs.
- **Population priorities and resources:** developing a consistent approach to identifying priority population cohorts and linking this to the planned 1% resource shift.
- **Neighbourhood Health Centres:** undertaking further population needs analysis and developing an estates prioritisation tool to inform the future role, clinical focus and investment requirements of individual sites.

The next phase will bring these workstreams together through a coordinated delivery plan, with clear priorities, ownership, milestones, governance and measures of impact. This will be supported by the emerging neighbourhood and multi-neighbourhood arrangements set out below.

Neighbourhood and Multi-Neighbourhood Arrangements

The 38 neighbourhoods remain the foundation for integrated local delivery, building on the relationships, plans and infrastructure already established across Essex. Work is progressing to confirm the appropriate multi-neighbourhood footprints and governance arrangements needed to coordinate services and partnerships operating across a larger geography.

These arrangements will be developed around population need, inequalities, patient flows, provider geographies and existing partnership maturity. This will enable work to take place at the right scale: through a common Essex-wide approach where consistency is required, at multi-neighbourhood level where coordination is needed, and locally through the 38 neighbourhoods.

The evolving position on Local Government Reorganisation will inform the wider partnership context, particularly future governance, accountability and relationships with councils. The proposed arrangements will therefore retain sufficient flexibility to respond to future decisions, without allowing this uncertainty to pause or significantly delay ongoing neighbourhood development.

Primary Care

Continued progress has been made on the implementation of the Primary Care Action Plan for 2026/27:

- Same-day access for clinically urgent patients – The Connected Pathways Team is working closely with individual practices that are outliers against this target. July data shows Essex ICB performance at 76.8%. We remain on track to meet the March 2027 requirement of 90% of clinically urgent patients being seen on the same day. Initiatives such as improved data accuracy, improving triage arrangements and increased clinical capacity will support the continued compliance against the ICB trajectory to achieve 90%.
- Ease of Access to General Practice – The national patient survey results were published in July 2026. These show a 3% overall improvement in ease of access to general practice, a 4% increase in access by telephone, and a 10% increase in those who describe access to practice websites as easy. The Connected Pathways team continues to monitor telephony and online consultation data and are working with outlier practices.
- Continuity of care – Practices and PCNs are continuing to identify those patients marked as requiring continuity of care.
- GP to patient ratios – As at August 2026, 40 out of 206 practices were classified as showing “negative variation”. “Negative Variation” is a classification within the NHS England GP Dashboard where a practice’s performance on a particular metric or series of metrics is low relative to peers. It should be noted that there may be warranted or unwarranted reasons for this performance. The ICB has been working with those practices to understand the drivers of these issues. Data quality has improved and workforce return data is showing an increase in headcount and full-time equivalent (FTEs) between April and June 2026.

General Medical Services

The ICB continues to monitor the impact of Collective Action. This was initially focused on the potential withdrawal from data sharing agreements. The ICB received letters from over 20 practices highlighting concerns and seeking assurance regarding data sharing. No further action has been taken by practices at this stage. More recently, further guidance from the British Medical Association (BMA) has been issued to practices regarding “unfunded work” indicating that practices should be remunerated where they are undertaking work outside of that covered under general medical services. Emphasis was placed on shared care arrangements. The ICB has received a further correspondence from several local practices on this matter, but no specific action has been taken to date.

Consultation Numbers

Across Essex, there has been continued growth in consultation numbers within primary care. The table below is extracted from NHS Digital.

Month	2025/26 Consultations (k)	2026/27 Consultations (k)	Net Change (k)
April	861	929	68
May	865	866	1
June	905	1,008	103
July	965	1,009	44
Year to Date	3,596	3812	216

66.4% of this activity was delivered face to face (over 2.5m consultations across the four-month period).

Community Pharmacy

The Connected Pathways Team continues to work with Practices, Primary Care Networks and Community Pharmacies to improve the integrated working between community pharmacy and general practice. Although much of this work focuses on Pharmacy First, it also covers contraception, the New Medicines Services and health-promotion services.

The Primary Care Team has established a Community Pharmacy Transformation Group. The group focusses on the development of community pharmacy as part of the out-of-hospitals model.

Following the success of the Summer Health campaign, which promoted the advice and services available through community pharmacies, a new campaign has been launched to raise students' awareness of the support available. This focuses on the

role of pharmacies in offering advice on ailments, Pharmacy First pathways, contraceptive services, vaccination services and other provision.

The ICB is working with stakeholders to develop independent prescribing in community pharmacy settings.

Dental Services

The ICB continues to perform well against several key dental requirements for 2026/27.

Between April and August 2026, providers delivered 1.04 million Units of Dental Activity (UDA), against a contracted level of 1.11 million. Whilst this is 93.6% of contracted activity, figures for July and August are likely to be understated due to reporting delays. Based on previous trends, we are confident that we will deliver at least 100% of contracted UDAs across the financial year. We have approved providers to deliver up to 110% of contracted activity.

Although the available data is limited, provisional figures indicate we are on track to deliver the requirement for 8.2% of all contracted activity to be delivered as mandated urgent access to services. This national initiative sits alongside the ICB's access scheme which has now rolled out across Essex. 15,000 patients have been seen through the ICB's access scheme since April 2026.

The ICB has had good engagement from practices regarding the clinical review of recall intervals. This is a further aspect of national dental reform. This will be a particular focus for the second half of 2026/27.

Alert	There are currently no significant issues to bring to the Board's attention.
Advise	Implementation of the neighbourhood health agenda continues to progress; however, delivery remains dependent on system capacity, continued partner alignment and resolution of dependencies relating to Local Government Reorganisation and future governance arrangements. The impact of collective action continues to be monitored – no significant impact at this stage.
Assure	Executive Committee approval has enabled progression of key transformation programmes, including the Community Commissioning Review and Diabetes 8 Care Processes programme. Procurement, mobilisation and programme governance arrangements are in place across WorkWell, Community Commissioning and Health Inequalities and Prevention workstreams.

Celebrate	Significant progress has been made in developing the Essex neighbourhood health infrastructure, including neighbourhood baselining work, cardiometabolic programme development, mobilisation of the Diabetes 8 Care Processes programme and continued progress towards implementation of the Essex WorkWell service. Progress has also been made against the Primary Care Action Plan, particularly in relation to dentistry, urgent dental care and same-day general practice access for clinically urgent patients. Positive feedback from the Neighbourhood Health Readiness Visit has been well received and has provided greater clarity about next steps.
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3. Assessment / Analysis

Dashboard and Reporting:

Work continues the development of the neighbourhood health dashboard which will be presented to future meetings of the Board. This will provide assurance regarding delivery against Directorate objectives, National Oversight Framework metrics and operational planning requirements.

The proposed measures are:

- Improved access to primary care.
- Improved patient experience of accessing general practice services.
- Reduced waits for community services.
- Increased activity delivered in neighbourhood settings.
- Improved hypertension control rates.
- Increased uptake of screening and vaccinations.
- Increased delivery of diabetes care processes.
- Improved uptake of health checks for priority groups.
- Increased numbers of people recorded on frailty registers.
- Reduced avoidable emergency admissions for people aged over 65.
- Increased achievement of preferred place of death.
- Increased numbers of people recorded on end-of-life care registers.

4. Financial Implications

There are no financial implications associated with this paper.

5. Associated Risks

The Neighbourhood Directorate has identified several risks for inclusion in the risk register. These risks are being developed for formal inclusion in the risk register. The

risks are overseen by the Neighbourhood Health Programme Board or Primary Care Commissioning Group, as appropriate.

6. Recommendations

The Board is asked to note the assurance provided in this report regarding progress in delivering the neighbourhood health strategic objectives and associated PHIP programmes.

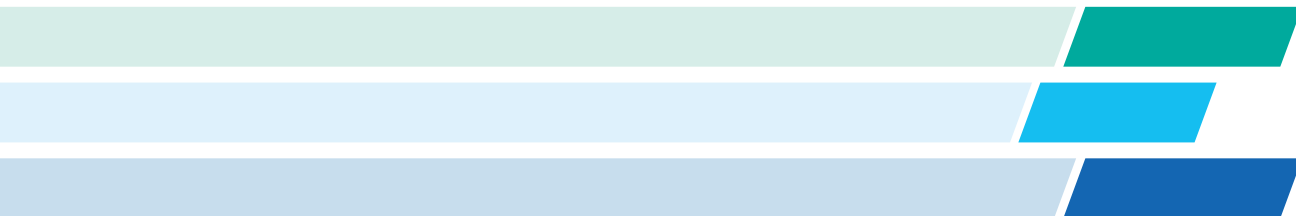
7. Appendices

Appendix A – Neighbourhood Health Readiness Letter from NHS England, 17 September 2026 (See Appendix A of the Chief Executive's Report)

Appendix B – Neighbourhood Health Readiness – single page summary (See Appendix A of the Chief Executive's Report)

Strategic Assurance Framework Report

15 October 2026



3. Timely access and excellent outcomes across services

Risk Narrative: Datix Risk Ref: 167, 178, 183, 190, 191, 199, 200, 205, 228	There is a risk that that Essex ICB does not commission and transform services to ensure timely access and excellent outcomes across services. This is caused by changing demand for healthcare services, capacity constraints to deliver multiple programmes of change with provider organisations, long-standing intrinsic variation in service performance, and regulatory oversight requiring involvement of ICB teams. This could lead to patients experiencing delays in access to care, poorer clinical outcomes and patient experience, and a failure to achieve expected standards to address inequality gaps in access and outcomes, reducing confidence of patients, partners and regulators in Essex health and care system.	Current Risk Score: (impact x likelihood) Target Score Risk Appetite Category	4 x 4 = 16 (Red)  S 4 x 2 = 8 (Amber) Quality: 4 (Seek) Regulatory: 3 (Open)
Risk Owner/Lead:	Sam Goldberg, Executive Director of Commissioning Natalie Hammond, Interim Executive Chief Nursing Officer	Directorate: Board Committee:	Strategy Commissioning, Quality and Resource Committee
PHIP Deliverables and RAG Status: Link to: 2. NH – Community Commissioning Review / Strengthen Primary Care	Reduction in long waiting lists for elective care (all age)  MC ▶ Improvements & left shift for priority elective pathways (focus on OPs)  MC ▶ Implementation of agreed cancer recovery plans  HC ▶ Increase community diagnostics through CDCs and NHCs  HC ▶ Support delivery on ERP for children and young people  MC ▶ Implement the SEND Quality Assurance framework  MC ▶	Overall Assurance Level: Trend: Risk Appetite Position:	Assessment:  M  S Outside Appetite

Alert (Strategic issues or external factors)	Advise (Gaps in control or assurance)	Assure (Controls and Assurance)	Celebrate (Controls and Assurance)
- Working with providers to meet demand growth that continues to place pressure on waiting times and service standards at pace. - Identifying where long waits increases risk to patient outcomes and experience.	- Managing increased scrutiny on maternity, neurodevelopmental pathways and mental health services requires continued focus. - Multiple service redesigns and specifications are progressing (urgent care, elective, cancer, diagnostics and mental health) to improve access, strengthen demand management, reduce avoidable acute demand and support waiting list reduction. - Progress on Talking Therapies procurement and pathway redesign.	- Additional capacity has been commissioned for ASD and ADHD assessment and diagnosis. - Dermatology and MSK procurement continues to release benefits to improve access and resilience. - A further £10m has been released for the second half of the year, taking additional investment to £20m, to accelerate waiting-list reduction and improve timely access. - Earlier cancer diagnosis improvement at 59.3%, above the England average	- Local Area Inspections for SEND concluded across all 3 UTLAs, and Local Area SEND Reform Plans submitted. - Concluded re-organisation of All Age Continuing Care teams by pathway areas improving responsiveness and compliance - Overall waiting list reduction: 4.1% reduction in July, compared with 3.8% in April. - Same-day access for clinically urgent appointments improved from 74% to 77%. - New Community Diagnostic Centre (CDC) Braintree now open.

Leading Indicators	RAG	Assurance
Overall waiting-list size: % change versus previous year Cancers diagnosed at stage 1 or 2 Clinically urgent appointments delivered on the same day Adult mental health admissions with no prior community contact Talking Therapies reliable recovery rate	 MC  MC  MC  LC  MC	Moderate assurance is provided with ICB commissioning, transformation and targeted investment are supporting improved access, with the overall waiting list reducing. However, variation in access, long waits within some pathways, health inequalities and system capacity constraints remain. Meeting Pack Page 77 <i>Note: Leading indicators have been replaced with more specifically measurable KPIs.</i>

NHS Essex Integrated Care Board

15 October 2026

Agenda Item No:	12																		
Report Title:	Essex System Winter Plan 2026/27 and Board Assurance Statement																		
Purpose of Report: 'Check' (x) relevant box(es).	<table style="width: 100%; border: none;"> <tr> <td>Approval</td><td>☐</td> <td>Endorsement</td><td>☐</td> <td>Ratify</td><td>☒</td> </tr> <tr> <td>Discussion</td><td>☐</td> <td>Alert</td><td>☒</td> <td>Advise</td><td>☒</td> </tr> <tr> <td>Assure</td><td>☒</td> <td>Celebrate</td><td>☐</td> <td></td><td></td> </tr> </table> Assurance Rating: ● M	Approval	☐	Endorsement	☐	Ratify	☒	Discussion	☐	Alert	☒	Advise	☒	Assure	☒	Celebrate	☐		
Approval	☐	Endorsement	☐	Ratify	☒														
Discussion	☐	Alert	☒	Advise	☒														
Assure	☒	Celebrate	☐																
Confidentiality Status:	General – no additional protection																		
Executive Director Sponsor:	Samantha Goldberg, Executive Director of Commissioning																		
Report Author / Presenter:	Samantha Goldberg, Executive Director of Commissioning																		
Previously considered by:	- Essex Winter Strategic Group and supporting winter workstreams; provider organisational governance and Board assurance processes. - Essex ICB Executive Committee – Supported on 29 September 2026 - Essex ICB Board – Approved at extraordinary meeting on 2 October 2026, subject to some minor amendments.																		
Subject of Report:	This paper presents the Essex System Winter Plan 2026/27 and accompanying Board Assurance Statement for approval and sign-off. The plan establishes a single Essex wide approach to winter preparedness, operational coordination and escalation across urgent and emergency care, acute, community, mental health, primary care, ambulance, local authority and supporting services. The three key messages are: - Governance and command arrangements are established, led through the Essex Winter Strategic Group and seven-day System Coordination Centre - Quantified core, additional and extremis capacity and provider escalation plans are in place, but material risks remain in acute bed capacity, discharge, workforce, infection, mental health, community capacity and transport. - The plan is dynamic and will continue to be strengthened through operational oversight, risk mitigation and Board Assurance Statement monitoring.																		
Recommendations:	The Board is asked to: Ratify the Essex System Winter Plan 2026/27 and accompanying Board Assurance Statement, and its implementation across the Essex health and care system.																		

	• Receive assurance on the governance, command, capacity and mitigation arrangements, noting the residual risks and funding dependencies requiring continued executive oversight. • Note that the plan is dynamic and will be updated through the winter governance arrangements as risks, capacity and operational pressures change.																		
Strategic Objectives: 'Check' (x) relevant box(es).	<table border="0"> <tr> <td>1. Health inequalities narrowing year on year</td><td>☒</td></tr> <tr> <td>2. A decisive shift towards neighbourhood care delivery and prevention</td><td>☒</td></tr> <tr> <td>3. Timely access and excellent outcomes across services</td><td>☒</td></tr> <tr> <td>4. Financially and clinically sustainable services across Essex which are safe and high quality</td><td>☐</td></tr> <tr> <td>5. An organisation that is up to the job, good to work for and good to partner with</td><td>☒</td></tr> </table>	1. Health inequalities narrowing year on year	☒	2. A decisive shift towards neighbourhood care delivery and prevention	☒	3. Timely access and excellent outcomes across services	☒	4. Financially and clinically sustainable services across Essex which are safe and high quality	☐	5. An organisation that is up to the job, good to work for and good to partner with	☒								
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Impact Assessments (IA):	<table border="0"> <tr> <td>EQIA</td><td>☒</td> <td>DPIA/DTAC</td><td>☐</td> <td>Sustainability</td><td>☐</td> </tr> <tr> <td>Primary care</td><td>☐</td> <td>Not Applicable</td><td>☐</td> <td></td><td></td> </tr> </table> <i>The plan is intended to support a positive impact on quality, access and health inequalities through prevention, vaccination, neighbourhood care and targeted support for vulnerable cohorts. No new data processing proposal is submitted through this paper.</i>	EQIA	☒	DPIA/DTAC	☐	Sustainability	☐	Primary care	☐	Not Applicable	☐								
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Financial Implications:	No direct financial approval is sought through this paper. The plan is based primarily on existing commissioned capacity and organisational resources. Certain additional or extremis actions, including some acute, community, discharge and transport capacity, are explicitly subject to provider funding approval.																		
Details of patient or public engagement or consultation:	The plan has been developed with system partners across NHS providers, local authorities, primary care, ambulance, community, mental health and supporting services. Targeted public and community engagement is embedded within vaccination, prevention and access communications. No separate formal public consultation has been undertaken because the paper concerns operational winter preparedness rather than a service change proposal.																		
Conflicts of Interest:	None identified.																		
Related risks / new risks:	The plan addresses existing system and provider risks relating to demand exceeding capacity, delayed discharge and patient flow, workforce resilience, infectious disease outbreaks, system disruption, acute bed capacity, ambulance handovers, mental health and community capacity, medicines resilience and patient transport. There are no risks for inclusion on risk register/BAF																		
Internal Engagement:	<table border="0"> <tr> <td>Finance</td><td>☐</td> <td>Procurement</td><td>☐</td> <td>Contracting</td><td>☐</td> </tr> <tr> <td>Quality</td><td>☐</td> <td>IG Team</td><td>☐</td> <td>Delivery Unit</td><td>☐</td> </tr> <tr> <td>Governance</td><td>☐</td> <td>Comms</td><td>☒</td> <td>Clinical</td><td>☐</td> </tr> </table> <i>SCC, EPRR, IPC, Vaccination, Primary Care, NHS 111, EEAST, acute, community and mental health providers, Local Authorities and patient transport providers.</i>	Finance	☐	Procurement	☐	Contracting	☐	Quality	☐	IG Team	☐	Delivery Unit	☐	Governance	☐	Comms	☒	Clinical	☐
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Essex System Winter Plan 2026/27 and Board Assurance Statement

1. Context and Purpose

The Essex System Winter Plan 2026/27 (Appendix A) is presented for ratification alongside the Board Assurance Statement. It responds to NHS England winter planning expectations (Appendix B) and sets out how Essex partners will maintain safe, timely and effective care through collaborative leadership, proactive planning, real-time operational management and collective accountability.

The plan provides an Essex-wide framework across acute, community, mental health, primary care, NHS 111, ambulance, local authority, patient transport, pharmacy, dentistry and mortuary services. It remains dynamic and will evolve as emerging interventions, risks and mitigations are identified through the Strategic and Operational Winter Groups.

The central assurance question is whether the governance, operational control, capacity, escalation and mitigation arrangements provide sufficient confidence that the system can respond safely to winter demand, while recognising the risks and dependencies set out in this paper and the Board Assurance Statement (available upon request).

Ref	PHIP Deliverable	Delivery Rating
Unplanned Care - A	Work with providers to support implementation of winter plans	● MC

2. Key Issues and Assurance Summary

The Essex System Winter Plan 2026/27 provides a comprehensive system-wide framework to support safe, coordinated and resilient services throughout winter, underpinned by clear executive leadership, seven day operational co-ordination, real time oversight of demand and capacity, and established escalation and mutual aid arrangements. The plan brings together quantified core, additional and extremis capacity across health and care services, alongside actions to strengthen prevention, attendance and admission avoidance, patient flow and discharge. However, material risks remain in relation to acute and community capacity, ambulance handovers, corridor care, delayed discharge, workforce resilience, infection outbreaks, mental health flow and patient transport, with some escalation measures dependent on workforce availability and provider executive authorisation to expand capacity.

The Essex ICB Board held an extraordinary meeting on 2 October 2026 and approved the Winter Plan and associated documentation for submission to NHS England by the 5 October deadline.

Ratification of this decision is therefore sought alongside continued executive oversight through the Essex Winter Strategic Group and System Co-ordination Centre (SCC), with delivery, risks and mitigations monitored throughout the winter period and further assurance provided where required.

Alert	Material residual risks remain in acute bed capacity, ambulance handovers, discharge pathway capacity, workforce availability, infection outbreaks, mental health flow, community capacity, medicines resilience and patient transport. Some surge and extremis capacity depends on workforce and provider executive authorisation.
Advise	The plan remains dynamic. Capacity assumptions, provider mitigations and operational risks will be monitored through the Essex Winter Strategic Group, the System Co-ordination Centre (SCC) and provider governance. Corridor care remains a patient safety concern requiring continued focus.
Assure	Executive leadership, provider Winter Leads, four system workstreams, seven day SCC oversight, daily tactical co-ordination, Operational Pressures Escalation Levels (OPEL) escalation, Emergency Preparedness, Resilience and Response (EPRR) arrangements, SHREWD intelligence, mutual aid and provider surge plans are established.
Celebrate	The plan provides a single Essex-wide winter framework bringing together provider plans, quantified system capacity, local authority arrangements, prevention, vaccination, infection prevention control (IPC) and escalation planning.

3. Assessment / Analysis

The evidence within the Essex System Winter Plan 2026/27 demonstrates a comprehensive level of system preparedness, supported by defined governance, operational control, escalation and provider delivery arrangements. Whole-system demand and capacity planning has identified 2,961 acute beds, including paediatric and critical care capacity; 426 community and admission-avoidance places; 340 acute and older adult mental health bed, and 2.9 million primary care appointments; and 737,000 dental appointments across December to February. Delivery is supported by seven day system coordination, real-time operational intelligence, provider surge and extremis plans, integrated discharge arrangements, mutual aid, workforce resilience measures, vaccination and infection prevention programmes.

The accompanying ICB Board Assurance Statement provides assurance across most assessed areas, with lower assurance in flow, occupancy and discharge, and primary care, NHS 111 and admission avoidance. Evidence gaps and delivery dependencies remain, including completion of the Equality and Health Inequalities Impact Assessment (EQIA) (available upon request), quantified pre-Christmas occupancy reduction plans, consistent Directory of Services mapping, finalisation of the Essex-wide communications plan, and further assurance regarding the sustained utilisation of commissioned community capacity. In addition, elements of surge and extremis

capacity remain dependent on workforce availability and provider executive authorisation.

Overall, delivery confidence is assessed as moderate: the required plans, controls and governance arrangements are substantially in place, but their effectiveness must be demonstrated through sustained delivery during the winter period. The assurance level is therefore supported by comprehensive planning and system oversight but remains moderated by high occupancy, capacity constraints, discharge pressures, workforce and infection risks, and outstanding dependencies. Continued monitoring through the Essex Winter Strategic Group and SCC will be required, with escalation where delivery falls below trajectory or mitigations do not provide the intended impact

4. Strategic priorities and delivery model

The plan is structured around eight delivery priorities set out in the NHS England winter planning expectations: system co-ordination and mutual aid; winter preparedness and prevention; ambulance handover and urgent care performance; patient flow, discharge and capacity; safe care environments; digital visibility and operational intelligence; community access, mental health and prevention; and workforce, leadership and accountability.

4.1. Governance, leadership and accountability

The Executive Director of Commissioning provides executive leadership and strategic oversight for system winter leadership and co-ordination. Each provider has an Executive Winter Lead accountable for organisational preparedness and delivery. The Essex Winter Strategic Group provides system leadership, assurance and co-ordination, supported by four workstreams: Operational Flow, Prevention and Resilience; Infection Prevention and Control; Vaccination; and Emergency Preparedness, Resilience and Response.

Overall provider accountability remains with system leaders and provider Boards, including responsibility for robust and deliverable organisational plans that maintain urgent, emergency, elective and cancer services.

System winter preparedness was tested through a face-to-face Essex tabletop exercise on 23 September 2026. Health and care partners tested provider winter plans against national and regional scenarios, examining the effectiveness of operational responses, escalation arrangements, system coordination and mutual aid. The exercise provided additional assurance on system readiness and identified areas requiring further action and continued oversight through the winter governance arrangements.

4.2. Operational coordination and escalation

The SCC will operate seven days a week as the central hub for demand and capacity oversight, patient flow, escalation and operational decision-making. Integration with

the Unscheduled Care Coordination Hub (UCCH) and Integrated Care Transfer Hub (ICTH) strengthens multidisciplinary action across admission avoidance, community capacity, discharge and transfer of care.

Daily co-ordination includes SCC, UCCH and ICTH ‘huddles’ and Essex tactical Situation Awareness Meetings. SHREWD is the primary operational intelligence platform. Out-of-hours executive oversight is provided through ICB and provider on-call arrangements, with EPRR leading incident management and major disruption response.

4.3. Capacity and performance assumptions

Capacity area	Core	Additional	Extremis	Total
Acute beds (including paediatric and critical care)	2,724	146	91	2,961
General and acute beds (excluding paediatric and critical care)	2,536	115	91	2,742
Community and admission avoidance places	388	38	-	426
Adult Mental Health (including 197 adult & 143 older adult)	340	-	-	340
Mortuary capacity	644	174	220	1,038
Primary care appointments, Dec-Feb	2,877,000	24,000	-	2,901,000
Dentistry appointments, Dec-Feb	670,000	67,000	-	737,000
Non-emergency patient transport journeys	2,689	-	-	2,689

Capacity does not, by itself, provide assurance of deliverability. Escalation options remain dependent on workforce availability, estates, Infection Prevention and Control (IPC) requirements and provider executive authorisation. Active monitoring of utilisation, occupancy, discharge, workforce and quality indicators is therefore required throughout winter.

4.4. Principal risks and controls

Risk	Key controls and mitigations
Demand exceeds available capacity	Seven day SCC, OPEL oversight, escalation, additional and extremis capacity, admission avoidance, discharge actions and mutual aid.
Delayed discharge and reduced flow	ICTH, Home First, seven-day discharge arrangements, pathway escalation and executive oversight.

Risk	Key controls and mitigations
Workforce resilience	Vaccination, flexible deployment, bank and temporary staffing, mutual aid, business continuity and wellbeing arrangements.
Winter infection and outbreaks	System IPC programme, surveillance, cohorting and isolation capacity, outbreak management, Personal Protective Equipment (PPE) assurance and vaccination.
System disruption and concurrent incidents	EPRR command arrangements, 24/7 on-call coverage, adverse weather and business continuity plans, exercises and mutual aid.
Acute bed and ambulance handover pressure	Provider surge plans, protected Same Day Emergency Care (SDEC), improved streaming, discharge acceleration, Handover 45 (HO45) processes and alternative pathways.
Mental health and community capacity	Crisis alternatives, daily flow oversight, out-of-area placement management, virtual wards, Hospital at Home and Urgent Community Response Team (UCRT).
Transport, pharmacy and medicines resilience	Priority discharge journeys, escalation arrangements, business continuity, critical medicines prioritisation and mutual aid.

4.5. Board Assurance Statement and assurance judgement

The Board Assurance Statement (available upon request) provides the formal statement of assurance against national winter planning expectations. The current self-assessment indicates full assurance across most domains, with substantial assurance in flow, occupancy and discharge and in primary care, NHS 111 and admission avoidance. The principal gaps relate to completion of the EQIA, quantified pre-Christmas occupancy reduction plans, consistent Directory of Services mapping, and finalisation of the Essex-wide winter communications plan.

An overall Moderate Confidence rating is recommended. This reflects strong governance, planning and escalation arrangements, balanced against material capacity and flow risks, high occupancy, delivery assumptions, outstanding funding dependencies and the need to demonstrate sustained implementation through winter.

4.6. Quality, equality, patient experience and engagement

The plan prioritises safe care environments, timely access, attendance and admission avoidance, care closer to home, vaccination, proactive support for vulnerable populations and improved mental health crisis pathways. A separate EQIA accompanies the plan, and monitoring and evaluation of winter will include differential impacts on underserved communities, people with frailty, children and young people, people with mental health needs and residents requiring social care support.

Conclusion

The Essex System Winter Plan 2026/27 provides a comprehensive Essex framework for governance, command and control, capacity deployment, prevention, escalation and operational delivery. It demonstrates substantial system preparation and collective planning. However, forecast demand, capacity constraints, discharge dependencies, workforce pressures and infection risks mean that residual risk remains material. Therefore, there will be continued executive oversight, clear tracking through the Board Assurance Statement and timely escalation where controls or capacity are not delivering the required impact.

5. Associated Risks

The report provides assurance against the principal winter risks but does not remove them. No new standalone risk is proposed solely because of this paper.

6. Financial Implications

No direct financial approval is requested. The plan is based on existing commissioned services. Elements of additional and extremis provider capacity are subject to provider funding approval, including aspects of acute escalation, community capacity and patient transport. Approval of the plan does not itself authorise additional expenditure.

7. Recommendations

The Board is asked to:

1. Ratify the Essex System Winter Plan 2026/27 and accompanying Board Assurance Statement, and its implementation across the Essex health and care system.
2. Receive assurance on the governance, command, capacity and mitigation arrangements, noting the residual risks and continued Winter Strategic Group and executive oversight.
3. Note that the plan is dynamic and will be updated through the winter governance arrangements as risks, capacity and operational pressures change.

8. Appendices

Appendix A – Essex System Winter Plan 2026/27

Appendix B – NHS England winter planning framework letter

Appendix C – Essex ICB Board Assurance Statement 2026/27 (available upon request)

Appendix D – Quality, Equality and Health Inequalities Impact Assessment (available upon request)



2026/27 Essex System Winter Plan

**Delivering a coordinated, safe and
resilient Essex health and care system
throughout Winter 2026/27**

VERSION CONTROL

Version Control	Date	Action
Version 0.1	08/09/26	• Draft version
Version 0.2	23/09/26	• Draft version – Inclusion of Local Authority information Inclusion of overall winter system capacity
Version 0.3	30/09/26	• Draft version – Inclusion of Primary Care and Dentistry core and additional winter capacity
Version 0.4	01/10/26	• Draft version – Inclusion on EPUT adult mental health capacity
Version 0.5	02/10/26	• Draft version – revision of capacity ‘additional and extremist’ numbers Inclusion of SDEC capacity at PAHT

The Winter Plan remains dynamic and will continue to evolve, incorporating emerging interventions, risks and mitigations identified through the Strategic and Operational Winter Groups.

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Essex System Winter Planning, Governance & Oversight

Delivering Safe, Coordinated and
Resilient Health and Care Services
Through Winter 2026/27"

Essex Winter Delivery Priorities 2026/27

Alignment with the NHS England Winter Letter requirements: <https://www.england.nhs.uk/long-read/winter-planning-2026-27-expectations-and-assurance/>

To provide safe, timely and effective care throughout Winter 2026/27 through collaborative system leadership, proactive planning, real-time operational management and collective accountability.

1. System Coordination, Operational Control and Mutual Aid

- Maintain effective system-wide oversight of demand, capacity, escalation and patient safety through coordinated command and control arrangements.
- Tested surge, extreme surge and escalation plans, supported by mutual aid arrangements to ensure operational resilience.
- Support timely decision-making through real-time operational management, intelligence and system collaboration.

2. Winter Preparedness, Prevention and Organisational Resilience

- Organisations are operationally prepared for winter through planning, readiness and business continuity arrangements.
- Deliver seasonal vaccination programmes and effective infection prevention and control measures to reduce avoidable illness and admissions.
- Implement prevention initiatives, public communications and executive-led assurance processes to support appropriate service utilisation and organisational resilience.

3. Ambulance Handover and Urgent Care Performance

- Reduce ambulance handover delays and improve Category 1 and Category 2 response performance.
- Maximise hear-and-treat, see-and-treat and alternative care pathways to reduce avoidable conveyance and Emergency Department attendance.
- Improve timely access to urgent, emergency care through effective system coordination and pathway utilisation.

4. Patient Flow, Discharge and Capacity

- Optimise patient flow, discharge and capacity across acute, community, mental health, local authority and out-of-hospital services.
- Reduce discharge delays and maximise system capacity through the utilisation of virtual wards, Hospital at Home, urgent community response and intermediate care services.
- Support timely access to the most appropriate care setting and promote care closer to home.

Essex Winter Delivery Priorities 2026/27

5. Safe Care Environments

- Reduce overcrowding and eliminate corridor care to ensure patients receive safe, effective, dignified and high-quality care in appropriate clinical environments.

6. Digital Visibility and Operational Intelligence

- Strengthen system-wide visibility of demand, capacity and escalation pressures through SHREWD, real-time operational intelligence and timely data sharing.
- Support coordinated decision-making, escalation management, risk mitigation and resource deployment across the system.

7. Community Access, Mental Health and Prevention

- Improve access to primary care, community services and mental health support through NHS 111, Pharmacy First, direct booking and alternative community pathways.
- Strengthen mental health crisis support and proactive management of vulnerable and high-risk populations.
- Increase uptake of seasonal vaccination programmes to reduce avoidable demand, attendances and admissions.

8. Workforce, Leadership and Accountability

- Maintain resilient workforce capacity through effective staffing, capacity planning and workforce wellbeing initiatives.
- Strengthen operational, tactical and strategic leadership through clear accountability, governance and executive oversight arrangements.
- Support staff through compassionate leadership and targeted wellbeing interventions during periods of sustained operational pressure.

Winter Governance, Leadership & Accountability

The Essex ICB Executive Director of Commissioning provides executive leadership and strategic oversight for winter planning and delivery across Essex. All provider organisations have an identified Executive Winter Lead who is accountable for winter preparedness and operational delivery within their organisation and is a member of the Essex Winter Strategic Group.

The Essex Winter Strategic Group, chaired by the Executive Director of Commissioning, provides system-wide leadership, assurance and coordination of winter planning and delivery. The Group is responsible for overseeing winter preparedness, monitoring delivery of key priorities, reviewing system performance and risks, and ensuring a coordinated response to emerging operational pressures. The Strategic Group is supported by four system-wide workstreams:

- Operational Flow, Prevention & Resilience
- Infection Prevention and Control (IPC)
- Vaccination
- Emergency Preparedness, Resilience and Response (EPRR)

Workstreams are responsible for the development, coordination and delivery of actions within the respective areas, incorporating learning from the 2025/26 Winter Debrief and evaluation, identifying emerging system risks, and implementing mitigating actions to strengthen resilience. The workstreams provide regular reporting and assurance to the Essex Winter Strategic Group, escalating significant risks, delivery issues and emerging pressures through appropriate governance arrangements. The Group meet bi-weekly throughout the planning and delivery period to monitor progress, review operational intelligence, oversee delivery of key actions and ensure alignment across partner organisations.

Overall accountability for winter preparedness and delivery rests with system leaders and provider Boards. Each organisation is responsible for ensuring that its winter plan is robust, deliverable and responsive to fluctuations in demand, capacity and patient acuity. Plans must support the continued delivery of safe, high-quality urgent and emergency care, whilst maintain planned care activity and deliver the commitments and performance trajectories set out within the 2026/27 Operating Plan.

Essex Winter Governance Framework

The Essex Winter Strategic Group provides strategic oversight and assurance for winter preparedness and delivery across Essex. The Group oversees delivery of the Essex Winter Plan, monitors system performance and risks, and ensures a coordinated response to winter pressures. Delivery is supported through four dedicated responsible for coordinating delivery within their respective areas, providing assurance, and escalating risks and issues to the Strategic Group as required.

Operational Flow, Prevention & Resilience

Admission Avoidance

- NHS111, Pharmacy First, primary care alts
- Urgent Care Coordination Hubs (UCCH).
- Same Day Emergency Care (SDEC).
- Urgent Community Response Team (UCRT).
- Hospital at Home.
- Virtual Wards.
- Community and frailty alternatives to admission

Urgent & Emergency Care

- Urgent and emergency care performance.
- Cat 1 and Category 2 response performance.
- Ambulance handover improvement.
- Emergency department flow and crowding.
- Elimination of corridor care.

Flow & Capacity Management

- Capacity and demand management.
- System patient flow.
- Discharge and transfer of care.
- Community capacity optimisation.
- Care home escalation, support arrangements.
- Elective capacity protection.

Operational Resilience

- Escalation and OPEL management.
- System surge arrangements.
- Mutual aid coordination.
- Operational risk, oversight. escalation.

Vaccination

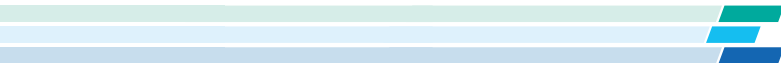
- Delivery of seasonal vaccination programme: Flu, Covid & RSV programme oversight.
- Vaccination uptake and monitoring.
- Workforce vaccination.
- Vaccination campaigns: comms/engagement.

Infection Prevention Control

- Flu
- Covid
- Norovirus
- Outbreak management.
- Care home IPC support.
- Healthcare associated infection monitoring

EPRR Winter Preparedness

- Severe weather planning.
- Industrial action preparedness.
- Incident response.
- Business continuity.
- Major incident readiness.



Integrated Operational Co-ordination

The System Coordination Centre (SCC) will provide operational leadership and coordination of winter pressures across the Essex health and care system, operating seven days a week as the central hub for system oversight, demand and capacity management, escalation, and operational decision-making.

The SCC is strategically co-located with the Unscheduled Care Coordination Hub (UCCH) and the Integrated Transfer of Care Hub (ITCH), creating a single integrated operational function that strengthens multidisciplinary and multi-agency working across health, social care and community services. This co-located model supports a coordinated approach to demand management, admission avoidance, discharge planning and patient flow, enabling earlier intervention, more effective utilisation of community-based services, and timely transfers of care to reduce avoidable hospital attendances and support discharge from acute settings.

Working closely with system partners, the SCC will coordinate patient flow and capacity management across urgent, emergency, community, mental health and social care services. Real-time operational oversight will be supported through SHREWD, providing system-wide visibility of demand, capacity, escalation status and emerging pressures. This intelligence will support timely, data-driven decision-making, proactive management of risks, and coordinated escalation and de-escalation across the system.

The SCC maintains direct escalation routes to the Executive Director of Commissioning, who serves as the Essex executive lead for winter planning and delivery. Out-of-hours leadership and decision-making will be provided through established Integrated Care Board and provider on-call arrangements, ensuring continuous executive oversight and operational resilience throughout the winter period.

To maintain the SCC's focus on day-to-day operational coordination and patient flow, responsibility for the management of incidents and major disruptions will sit with the Emergency Preparedness, Resilience and Response (EPRR) function. This clear separation of responsibilities ensures that incident response, business continuity and emergency management arrangements are coordinated effectively without impacting the SCC's ability to oversee operational performance and system resilience.

Daily Operational Co-ordination

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
09:00	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle
09:00	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)
12:00	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle
12:30	NHSE East of England UEC Tactical Meeting	<i>Stand up meeting to prevent Regional OPEL 4/Extremist</i>	NHSE East of England UEC Tactical Meeting	<i>Stand up meeting to prevent Regional OPEL 4/Extremist</i>	NHSE East of England UEC Tactical Meeting	<i>Stand up meeting to prevent Regional OPEL 4/Extremist</i>	<i>Stand up meeting to prevent Regional OPEL 4/Extremist</i>
15:00	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle	SCC, UCCH & ICTH Huddle
16:00	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)	Essex Situation Awareness Meeting (Tactical)

Essex System Risks

Subject	Risk	Mitigation
Demand Exceeding Available Health and Care Capacity	Winter demand exceeds forecast capacity across acute, community, mental health, urgent care and social care services, leading to flow delays, ambulance handover pressures and increased patient safety risks.	SCC oversight and OPEL escalation arrangements, supported by additional acute, community and virtual capacity, admission avoidance pathways, and enhanced discharge processes to maintain patient flow and reduce demand on acute services
Delayed Discharges and Reduced Patient Flow	Delays in discharge arising from limited community, social care, care home, transport, equipment and mental health capacity reduce bed availability and constrain patient flow across the system.	Integrated Care Transfer Hub, Home First approach and enhanced seven-day discharge model support timely discharge and patient flow, with executive oversight and community capacity escalation arrangements in place to maximise bed availability and reduce delays across the system.
Workforce Resilience and Staff Availability	Workforce resilience is reduced by sickness absence, vacancies, recruitment pressures and seasonal illness, impacting service delivery and the ability to respond to operational escalation.	Vaccination programmes, workforce escalation arrangements, mutual aid and flexible workforce deployment are supported by business continuity plans for staffing resilience and service continuity during periods of heightened operational pressure
Winter Infection and Outbreak Pressures	Increased prevalence of influenza, RSV, COVID-19, norovirus and other infectious diseases reduces workforce, bed capacity, increases service demand, and places pressure on health and care services.	System-wide IPC programme, vaccination campaigns, enhanced surveillance, outbreak management arrangements, and cohorting and isolation capacity, is in place to minimise the impact of infectious diseases on service delivery and operational capacity.
System Disruption and Escalation Events	Severe weather, major incidents, infrastructure failures, transport disruption and prolonged escalation pressures can impact system resilience, operational performance and continuity of services.	EPRR arrangements, SCC command and control, mutual aid agreements, business continuity plans and on-call escalation to support coordinated response to incidents, severe weather and operational disruptions, maintaining service continuity and system resilience during periods of sustained pressure

Essex Collective Provider Risks

Subject	Risk	Mitigation
Acute Bed Capacity Deficit	Demand exceeds available bed capacity, resulting in high occupancy, delayed admissions and reduced patient flow.	Additional escalation and surge capacity, protected SDEC services, expanded virtual wards and Hospital at Home provision, supported by daily operational oversight, OPEL escalation arrangements and mutual aid where required.
Ambulance Handover Delays	Hospital congestion delays ambulance handovers, reducing ambulance availability and impacting patient flow across the system.	Executive-led flow and discharge arrangements, enhanced ED streaming and assessment, seven-day discharge processes, real-time performance monitoring and admission avoidance pathways support timely handovers and system flow.
Workforce Shortages and Sickness	Workforce vacancies, sickness absence and seasonal illness reduce operational resilience and service delivery.	Advanced workforce planning, vaccination programmes, temporary staffing arrangements, flexible deployment, daily workforce oversight and business continuity plans help maintain service capacity during periods of pressure.
Discharge Pathway Capacity Constraints	Limited community, social care and care home capacity delays discharge and contributes to sustained bed occupancy pressures.	The Integrated Care Transfer Hub, Home First approach, seven-day discharge model, discharge command arrangements and enhanced community capacity support timely discharge and maximise bed availability.

Essex Collective Provider Risks

Subject	Risk	Mitigation
Infection Outbreaks Reducing Capacity	Influenza, RSV, COVID-19 and norovirus outbreaks reduce workforce and bed capacity through staff absence and isolation requirements.	Robust IPC arrangements, vaccination programmes, outbreak surveillance, cohorting and isolation capacity, PPE assurance and rapid outbreak management processes minimise operational disruption.
Mental Health Capacity and Flow Pressures	Insufficient mental health assessment, crisis and inpatient capacity delays access to care and specialist intervention.	Daily monitoring, Provider Collaborative escalation processes, enhanced crisis support, robust bed management and system oversight arrangements help maintain flow through mental health services.
Community Demand Exceeding Capacity	Demand for community services exceeds available capacity, reducing the ability to support admission avoidance and hospital discharge.	Virtual wards, Hospital at Home, Urgent Community Response services, flexible workforce deployment and integrated neighbourhood working increase community resilience during periods of escalation.
Pharmacy and Medicines Resilience	Pharmacy workforce pressures, medicines shortages or service disruptions affect patient safety and timely discharge.	Business continuity arrangements, prioritisation of critical medicines, mutual aid agreements, enhanced discharge medicines processes and active management of supply risks support service continuity.
Patient Transport Constraints	Limited patient transport availability delays discharge and restricts patient flow.	Transport escalation arrangements, prioritisation of discharge journeys, additional transport capacity and daily operational oversight help minimise transport-related delays.

Essex Winter Capacity

Acute Hospital Capacity				
Capacity Type	Core	Additional	Extremist	Total
General & Acute Beds	2,536	115	91	2,742
Paediatric & Neonatal Beds	108	22		130
Critical Care Beds	80	9		89
Total	2,724	146	91	2,961

Acute Hospital Contribution		
Capacity Type	Total Beds	Percentage of Essex Capacity
Colchester Hospital	664	24%
Mid & South Essex Foundation Trust	1,589	58%
Princess Alexandra Hospital	489	18%
Total	2,742	100%

- Mid & South Essex Foundation Trust provides most of the acute winter capacity, although represents three hospital sites
- Princess Alexandra Hospital delivers the largest volume of additional winter beds
- Colchester Hospital provides the largest extremis escalation capacity

Essex Winter Capacity

Adult Mental Health

	Core Winter Capacity	Additional Capacity	Extremist Capacity	Total
136 suites	6	0	0	6
Urgent Care Department	8	0	0	8
Crisis House	5	0	0	5
Assessment Units	32	0	0	32
Adult Acute Beds	197	Out of area placements	Out of area placements	197
Older Adult Beds	143	0	0	143

In Patient Bed / Flow	Current	Winter Target (1 Dec – 31 Mar 27)
Average occupancy – Adult Acute Pathway	97.4%	97.4%
Length of stay < 60 days (NOF standard) – Adult Acute	64.9	<60

Essex Winter Capacity

Admission Avoidance & Community Capacity			
Capacity Type	Core	Additional	Total
Intermediate Care Beds	40	26	66
Stroke Beds	14		14
Virtual ward beds	106		106
Hospital at Home	186		186
Community Assessment & Treatment Unit (CATU)	22		22
UCRT Capacity	20	6 + 6	32
Total	388	38	426

- Essex has identified 388 core community and admission avoidance places, with a further 38 additional winter escalation places, providing a total of 388 quantified places across community beds, virtual wards, UCRT, CATU and Hospital at Home services.
- This OPAT service provision is not included within the capacity and is operational for 10 hours per day per site at Basildon and Southend Hospitals within Mid & South Essex Foundation Trust

Essex Winter Capacity

Supporting System Capacity

Primary Care & Dentistry	Core (Dec – Feb)	Additional (Dec – Feb)	Total (Dec – Feb)
Primary Care appointments <i>The additional capacity is targeted at proactive and reactive exacerbations of winter illness</i>	2,877,000	24,000	2,901,000
Dentistry appointments <i>Additional 10% provision within dental contracts</i>	670,000	67,000	737,000

Mortuary	Core	Additional	Total
Mortuary Capacity	644	174	818

Non-Emergency Patient Transport	Core	Additional	Total
Monday to Friday	1,617		1,617
Saturday	817		817
Sunday	255		255
Total	2,689		2,689

Winter Operational Delivery Groups & System Co- ordination



Essex System Co-ordination Centre (SCC)

OPERATIONAL READINESS

- The SCC will operate under the leadership of the Head of System Coordination Centre (SCC), providing overall oversight and coordination of winter preparedness and response arrangements across the system.
- The SCC will maintain effective system-wide situational awareness through daily operational meetings, real-time monitoring of demand, capacity, patient flow and patient safety risks, enabling timely escalation of emerging issues and coordinated action across partners.
- Enhanced SCC staffing support will be in place during periods of increased pressure, alongside support for tactical and strategic on-call arrangements, winter incident management and severe weather responses to maintain operational resilience and patient flow across the Essex system.

SYSTEM INTEGRATION

- The SCC will provide a single point of coordination for operational intelligence, escalation, and system-wide action, bringing together acute, community, mental health, local authority, and ambulance services to maintain a system view of demand, capacity, flow, and risk. Through daily multi-agency oversight, the SCC will support timely decision-making and coordinated responses to emerging pressures.
- The Unscheduled Care Co-ordination Hub (UCCH) and Integrated Care Transfer Hub (ICTH) will work closely with the SCC to enable timely intervention, improve patient flow, and maximise the use of out-of-hospital pathways. The SCC will provide seven-day oversight of operational performance, coordinating discharge, flow, mutual aid, and the deployment of available capacity in response to system pressures.
- Working in partnership with EEASt, the SCC will oversee ambulance demand, handover performance, and interface pressures, ensuring timely escalation and coordinated action to minimise delays, maintain patient safety, and strengthen system resilience throughout winter.

PATIENT FLOW, DISCHARGE & CAPACITY

- The SCC will maintain a real-time view of demand and capacity across acute, community, mental health and social care services, enabling proactive management of pressures and timely operational decision-making. Through continuous monitoring of Emergency Department activity, ambulance demand and handovers, bed occupancy, discharge pathways and community capacity, the SCC will identify risks early and coordinate system-wide action to maximise capacity and maintain flow.
- Working with system partners, the SCC will support attendance avoidance through effective use of Urgent Community Response Teams (UCRT) and other out-of-hospital pathways, ensuring patients receive care in the most appropriate setting. A key focus will be optimising discharge processes, reducing delays and supporting timely transfers of care to create capacity for patients requiring admission.
- The SCC will also oversee mental health demand and capacity, working closely with providers to monitor bed availability, crisis pathway pressures, delayed discharges and extended waits for assessment or placement. This will support timely access to appropriate care, improve mental health pathway flow and reduce impacts on urgent and emergency care services.
- In addition, the SCC will monitor key patient safety indicators, including overcrowding, extended waits, stranded patients and the risk of corridor care, ensuring timely escalation and intervention where concerns arise.
- Through a whole-system approach to demand, capacity and escalation management, the SCC will provide coordinated oversight throughout the winter period, supporting improved patient flow, maximising capacity, reducing delays in care and ensuring safe, timely and appropriate access to services across Essex.

Essex System Co-ordination Centre (SCC)

WORKFORCE

- The SCC will enter winter fully staffed, with workforce plans in place to maintain resilience during periods of increased demand. Daily operational leadership will be provided through a Duty Manager and Deputy Duty Manager model, supported by dedicated administrative and analytical resource.
- Operating Monday to Friday, with Duty Manager cover at weekends and bank holidays, the SCC will maintain system oversight and escalation management throughout the winter period. Enhanced staffing and senior leadership presence will be in place over Christmas and New Year to support anticipated peak demand.
- Proactive annual leave planning, cross-cover arrangements and business continuity measures will ensure safe staffing levels are maintained, while continued focus on staff wellbeing will support workforce resilience and operational effectiveness.
- This approach will ensure consistent oversight of demand, capacity, escalation and patient safety throughout winter.

DIGITAL & DATA

- The SCC will utilise SHREWD as the primary system-wide operational intelligence platform, providing real-time visibility of demand, capacity, patient flow and escalation status across Essex. Daily monitoring will support the early identification of pressures and timely intervention.
- Daily SHREWD reporting and escalation dashboards will support trend analysis, performance monitoring and decision-making at system and regional level. The Federated Data Platform (FDP) will complement SHREWD by supporting the development of system reporting capabilities.
- A dedicated Directory of Services (DoS) Lead will ensure service availability and capacity information remains accurate and accessible to support patient navigation and operational decision-making.
- Together, these capabilities will provide robust operational intelligence, strengthen escalation management and support proactive deployment of resources throughout the winter period.

INFECTION PREVENTION CONTROL & VACCINATION

- The SCC will work closely with provider Vaccination Leads, the System Vaccination Programme, and the System Infection Prevention and Control (IPC) Programme to support delivery of the winter vaccination programme and maximise staff flu vaccination uptake through targeted communications, awareness campaigns and accessible vaccination clinics.
- The SCC will oversee infection-related pressures across the system, working collaboratively with the System IPC Programme to monitor outbreaks, support infection prevention and control measures, and coordinate responses where required. Where significant outbreaks occur, appropriate escalation measures will be implemented in line with provider policies to protect patients, staff and services.
- Through close partnership with the System Vaccination Programme and System IPC Programme, the SCC will support workforce resilience, patient safety and continuity of services throughout the winter period.

Essex System Co-ordination Centre (SCC)

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

The SCC will enter winter fully staffed, with the flexibility to extend operating hours should system pressures require additional support. The Head of SCC will provide overall leadership of winter preparedness and response arrangements, working closely with system partners to ensure a coordinated approach.

During the Christmas and New Year period, the SCC will maintain, as a minimum, two operational managers and administrative support seven days a week, including weekends and bank holidays, supported by the Strategic Lead to provide senior decision-making and system leadership.

Regular winter assurance meetings will bring together operational leads from across the Essex health and care system to review pressures, risks and mitigations, ensuring coordinated action and escalation where required.

The SCC will also coordinate mutual aid arrangements and the deployment of available capacity across organisations to maintain patient flow, service continuity and patient safety during periods of increased demand.

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

During periods of significant escalation, the SCC will extend operating hours to 20:00 and increase operational capacity to maintain oversight of demand, capacity, patient flow and patient safety.

Additional support will be provided by the Winter Executive Lead and/or Deputy, ensuring senior leadership and executive oversight of system pressures and mitigation actions.

Enhanced Winter Assurance Meetings will bring together senior leaders from acute, community, mental health, local authority and ambulance services to review risks, agree actions and coordinate system responses.

The SCC will coordinate mutual aid and capacity deployment across organisations to maximise available capacity, support patient flow and maintain service continuity during periods of exceptional demand.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

UCCH Funding Confirmation

Risk: Delayed confirmation of UCCH funding could impact SCC clinical input and limit opportunities to expand the model across Essex.

Mitigation: Ongoing engagement with Regional and National NHS England colleagues, with escalation through established winter governance arrangements as required.

Workforce Sickness

Risk: Increased staff sickness during periods of high demand could reduce SCC resilience and operational capacity.

Mitigation: Prioritise SCC core functions, pause non-essential activity where required, and utilise cross-cover arrangements and business continuity plans to maintain service delivery.

SCC Relocation to Seax House, Chelmsford

Risk: Delays to Seax House readiness could impact SCC co-location arrangements.

Mitigation: Continue operations remotely and/or utilise alternative accommodation identified with system partners to ensure continuity of service.

Extreme Winter Pressures

Risk: Demand exceeding forecast levels may place additional pressure on patient flow and system capacity.

Mitigation: Implement enhanced escalation measures, including extended SCC operating hours, additional assurance meetings, increased senior oversight, and coordination of mutual aid across the system.

Emergency Preparedness Resilience & Response

OPERATIONAL READINESS

EPRR will support the ICB and wider Integrated Care System (ICS) in preparing for winter-related incidents, as well as other incidents that may occur concurrently during winter.

EPRR will do this by:

- Maintaining the ICB on-call arrangements to ensure the organisation can provide 24/7 Strategic and Tactical leadership over the winter period as and when required.
- Coordinating the System's Festive and New Year Period On-call Plan, covering the period from Friday 12/12/26 to Sunday 10/01/2027.
- Working with the System Coordination Centre (SCC) to design, deliver and evaluate the Essex ICS Winter Readiness Tabletop Exercise which will support the systems winter planning and preparedness.

SYSTEM INTEGRATION

EPRR will maintain effective relationships and collaborative working across system and multi-agency partners before, during, and after the winter period.

EPRR will do this by:

- Maintaining generic (i.e. non-winter specific) EPRR functions throughout the winter period while continuing to lead and coordinate system-wide resilience activity, including chairing the monthly EPRR Forum with NHS Providers, engaging with Essex Resilience Partners.
- Strengthening the application of NHS EPRR incident declaration terminology and timely escalation to both the ICB and NHSE EoE, ensuring a more consistent approach across all NHS Providers.
- Representing and advocating EPRR interests at the Essex Winter Strategy Group.
- Conducting lessons and debriefing activity to capture lessons, noticeable practice and opportunities for improvement, informing resilience planning and preparedness for winter 2027/28.

PATIENT DEMAND & CAPACITY

The EPRR Team will work closely with the SCC Team to ensure that ICB on-call staff are trained in their role in managing patient demand and capacity escalations out-of-hours. This includes ensuring on-call staff have access to relevant documentation including action cards.

Through the annual NHSE EPRR Core Standards Assurance process the EPRR Team will obtain assurance from NHS Providers that robust business continuity arrangements are in place for services that contribute to the management of patient care including flow, capacity and discharges. The team will also obtain assurances relating to adverse winter weather and other standards relevant to winter.

The EPRR Team will maintain their competencies as SCC Leads to ensure that while they are working in the SCC, as part of a seven-day-a-week rota, they are confident providing Tactical level leadership of the system during OPEL 4 operational pressures.

Emergency Preparedness Resilience & Response

WORKFORCE

It is vital to maintain the health, wellbeing and resilience of our staff during winter.

EPRR will do this by:

- Promoting the organisation's existing health and wellbeing initiatives to help reduce the risk of stress, fatigue, and burnout during periods of increased operational pressure.
- Ensuring appropriate EPRR staffing arrangements are in place, including annual leave management and on-call cover, to maintain resilience and operational readiness throughout the winter period.
- Supporting the provision and resilience of the seven-day-a-week SCC.
- Capturing lessons identified relating to the workforce during winter pressures to strengthen future resilience, preparedness, and response arrangements.

DIGITAL & DATA

It is essential that digital services, information systems, and data flows remain resilient and available to support safe patient care throughout the winter period.

EPRR will do this by:

- Utilising existing systems to support situation awareness and decision making during an EPRR incident.
- Maintain an up-to-date and user friendly on-call section within MS Teams.

INFECTION PREVENTION CONTROL & VACCINATION

Effective infection prevention, control, and vaccination measures are essential to protecting patients, staff, and services throughout the winter period.

EPRR will do this by:

- Working closely with Infection Prevention and Control (IPC), Public Health, UKHSA, and system partners to support a coordinated approach to managing seasonal infections and outbreaks.
- Supporting the timely escalation, coordination, and management of outbreaks where infection-related pressures affect patient safety, capacity, or workforce resilience.
- Promoting awareness of vaccination programmes and public health initiatives designed to reduce the impact of seasonal illness on patients and staff.
- Ensuring robust business continuity arrangements are in place to help services respond to increased demand associated with winter illnesses.

Emergency Preparedness Resilience & Response

INCREASE CAPACITY & CAPABILITY:
OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

The EPRR Team will work closely with the SCC Team to ensure that ICB on-call staff are trained in their role in managing OPEL 4 operational pressures out-of-hours. This includes ensuring on-call staff have access to relevant documentation including action cards.

The EPRR Team will maintain their competencies as SCC Leads to ensure that while they are working in the SCC, as part of a seven-day-a-week rota, they are confident providing tactical level leadership of the system during OPEL 4 operational pressures.

INCREASE CAPACITY & CAPABILITY:
EXTREMIST

The EPRR Team will work closely with the SCC Team to ensure that ICB on-call staff are trained in their role in managing in extremist (OPEL4+) operational pressures out-of-hours. This includes ensuring on-call staff have access to relevant documentation including action cards.

The EPRR and SCC Teams will work jointly to ensure a coordinated response during times of extremist, which may escalate and be managed via EPRR arrangements. The teams will agree the relationship between OPEL and EPRR frameworks.

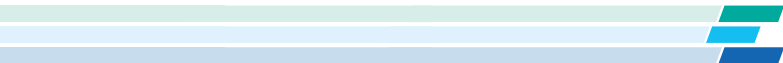
The EPRR Team will maintain their competencies as SCC Leads to ensure that while they are working in the SCC, as part of a seven-day-a-week rota, they are confident providing tactical level leadership of the system during OPEL 4 operational pressures.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Workforce (EPRR and On-call) Workforce Risks (*such as prolonged incidents, loss of/availability of key personnel, staff fatigue*)
Mitigation: Maintain business continuity arrangements, maintain handover processes, monitor workloads, promote wellbeing services, manage annual leave effectively and rotate responsibilities during prolonged incidents.

Risk: Season Risks (*such as adverse winter weather including snow and low temperatures, storms, flooding, and outbreaks of winter infectious diseases*)
Mitigation: Maintain robust EPRR arrangements including winter readiness exercises. Pro-active horizon scanning and timely cascade of information to support operational planning and resilience.

Risk: Concurrency Risk (*such as risk of a single, or multiple EPRR incidents occurring simultaneously during times of operational pressures*)
Mitigation: Maintain robust EPRR arrangements including winter readiness exercises. Pro-active horizon scanning and timely cascade of information to support operational planning and resilience.



System Vaccination Programme

OPERATIONAL READINESS

Primary Care and Medicines Teams will coordinate delivery of the ICB Winter 2026/27 Vaccination Programme, encompassing Flu, COVID-19, Pneumococcal and RSV vaccinations, to maximise uptake and support system resilience.

- Vaccination capacity to be expanded through targeted outreach and proactive delivery models, including community clinics and roaming vaccination teams to improve access for eligible cohorts.
- A coordinated programme is in place to increase frontline staff vaccination uptake, supported through occupational health services, peer vaccinators, targeted communications, incentives and performance monitoring, with oversight provided through the Vaccination Group.
- Targeted community engagement and communications, delivered in partnership with voluntary, faith and community sector organisations, will support uptake amongst underserved populations and address health inequalities.
- Vaccination infrastructure, including estates, workforce, digital systems and supply chain arrangements, will be maintained and strengthened to ensure resilient delivery throughout the winter period, supported by clear escalation processes for emerging pressures.

SYSTEM INTEGRATION

The winter vaccination programme will play a key role in effective collaboration across system and multi-agency partners before, during, and after the winter period. This will be achieved by:

- Maintaining the ICB-wide Winter Vaccination Group to coordinate strategic oversight and delivery.
- Collaborative planning will be actively supported across NHS organisations, Local Authorities, Hospices, and the Voluntary and Community Sector to ensure aligned approaches and shared priorities.
- In addition, joint working with multi-agency partners will help promote vaccination uptake among eligible staff and amplify NHS messaging to the public.

DISCHARGE & CAPACITY

The winter vaccination programme supports patient flow and timely discharge by reducing the incidence and impact of seasonal illness across vulnerable populations and the workforce.

- A proactive, targeted vaccination approach will focus on vulnerable cohorts to reduce avoidable illness, hospital attendance and admission.
- Vaccination uptake amongst frontline staff will be prioritised to maintain workforce resilience and continuity of critical services that support patient flow and discharge.
- Vaccinations will be offered, where appropriate, to patients being discharged to care homes to reduce transmission risk and support safe, timely transitions of care.
- Targeted vaccination delivery will help mitigate seasonal pressures on urgent and emergency care services, supporting system capacity throughout winter.

System Vaccination Programme

WORKFORCE

- A coordinated programme is in place to increase vaccination uptake amongst frontline and eligible staff, supporting workforce resilience and reducing illness-related absence, with a target of a 5% improvement on the 2025/26 baseline.
- Staff education and communications will promote the benefits of vaccination in protecting staff, patients and services throughout the winter period.
- Provider organisations will proactively monitor sickness absence trends to inform local vaccination delivery, workforce planning and resilience measures.
- The ICB Vaccination Group will oversee workforce vaccination performance and support targeted interventions where uptake requires improvement.

DIGITAL & DATA

To enhance situational awareness and support informed decision-making throughout the winter period, the vaccination programme will be underpinned by robust digital and data systems. Key actions include:

- **ICB-Level Dashboard Monitoring** An integrated dashboard will be maintained at the ICS level to track vaccination uptake across eligible cohorts and frontline staff, measured against pre-agreed trajectories. This will enable timely identification of gaps and inform targeted interventions.
- **Booking and Capacity Oversight** Real-time monitoring of vaccination bookings and site capacity will be conducted to ensure adequate availability and responsiveness. This will support operational planning and facilitate swift action where uptake or access issues are identified.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Low vaccination uptake results in increased staff illness and reduced workforce resilience.

Mitigation: Targeted staff vaccination campaigns, supported by communications, education and uptake monitoring.

Risk: Limited access to vaccination services reduces uptake amongst eligible populations and staff.

Mitigation: Multiple delivery models, including community clinics and outreach services, to maximise accessibility and coverage.

Risk: Staff are unaware of vaccination benefits or eligibility criteria.

Mitigation: Consistent communications and accessible educational resources promoting the benefits of vaccination for staff, patients and services.

Risk: Emerging sickness absence trends are not identified early enough to inform operational response.

Mitigation: Proactive monitoring of workforce absence data to enable timely interventions and workforce planning adjustments.

Risk: Staff not eligible for nationally commissioned flu vaccination programmes remain unvaccinated.

Mitigation: ICB-funded flu vaccination provision, including on-site clinics, to broaden access for clinical and non-clinical staff.

Risk: Increased transmission of seasonal infections impacts service delivery and operational resilience.

Mitigation: Comprehensive vaccination programme, targeted outbreak prevention measures and ongoing monitoring of uptake and infection trends.

System Infection Prevention Control Programme

OPERATIONAL READINESS

- Winter IPC escalation arrangements are in place, with isolation and cohort capacity regularly reviewed to support surge demand.
- PPE stock levels are monitored and assured across all providers.
- Robust outbreak management processes are established, tested and supported by clear stakeholder responsibilities.
- Enhanced cleaning contracts and contingency arrangements are in place across acute, community and mental health services.
- Specialist IPC support is available during working hours, with out-of-hours cover provided through the on-call Microbiologist/Infection Control Doctor
- Established communication and engagement processes ensure IPC risks, alerts and site-specific issues are rapidly shared and escalated across commissioned provider services.

SYSTEM INTEGRATION

- SCC participation & escalation
- Optional mutual aid arrangements for IPC staffing and expertise
- Cross-organisational escalation and communication routes defined
- Joint working with UKHSA and Local Authorities
- Regular IPC Winter Cell meetings being established (fortnightly as a minimum)
- Escalation to ICB IPC in the event of issue arising affecting patient safety and or flow
- Limited IPC provision for social care settings although overseen by UKHSA and the Local Authority

PATIENT FLOW, DISCHARGE & CAPACITY

Overall Aim: To optimise patient flow, discharge and capacity across acute, community, mental health, local authority and wider out-of-hospital services, maximising system capacity, reducing delays in care and ensuring patients access the most appropriate setting as quickly as possible.

- Processes are in place to minimise infection-related discharge delays through effective communication, coordination and system-wide engagement.
- Isolation requirements are incorporated into discharge planning, with visibility of community and care home capacity across the system.
- Agreed pathways for infectious patients are established across all providers to support safe and timely transfers of care.
- Infection-related bed closures are actively managed through regular incident and outbreak meetings, supported by ICB IPC oversight.
- Surge capacity plans are in place to respond to periods of increased respiratory virus activity.

System Infection Prevention Control Programme

WORKFORCE

- IPC workforce capacity reviewed, (some gaps in knowledge, and capacity, which is supported via the ICB IPCT.
- No on call IPCN cover in place, however mitigated with access to on call Microbiology/Virology or IPC Dr.
- Mandatory IPC training completion assured
- Staff vaccination uptake monitored and action plans in place
- Appropriate FIT testing across high acuity/high risk areas, with data available in some providers
- Limited IPC provision for social care settings although overseen by UKHSA and the LA

DIGITAL & DATA

- Surveillance data shared across the system through the winter Infection Prevention Control Cell
- Outbreak and incident reporting systems aligned following national guidelines
- Bed closures and infection-related capacity losses tracked (i.e. bed days lost)

Enhancing visibility and decision-making through SHREWD and real-time operational intelligence to support effective coordination, escalation and resource deployment.

INFECTION PREVENTION CONTROL & VACCINATION

- Seasonal flu and COVID-19 vaccination programmes are delivered across all sectors, with staff uptake monitored against agreed targets.
- Ongoing surveillance of influenza, COVID-19, RSV, norovirus and emerging infectious diseases to support early identification and response.
- Outbreak response arrangements are regularly reviewed and tested to ensure operational readiness.
- Comprehensive hand hygiene and IPC audit programmes are in place to maintain compliance and support continuous improvement.
- Antimicrobial stewardship arrangements are embedded to promote appropriate prescribing and reduce the risk of antimicrobial resistance.



Organisational Winter Plans and Delivery Arrangements

Preparing and Responding Together for Winter 2026/27

Pharmacy

OPERATIONAL READINESS

Stock Resilience: Community pharmacies maintain stock levels of winter respiratory and mental health medications, aligned with historical usage and anticipated demand.

- **Pharmacy First Delivery:** Majority of community pharmacies are signed up to deliver the Pharmacy First service, covering seven designated clinical pathways.
- **Hospital Discharge Medicines:** Standard procedures for hospital pharmacy discharge medicines will continue to be followed to ensure continuity of care.

Holiday Opening:

- Christmas Day is formally commissioned; other bank holidays rely on voluntary opening.
- Christmas Day hours are limited (2–3 hours per pharmacy), staggered across the day.

End-of-Life (EoL) Medicines:

- All pharmacies can order EoL medicines.
- ICB pharmacies are commissioned to stock and available during normal hours.
[End of life medicines Essex | Urgent pharmacy support](#)
- Boots voluntarily stock the national list, though with a slightly reduced range.

SYSTEM INTEGRATION

- Community pharmacies receive referrals to the Pharmacy First service from NHS 111, IC24, and general practice.
- The service remains accessible to patients presenting directly without a prior referral.
- General practices are encouraged to adopt formal referral mechanisms to Pharmacy First, rather than informal signposting, to alleviate pressure on GP appointments.
- Pharmacy First referral pathways embedded across NHS 111, General Practice, UEC and Emergency Departments.
- Use of NHS 111 Directory of Services profiles to ensure service availability and opening hours remain accurate.
- Emergency Departments have an opportunity to direct appropriate patients to community pharmacies via signposting, pending the establishment of a formal referral pathway.
- Implementation of formal referral processes supports improved clinical governance by ensuring a documented and auditable record of referral receipt within community pharmacy settings.

PATIENT FLOW, DISCHARGE & CAPACITY

- Standard hospital discharge medicines processes maintained to support timely discharge and continuity of care across all care settings.
- TTA dispensing arrangements in place to minimise medicines-related discharge delays and support effective patient flow.
- Patients' Own Drugs (PODs) and existing home medication supplies utilised where clinically appropriate, in accordance with local policy, reducing unnecessary dispensing and facilitating discharge.
- Early identification and prioritisation of discharge prescriptions to support timely patient discharge and optimise bed capacity.
- Ward teams to confirm existing medicines supplies with patients and carers at the earliest opportunity to enable effective discharge planning and minimise avoidable delays.
- Robust transfer of care arrangements in place to ensure continuity of medicines management between hospital, primary care and community settings.
- Joint working with community pharmacy providers
 - to support timely access to medicines and ongoing pharmaceutical care following discharge.
- Repeat prescribing arrangements through general practice utilised where clinically appropriate to maintain continuity of treatment and reduce delays in accessing medicines.
- Routine business continuity arrangements maintained for medicines supply and dispensing services to preserve operational resilience during periods of increased demand.
- Regular review of medicines-related discharge delays undertaken, with local mitigation actions implemented to address emerging issues and support patient flow.
- Contingency plans in place for pharmacy workforce pressures, including the pre-planned use of hospital FP10 prescriptions for discharge medicines where appropriate and in accordance with regulatory requirements and local pharmacy governance processes.

Pharmacy

WORKFORCE

- Providers and contractors to maintain resilient pharmacy workforce capacity to support commissioned services, including seven-day and extended-hours provision.
- Workforce plans in place to manage annual leave, festive period rotas, staff absence, and winter surge pressures, ensuring continuity of essential services.
- Business continuity, staff wellbeing, vaccination, and resilience arrangements maintained across acute, community, primary care, and community pharmacy services.
- The ICB to maintain oversight of pharmacy workforce risks, supporting system coordination, escalation, and mitigation where required.
- The MSE Virtual Pharmacy Service for Virtual Wards maintains service continuity arrangements, including collaborative community pharmacy support where required, with medicines supplied through established FP10 prescribing pathways.
- Virtual Ward pharmacy services in North East Essex and West Essex are delivered through managed service arrangements, with providers responsible for maintaining workforce resilience and service continuity.

DIGITAL & DATA

Prescribing Data: FP10 prescribing data via ePACT is based on dispensing dates and lags by 2–3 months, making it unsuitable for timely monitoring.

Pharmacy First Activity: Monthly data on consultations (minor ailments, urgent meds, clinical conditions) and outcomes is available but not yet integrated into Athena dashboards, despite requests. Access is currently via the homepage.

INFECTION PREVENTION CONTROL & VACCINATION

- All pharmacy staff are actively encouraged to receive seasonal influenza vaccination to support workforce resilience, reduce sickness absence, and minimise the risk of transmission during periods of increased winter demand.
- Staff eligible for the NHS flu vaccination programme should be supported to access vaccination through their GP practice or local community pharmacy.
- NHS provider organisations, including PAH, ESNEFT, MSEFT, Provide, EPUT and NELFT, maintain staff vaccination programmes through Occupational Health services or approved peer-to-peer vaccination arrangements.
- Community pharmacy staff without access to formal Occupational Health services should be supported to access vaccination through available NHS frontline worker arrangements, in line with national guidance.
- Primary Care Network (PCN) and GP-employed pharmacy staff should receive seasonal influenza vaccination through established general practice processes and in accordance with national programme guidance.
- Vaccination uptake is promoted and monitored where applicable, with providers encouraged to maximise coverage to maintain workforce capacity and operational resilience throughout the winter period.
- Infection prevention and control policies and procedures remain in place across all pharmacy settings to minimise infection transmission risks and maintain safe service delivery.

Pharmacy

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- Provider pharmacy contingency plans activated to maintain service continuity and mitigate the impact of workforce, capacity, or operational pressures.
- Community pharmacy contractors to maintain contractual services, supported by local business continuity arrangements and prioritised service delivery where required.
- Mutual aid arrangements and escalation processes implemented to manage significant service disruption and preserve critical pharmaceutical services.
- Workforce deployment and skill mix optimised across provider organisations to maximise available capacity and maintain safe and effective service provision.
- System-wide surveillance and engagement maintained to identify emerging pharmacy capacity risks, coordinate mitigations, and support operational resilience.
- Community pharmacy services maximised to support winter resilience, reduce demand on urgent and emergency care services, and improve access to medicines and clinical advice.

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

- Pharmacy business continuity and major incident plans enacted to maintain essential pharmaceutical services during periods of extreme system pressure.
- Critical medicines supply and pharmacy services prioritised to support patient safety and the delivery of urgent and essential care.
- Mutual aid arrangements and formal escalation processes utilised where required to sustain service provision and mitigate disruption.
- Community pharmacy contractors to implement contractual business continuity arrangements, ensuring continuity of access to core services wherever possible.
- Temporary service prioritisation or reconfiguration implemented as necessary to protect critical service delivery and maximise available capacity.
- System-wide coordination maintained to manage medicines resilience, monitor supply risks, and ensure patient safety throughout the escalation period.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Temporary community pharmacy closures due to the legal requirement for a pharmacist to be present on site and difficulties securing locum cover or delays in pharmacist attendance.

Mitigation: Established business continuity and escalation procedures are in place to manage unplanned closures, minimise disruption, and maintain patient access to pharmaceutical services.

Risk: Hospital pharmacy workforce shortages, particularly at Southend Hospital, impacting service delivery capacity and resilience.

Mitigation: A dedicated task and finish group is overseeing targeted recruitment, workforce planning, and retention actions to strengthen staffing resilience and maintain safe service provision.

Risk: Insufficient community pharmacy provision during bank and public holidays, potentially affecting access to medicines and Pharmacy First services.

Mitigation: Primary Care commissioning arrangements are reviewed to ensure adequate holiday service coverage, including consideration of both dispensing and Pharmacy First provision to support continuity of care.

Risk: Limited availability of End of Life (EoL) medicines during holiday periods if commissioned EoL pharmacies are not open, particularly on Christmas Day.

Mitigation: Expressions of Interest (EOIs) and commissioning arrangements are reviewed with the contracting team to ensure appropriate service coverage. Where required, access to medicines is supported through hospital on-call pharmacy arrangements as a contingency.

General Medical Services & PCN's

OPERATIONAL READINESS

- Winter preparedness is aligned to NHS England Board Assurance Statement requirements and the Essex system winter planning framework.
- General practice core services will remain available throughout contracted core hours, supported by established business continuity and critical incident arrangements.
- Pre-winter assurance processes are in place to confirm Christmas and New Year access and service continuity arrangements, enabling any gaps to be identified and addressed ahead of peak demand.
- Access, demand and service performance are monitored through GPAD, MGPAT/SLF, eDEC, NHS 111 booking assurance and local intelligence, with targeted support and intervention where variation is identified.
- PCN Enhanced Access provision forms an integral part of the winter same-day and routine access offer, with capacity expectations agreed through ongoing engagement with PCNs and practices.

SYSTEM INTEGRATION

- Patients will be directed to the most appropriate service through established pathways, including same-day general practice, NHS 111 Clinical Assessment Service (CAS), PCN Enhanced Access, community pharmacy and self-referral services.
- Existing self-referral pathways will be actively promoted to support direct access to care and reduce avoidable demand on general practice.
- Pharmacy First will be promoted as a key alternative access route for the assessment and treatment of common winter conditions.
- NHS Directory of Services (DoS) profiles will be reviewed and aligned with available general practice, Enhanced Access and community pharmacy capacity to support effective patient navigation.
- Coordinated public and provider communications will support access to services, prescribing, vaccination uptake and self-care messaging throughout the winter period.

PATIENT FLOW, DISCHARGE & CAPACITY

- Modern General Practice, online consultation and total triage models support demand management, clinical prioritisation and timely access to care.
- Practices and PCNs will proactively identify and support patients at increased risk of deterioration during winter, including frailty, care home residents and other priority cohorts.
- Enhanced Health in Care Homes arrangements provide a dedicated primary care pathway to support proactive care and reduce avoidable hospital attendance and admission.
- Admission avoidance initiatives and community-based alternatives will be promoted through Place and neighbourhood delivery arrangements.
- Risks relating to discharge information, medicines reconciliation, urgent follow-up and avoidable hand-offs between services will be managed through established system escalation routes.
- Repeat prescribing and discharge-related medicines processes will remain a key focus for winter communications, operational oversight and system monitoring.

General Medical Services & PCN's

WORKFORCE

- Additional Roles Reimbursement Scheme (ARRS) and Primary Care Network (PCN) workforces support service resilience and appointment capacity across neighbourhoods.
- Practice business continuity plans are in place to manage workforce shortages, adverse weather and the continuity of patient access.
- Seasonal vaccination programmes are actively promoted across general practice workforces as part of infection prevention and winter resilience arrangements.
- Practice-level workforce pressures and service risks are monitored through contract management, Place oversight and established escalation processes.
- Any requirement for additional surge capacity within general practice remains subject to agreed commissioning and funding arrangements.

DIGITAL & DATA

- Digital access channels, including online consultation, the NHS App, cloud telephony, patient messaging and electronic prescription ordering, support patient access and demand management.
- Remote and home-based monitoring services, where established locally, support the management of long-term conditions and identification of patients at risk of deterioration during winter.
- GPAD, eDEC, MGPAT/SLF and NHS 111 datasets are used to monitor access, practice opening, same-day urgent capacity and unwarranted variation.
- NHS 111 direct booking functionality and Enhanced Access appointment utilisation will be reviewed and validated ahead of peak winter demand.
- Data and intelligence will be used to target interventions and support proactive decision-making, avoiding unnecessary blanket escalation approaches

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Winter demand exceeds commissioned or core general practice capacity, impacting access and appointment availability.

Mitigation: Active demand monitoring, clinical prioritisation of urgent need, utilisation of PCN Enhanced Access capacity, and routing patients to appropriate alternative services, including Pharmacy First and self-referral pathways.

Risk: Variation in same-day access, online access, core-hours compliance or NHS 111 direct booking availability affects patient access and system flow.

Mitigation: Routine assurance processes, data-led performance monitoring, targeted support for providers and contractual escalation where required.

Risk: Increased demand over the Christmas and New Year period impacts access and repeat prescribing services.

Mitigation: Pre-winter assurance of service continuity, proactive practice communications, promotion of prescription ordering deadlines and coordinated public messaging.

Risk: Higher demand from frail patients, care home residents and other high-risk cohorts increases pressure on primary care and urgent care services.

Mitigation: Proactive identification and management through PCNs, Enhanced Health in Care Homes arrangements, neighbourhood teams and established escalation routes.

Risk: Workforce shortages resulting from sickness, adverse weather or other unforeseen events reduce service capacity.

Mitigation: Practice business continuity plans, workforce escalation processes, local mutual aid arrangements and operational oversight through Place and commissioning teams

Dentistry

OPERATIONAL READINESS

- The Essex Access Pilot provides additional urgent and routine dental capacity across Essex ICB, extending access beyond core contractual dental services.
- Twenty access provider sites have been identified across Essex, comprising 13 sites in Mid and South Essex, 5 in North East Essex, and 2 in West Essex, ensuring broad geographical coverage and improved patient access.
- Weekday arrangements include both additional capacity within core operating hours and extended access outside standard service hours to support increased winter demand.
- Weekend provision is available through participating providers, delivering dedicated five-hour sessions on Saturdays and/or Sundays.
- Bank holiday dental cover is planned across all bank holidays, with five-hour opening sessions delivered through the established access provider network to maintain access to urgent care services.

SYSTEM INTEGRATION

- Services (DoS NHS 111 can directly book patients into available urgent dental access appointments through participating practice booking systems.
- Patients may also book appointments directly with participating access providers, improving accessibility and patient choice.
- Emergency Department (ED) and Urgent Care teams have access to dental appointment booking systems, enabling appropriate redirection of patients to dental services and reducing avoidable attendances.
- Urgent dental access is fully integrated with NHS 111, Integrated Urgent Care (IUC) and local dental providers, ensuring patients are directed to the most appropriate setting for their needs.
- Appointment schedules, service information and booking arrangements are maintained within the Directory of Services (DoS), supporting accurate referral pathways, operational coordination and winter communications.), supporting accurate referral pathways, operational coordination and winter communications.

PATIENT FLOW, DISCHARGE & CAPACITY

- Urgent dental access appointments provide an alternative pathway to Emergency Departments, NHS 111 and general practice for patients presenting with dental concerns, supporting demand management across the urgent care system.
- Direct booking arrangements reduce hand-offs between services and facilitate timely access to urgent and same-day dental care.
- Extended weekday, weekend and bank holiday provision increases capacity during periods when routine dental services may be limited, improving patient access throughout winter.
- The availability of both urgent and routine appointment types supports the management of seasonal demand and reduces inappropriate presentations to wider urgent and emergency care services.
- Activity, utilisation and access data are routinely monitored to identify demand trends, capacity gaps and provider resilience risks, enabling targeted operational responses where required.

Dentistry

WORKFORCE

- Service delivery is supported through participating dental providers delivering locally agreed extended access sessions across Essex.
- Extended access arrangements operate across weekdays, weekends and bank holidays, with provider session plans coordinated and overseen by the ICB.
- Workforce resilience is dependent on provider staffing levels and estate availability, with risks and service continuity issues escalated through established dental commissioning processes.
- Planned weekend and bank holiday provision reduces reliance on reactive escalation arrangements and provides consistent access routes for patients, NHS 111 and Emergency Department teams.
- Provider engagement and assurance processes are in place to confirm service continuity over the Christmas and New Year period, including the management of any workforce or rota changes.

DIGITAL & DATA

- Appointment booking is digitally enabled, allowing NHS 111 to book patients directly into participating dental practice systems, supporting timely access to care.
- Emergency Department (ED) teams have access to dental booking systems, enabling real-time referral and redirection to available dental appointments where appropriate.
- Practice-level session data, including weekday, weekend and bank holiday availability, is maintained to support service assurance, operational oversight and Directory of Services (DoS) accuracy.
- Appointment utilisation, booking activity and access trends are monitored through NHS 111, provider and local dental access data to identify variations in demand, capacity pressures and potential gaps in provision.
- Data and performance intelligence are used to inform targeted communications, operational adjustments and escalation arrangements in response to emerging winter pressures.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Access Variation Across Providers: Geographic variation or reduced provider availability during evenings, weekends and bank holidays may result in inconsistent access to urgent dental care and uneven service coverage.

Mitigation: Access provider rotas are regularly reviewed and coordinated to maintain appropriate geographical coverage and ensure capacity is aligned to anticipated demand.

Risk: Awareness of Dental Access Pathways: Patients and healthcare professionals may be unaware of available urgent dental access routes, leading to inappropriate presentations to Emergency Departments, NHS 111 and general practice.

Mitigation: Clear communication and engagement are delivered through NHS 111, Emergency Departments, primary care and public-facing channels to promote awareness of available dental access services and referral pathways.

Risk: Booking System or Data Issues: Failures within booking pathways, or inconsistencies between practice systems, NHS 111 and Emergency Department booking platforms, could affect appointment availability and patient access.

Mitigation: Pre-winter system validation and testing are undertaken to ensure booking functionality, data accuracy and alignment of service information across all platforms.

Risk: Provider Workforce or Estate Disruption: Workforce shortages, unexpected staff absence or premises-related issues could reduce the availability of planned dental access sessions.

Mitigation: Established escalation procedures and provider contingency arrangements are in place to manage service disruptions and minimise the impact on patient access.

Risk: Demand Exceeding Capacity: Winter demand may exceed available appointment capacity, resulting in increased waiting times and pressure on urgent care services.

Mitigation: Appointment utilisation, capacity, missed slots and demand trends are routinely monitored to enable early identification of pressures and timely adjustments to service delivery where possible.

NHS111: HUC (West Essex)

OPERATIONNAL READINESS

- Winter Operational Plan, EPRR arrangements and OPEL escalation processes are agreed, tested and communicated across all services.
- Daily operational oversight of demand, capacity, queue position, workforce availability and performance, with rapid implementation of mitigating actions where required.
- Clear escalation routes are in place across CAS, ambulance services and wider system partners to support coordinated responses to operational pressures.
- Robust business continuity and incident management arrangements are maintained, including IT, telephony and site disruption plans.
- Pan-HUC resilience arrangements across all four operational sites support service continuity and operational flexibility.
- Winter surge plans are in place, with additional staffing capacity identified to respond to periods of sustained or exceptional demand.

SYSTEM INTEGRATION

- Active participation in System Coordination Centre (SCC) arrangements, including agreed escalation processes.
- Maintain clear communication and escalation pathways with UCCU, Urgent Care and wider system partners.
- Work collaboratively with ambulance services, utilising agreed escalation procedures and mutual aid arrangements where appropriate.
- Align operational delivery with local system winter plans and escalation frameworks.
- Share daily demand, capacity and operational intelligence through system coordination calls to support situational awareness and decision-making.
- Support ambulance avoidance through effective utilisation of NHS 111 clinical pathways and Directory of Services (DoS) dispositions.
- Escalate pathway gaps, service constraints and emerging system risks through agreed governance and escalation routes.

PATIENT DEMAND & CAPACITY

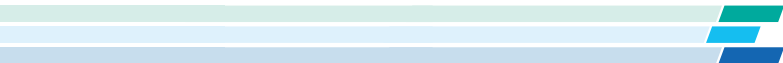
- Review and refresh the Integrated Assurance Plan (IAP) in line with emerging demand patterns and winter pressures.
Undertake hour-by-hour and seven-day demand and capacity modelling, with particular focus on peak evening activity.
- Monitor daily activity, workforce capacity and performance against forecast demand, implementing timely mitigations where required.
- Review Clinical Assessment Service (CAS) and Out of Hours capacity to ensure resilience against anticipated winter demand.
- Maintain effective ambulance service escalation processes and collaborative system working arrangements.
- Maximise utilisation of SDEC, Urgent Care and UTC pathways, where applicable, to support flow and reduce avoidable conveyance.
- Monitor repeat contacts and avoidable demand to identify opportunities for pathway optimisation and service improvement.
- Identify periods of sustained high demand and implement targeted workforce and operational interventions.
- Maintain flexible deployment of workforce resources across services, sites and functions to respond to changing operational pressures.
- Provide robust daily, weekly and monthly performance reporting to support operational oversight, capacity management and proactive decision-making.

NHS111: HUC (West Essex)

WORKFORCE
• Workforce establishment, vacancies and availability actively managed against forecast winter demand. • Flexible seven-day staffing model supported by bank, overtime and resilience workforce arrangements. • Cross-skilled staffing, targeted training and competency reviews ensure workforce resilience and safe service delivery. • Clinical and operational workforce capacity maintained to minimise avoidable escalations and support demand across NHS 111, CAS, OOH and UCCH. • Staff wellbeing, absence management and annual leave oversight incorporated into winter planning.

DIGITAL & DATA
• Daily monitoring of demand, capacity and performance through operational dashboards and Business Intelligence reporting. • Real-time oversight of queues, response times and abandonment rates to support operational decision-making. • Demand, capacity and workforce modelling used to inform resource planning and escalation. • Performance analytics used to identify emerging trends, capacity risks, repeat contacts and improvement opportunities. • Regular resilience testing of Storm, Adastra and associated IT infrastructure, supported by robust digital business continuity arrangements.

INFECTION PREVENTION CONTROL & VACCINATION
• Seasonal flu vaccination is actively promoted to all eligible staff, with uptake monitored and encouraged throughout the winter period. • Infection Prevention and Control (IPC) guidance is regularly communicated to staff to support safe practice and minimise the risk of transmission. • Clear processes are in place for the management of staff with infectious illnesses to reduce workforce transmission risks and maintain service continuity. • Hand hygiene standards are reinforced across all services as a key component of infection prevention measures. • Winter infection trends, including respiratory viruses and other seasonal illnesses, are actively monitored to assess and mitigate potential impacts on workforce capacity and operational resilience.



NHS111: HUC (West Essex)

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- Additional Health Advisor capacity is identified and available for rapid deployment to support sustained demand and maintain service performance.
- Bank, overtime and flexible workforce arrangements are available to provide additional resilience during periods of exceptional operational pressure.
- Staffing models and shift patterns can be extended or adapted in response to escalating demand and service requirements.
- Enhanced Operational Management oversight is in place to provide leadership, coordination and timely escalation management.
- Additional non-clinical and operational support can be deployed to protect clinical capacity and maximise frontline patient-facing resource.
- Agreed mutual aid escalation processes are in place to secure support from the wider network where local capacity is insufficient to meet demand.
- During periods of severe system pressure, critical NHS 111 activity will be prioritised to maintain patient safety and continuity of essential services.

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

- Safeguarding awareness is reinforced across the workforce to support appropriate decision-making and minimise unnecessary referrals while maintaining patient safety.
- Clear escalation and reporting processes are in place for safeguarding concerns identified during patient contacts.
- Mandatory training and ongoing workforce awareness programmes ensure staff remain prepared to respond to safeguarding, operational and major incident requirements.
- Robust Business Continuity Plans are in place to maintain critical services and support organisational resilience during significant external incidents.
- The service can implement escalation arrangements and deploy additional capacity to respond to demand associated with major incidents, severe weather events or significant community pressures.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Winter system pressures increase NHS 111 demand and reduce capacity across onward care pathways, impacting timely patient disposition and flow.

Mitigation: Daily system intelligence, SCC engagement, pathway escalation processes, collaboration with ambulance services and UTCs, and active monitoring of local service availability to support timely access to alternative pathways.

Risk: Demand exceeds Indicative Activity Plan (IAP) assumptions, particularly during evening and weekend periods, placing pressure on service performance and responsiveness.

Mitigation: Daily monitoring of actual versus forecast demand, regular review of demand profiles, and deployment of flexible staffing and additional capacity targeted to peak demand periods.

Risk: Workforce absence reduces available operational and clinical capacity during periods of sustained winter pressure.

Mitigation: Enhanced absence monitoring, early intervention and wellbeing support, utilisation of bank and overtime resource, and flexible deployment of a cross-skilled workforce across services and sites.

Risk: Increased Healthcare Professional (HCP) escalation activity overwhelms Clinical Assessment Service (CAS) capacity, resulting in delays to clinical assessment.

Mitigation: Continuous monitoring of escalation volumes and drivers, maintenance of appropriate clinical staffing levels, and detailed review of avoidable escalations, including utilisation of Clinical Feedback (CFW) and Non-Clinical Feedback (NCFW) processes to improve pathway effectiveness.

NHS111: IC24 (Mid & South Essex)

OPERATIONAL READINESS

- Winter Lead is Dudley Mountford and daily escalation Lead is the IC24 Service Management Team (ic24.servicemanager@nhs.net).
- Senior Management, Clinical, Directorate and Executive On-Call arrangements in place to provide 24/7 operational oversight and escalation.
- UCCH clinical review of EEAST calls to support appropriate patient pathways and avoid unnecessary conveyance where clinically appropriate.
- NHS 111, ambulance and ED dispositions targeted for clinical validation within 60 minutes.
- Daily huddles, SITREPs and OPEL reviews maintain situational awareness and support coordinated decision-making.
- Pre-agreed escalation triggers manage increased demand, call abandonment and response-time pressures.
- Winter plans reviewed monthly and weekly ahead of Bank Holidays to maintain operational readiness.
- Business Continuity / Incident Response plans in place for service resilience and continuity.

SYSTEM INTEGRATION

- Active participation in Essex ICB system huddles, escalation calls and coordination forums.
- Silver and Gold Command representation provided as required to support system-wide decision-making and escalation management.
- System intelligence and escalation updates incorporated into daily internal huddles and SITREPs.
- Category 5 (C5) EEAST calls transferred to NHS 111 via ITK to support timely clinical assessment and pathway management.
- UCCH multidisciplinary teams provide coordinated alternatives to hospital attendance and admission where clinically appropriate.
- Mutual aid arrangements available through the wider Integrated Urgent Care (IUC) network to support service resilience during periods of sustained pressure.

PATIENT DEMAND & CAPACITY

- NHS 111 demand forecasts are routinely reviewed and updated to reflect anticipated winter activity and emerging demand trends.
- Average handling time assumptions are continually monitored and adjusted to support accurate workforce and capacity planning.
- Respiratory illness and seasonal demand patterns are actively monitored to inform operational response and resource deployment.
- Workforce absence assumptions are regularly reviewed and updated to reflect sickness and winter-related staffing pressures.
- Additional CAS and GP Out of Hours (OOH) clinical capacity is in place to support increased winter demand.
- Daily rota reviews are undertaken to maximise staffing resilience, including the utilisation of agency and locum resource to address workforce gaps. GP OOH services are consolidated onto core sites, where appropriate, to optimise utilisation of available face-to-face clinical capacity and maintain service efficiency.

NHS111: IC24 (Mid & South Essex)

WORKFORCE

- Enhanced staffing capacity across NHS 111, CAS, UCCH and GP Out of Hours services, informed by monthly demand and workforce trend analysis, with weekly reviews ahead of Bank Holidays and peak demand periods.
- Additional clinical hours, overtime, agency and incentivised shifts available to strengthen workforce resilience and maintain service continuity during periods of increased demand.
- Annual leave is actively managed during the festive period to maintain safe staffing levels and operational resilience.
- Frontline managers provide direct operational support to service delivery and escalation management.
- Ongoing recruitment supports sustainable clinical and non-clinical rota coverage and workforce resilience.
- A comprehensive staff flu vaccination programme is in place to support workforce health, attendance and resilience throughout the winter period.

DIGITAL & DATA

- UCCH data and performance intelligence are used to monitor service effectiveness, demonstrate outcomes and support continuous service improvement.
- Daily operational reporting and monthly trend analysis inform demand forecasting, capacity planning and operational decision-making.
- Uploading of data to SHREWD and SCC reporting provide system-wide visibility of service pressures, capacity and performance.
- Routine operational performance reporting is supported by recovery programme reporting and governance oversight to monitor delivery, risks and improvement actions.

INFECTION PREVENTION CONTROL & VACCINATION

- IPC Lead: Laurel McGonigall (Laurel.McGonigall@ic24.nhs.uk) provides oversight of infection prevention and control arrangements across services.
- A comprehensive staff flu vaccination programme is in place, supported by targeted promotion of vaccine uptake and staff education on vaccine safety and effectiveness.
- PPE stock levels are maintained and monitored to ensure sufficient availability across operational bases and contact centres throughout periods of increased winter demand.
- IPC measures and surveillance arrangements are in place to minimise the impact of seasonal infections, protect staff and patients, and maintain service continuity.

NHS111: IC24 (Mid & South Essex)

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- Silver/Gold Command will enact pre-agreed escalation arrangements, including the deployment of additional staffing and extension of operational hours to maintain service resilience.
- Additional clinical and non-clinical capacity will be mobilised to support NHS 111, Clinical Assessment Services (CAS), Urgent Community Care Hubs (UCCH) and Out of Hours (OOH) services
- Clinical queue capacity will be increased in response to agreed escalation triggers to support timely clinical assessment and maintain performance.
- UCCH and CAS capacity will be expanded, where required, across both face-to-face and home visiting services to meet increased demand and maintain patient access.
-

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

- Flexible workforce deployment and staff redeployment arrangements will be utilised to protect critical clinical pathways and maintain service continuity during periods of exceptional demand.
- Agreed escalation parameters will support coordinated operational management across acute, community and EEAST partners to optimise system response.
- Enhanced clinical review and validation processes will prioritise safe non-conveyance, attendance avoidance and use of alternative care pathways where clinically appropriate.
- Rolling four-week demand forecasting, activity monitoring and outbreak surveillance will inform rapid capacity adjustments and escalation decisions.
- Robust business continuity arrangements are in place to support incident management, maintain critical services and enable timely service recovery.
-

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

- **Risk:** Winter demand exceeds forecast levels, resulting in increased pressure on NHS 111, CAS, UCCH and OOH services.
- **Mitigation:** Workforce plans, agreed escalation triggers and the rapid release of additional capacity will be utilised to maintain service delivery and performance.
- **Risk:** Clinical workforce shortages reduce operational resilience and service capacity.
- **Mitigation:** Ongoing recruitment initiatives and access to bank, sessional and agency workforce arrangements will support staffing resilience and continuity of service.
- **Risk:** Respiratory illness, seasonal infections or outbreak incidents significantly increase service demand and workforce absence.
- **Mitigation:** Robust surveillance processes, IPC escalation measures and business continuity arrangements will be implemented to manage pressures and sustain critical services.
- **Risk:** System-wide operational pressures lead to increased demand on Integrated Urgent Care (IUC) services.
- **Mitigation:** Escalation through the System Coordination Centre (SCC), coordinated system-wide response arrangements and optimisation of UCCH pathways will support demand management and reduce unnecessary conveyance or attendance.

NHS111: PPG (North Essex)

OPERATIONAL READINESS

- Maintain safe, responsive and high-quality patient care through robust workforce planning, effective escalation processes and resilient service delivery arrangements.
- Reduce avoidable Emergency Department attendances through timely clinical assessment, effective triage, clinical validation and optimal utilisation of alternative care pathways.
- Support ambulance service resilience through enhanced clinical oversight of ambulance dispositions, promoting appropriate alternative pathways and reducing unnecessary conveyance where clinically suitable.
- Protect workforce wellbeing, health and resilience through staff vaccination programmes, wellbeing support, proactive attendance management and compassionate leadership.
- Maintain commissioner, stakeholder, public confidence with strong governance, performance oversight, transparent communication and effective system partnership working.
- Ensure organisational resilience through established command and control arrangements, comprehensive business continuity planning, system-wide collaboration and continuous operational review throughout the winter period.

SYSTEM INTEGRATION

- Active participation in system command and control arrangements to support coordinated management of winter pressures and escalation incidents.
- Regular engagement with Integrated Care Boards (ICBs), NHS England, ambulance services, acute providers and local resilience partners to maintain system-wide situational awareness and response.
- Alignment of operational plans and escalation processes with local, regional and national winter planning requirements.
- Collaborative working across the health and care system to support demand management, patient flow and delivery of agreed winter priorities.
- Timely sharing of intelligence, performance information and emerging risks to inform system-wide decision-making and mutual support arrangements.

PATIENT DEMAND & CAPACITY

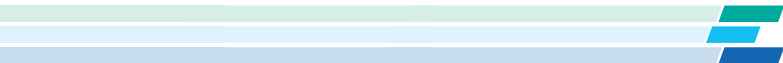
- Seasonal increases in NHS 111 contact volumes and urgent care demand are anticipated throughout the winter period.
- Increased workforce absence, including seasonal illness, may impact operational capacity and service delivery.
- Ongoing pressure across acute, ambulance and urgent care services is expected to influence demand patterns and escalation requirements.
- Enhanced clinical validation will be utilised during periods of high demand to support safe patient disposition and appropriate use of healthcare resources.
- Flexible workforce deployment, additional staffing arrangements and overtime capacity will be implemented to maintain service resilience during peak activity periods.
- Demand, capacity and performance modelling will be reviewed continuously throughout the winter period, with operational plans adjusted in response to real-time intelligence, service pressures and system-wide demand.

NHS111: PPG (North Essex)

WORKFORCE
PPG recognises that workforce wellbeing and resilience are essential to maintaining safe services throughout the winter period. • Maintain proactive monitoring of workforce attendance, sickness and staffing capacity. • Implement supportive absence management arrangements and promote staff wellbeing services. • Ensure safe staffing levels through effective workforce planning and flexible staffing arrangements. • Minimise abstraction from frontline duties during periods of peak demand to maximise operational capacity. • Provide compassionate leadership through robust tactical and strategic management oversight, supporting staff throughout periods of sustained pressure.

DIGITAL & DATA
• Daily monitoring and reporting through established system oversight arrangements, including participation in the Essex System Coordination Centre (SCC) call. • Utilisation of SHREWD to provide real-time visibility of demand, capacity, escalation status and system pressures • .Timely submission of daily and monthly operational, performance and activity data to support local, regional and national oversight. • NHS 111 National Contingency arrangements available to maintain service continuity in the event of telephony or system failures. • Continuous review of operational intelligence and performance data to inform decision-making, escalation and winter response actions.

INFECTION PREVENTION CONTROL & VACCINATION
• Deliver an enhanced staff flu vaccination programme, with an ambition to exceed previous uptake levels.



NHS111: PPG (North Essex)

INCREASE CAPACITY & CAPABILITY: OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- Deployment of additional overtime, bank and flexible workforce capacity to maintain service delivery.
- Redeployment of management, training and support staff to frontline operational roles where appropriate.
- Suspension of non-essential activities to maximise operational capacity and focus on critical services.
- Restriction of annual leave and implementation of enhanced staffing controls as required.
- Activation of national contingency arrangements and mutual aid processes where necessary to maintain safe service provision.
- Enhanced command, control and performance oversight through frequent operational reviews and escalation meetings.
- Business continuity arrangements are supported by comprehensive response plans covering: Major incidents and critical service disruption.
- Telecommunications and IT system failures.
- Severe weather events and other environmental disruptions.
- Infectious disease outbreaks and associated workforce impacts.
- Significant operational pressures affecting service delivery and patient safety.

INCREASE CAPACITY & CAPABILITY: EXTREMIST

- Enhanced clinical leadership presence and senior operational oversight throughout periods of sustained escalation.
- Increased frequency of operational command meetings to review demand, capacity, risks and mitigating actions.
- Close liaison with Integrated Care Boards (ICBs), ambulance services, acute providers and NHS England to support system-wide operational coordination.
- Prioritisation of clinically urgent contacts and maintenance of patient safety oversight through enhanced clinical governance arrangements.
- Dynamic management of staffing, shift coverage and resource deployment to maintain critical service functions.
- Escalation of emerging risks through established governance and command structures to enable timely decision-making and system support.
- Reinforced communications arrangements to ensure staff are informed of escalation status, operational priorities and required actions.
- Mutual aid and contingency arrangements utilised where available to support service resilience during periods of exceptional demand.
- Regular review of pathway availability and service capacity to ensure patients are directed to the most appropriate available service.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Workforce shortages.

Mitigation: Recruitment, retention, overtime, bank workforce, homeworking and national resource flexibility.

Risk: Flu and infectious disease outbreaks.

Mitigation: Vaccination programme, IPC measures, outbreak response arrangements and business continuity plans.

Risk: Excess demand.

Mitigation: Escalation framework, additional staffing, commissioner engagement and demand management initiatives.

Risk: Severe weather

Mitigation: Adverse weather planning, homeworking capability and national workforce deployment model.

Risk: System pressures affecting NHS111

Mitigation: ICB Collaboration, pathway reviews, increased validation activity and contingency capacity arrangements

999: East England Ambulance Service Trust

OPERATIONAL READINESS

- Tactical Operations Centre (TOC) operating as the central coordination hub for winter oversight, resource allocation and escalation management.
- Daily review of operational staffing aligned to forecast increases in winter demand.
- Clinical Safety Plan (CSP) actions proactively utilised to maintain patient safety during periods of operational pressure.
- Clinical Safety Cell (CSC) available to support management of demand surges, major incidents and significant patient safety risks.
- Winter-specific adverse weather arrangements, including preparedness for snow, flooding and cold weather alerts.
- Fleet availability and resilience measures in place, including extended workshop hours, operational support drivers and contingency vehicle deployment.
- Strategic and Tactical command structures available 24/7 throughout winter and festive periods.

SYSTEM INTEGRATION

- Local Operational Oversight Cells (LOOCs) embedded with ICB System Coordination Centres to provide joint situational awareness and escalation management.
- Strengthened partnership working through LOOCs, HALOs and local escalation calls.
- Delivery of coordinated responses aligned with wider health and care systems and partner agencies.
- Commitment to improving hospital handover performance through HO45/R2R processes and system escalation arrangements.
- Increased utilisation of primary care, community services, urgent community response (UCR) and mental health pathways.
- Close collaboration with acute trusts, ICBs and NHS England on Arrival to Handover (A2H) trajectories.
- Integration with Unscheduled Care Coordination Hubs (UCCHs) and Call Before You Convey (CB4YC) models.

PATIENT FLOW, DISCHARGE & CAPACITY

- Forecast demand increase of:
 - Calls answered: +3.5%
 - Incidents: +3.0%
- Focus on reducing handover delays and achieving the national 45-minute handover standard.
- Maximisation of Fit to Sit processes to release ambulance resources more quickly.
- Active management of critical standdowns and escalation processes.
- Expansion of alternative care pathways to reduce unnecessary ED conveyance.
- Increased referral to UCCH, SDEC, primary care and community services where clinically appropriate.
- Community First Response and Co-Responder expansion including Essex schemes to provide additional capacity and resilience.
- Monitoring of conveyance rates, excessive on-scene times and system bottlenecks through LOOCs.

999: East England Ambulance Service Trust

WORKFORCE

- Increased call handling workforce to approximately 315 FTE.
- Increased dispatch workforce to approximately 150 FTE.
- Expansion of Clinical Assessment Service clinicians from approximately 85 to 140 staff.
- Accelerated recruitment pipelines for winter-critical roles.
- Improved mentoring programmes to rapidly develop newly recruited staff into work-effective employees.
- Annual leave capped at 50% during the festive period.
- Reduction in non-essential absences and training during peak winter periods.
- Enhanced staff wellbeing support including Welfare Wagons, wellbeing campaigns and visible leadership.
- Flu vaccination campaign to support workforce resilience.

DIGITAL & DATA

- Improved access to real-time operational data and fleet information.
- Reduced duplication and enhanced operational information flow across services.
- Daily operational reporting through LOOCs and TOC structures.
- Expansion of ITK integration to enable referral of lower acuity patients into community and primary care pathways.
- Joint monitoring of clinical and operational risks across provider systems.
- Use of sickness surveillance, rostering intelligence and operational data to identify emerging pressures.

INFECTION PREVENTION CONTROL & VACCINATION

- Winter IPC communications across operational and EOC teams.
- Routine monitoring of vehicle, equipment and station cleanliness.
- Monitoring of PPE stocks, hand hygiene facilities and IPC compliance.
- Infectious disease oversight sessions to identify outbreaks and operational impacts.
- Sickness surveillance to identify infection-related trends and emerging risks.
- Enhanced cleaning arrangements during periods of increased infection prevalence.
- FFP3 fit testing programme and assurance framework for relevant staff.
- Target frontline flu vaccination uptake of 65% with improved uptake across all ICS footprints.

999: East England Ambulance Service Trust

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

Activation of Clinical Safety Plan Level 4 (Extreme Pressure) actions.
Stand-up of Clinical Safety Cell to support patient risk management.
Enhanced TOC oversight and tactical command arrangements.
Escalated use of Fit to Sit and alternative care pathways.
Increased system escalation through LOOCs and ICB coordination centres.
Additional fleet, overtime and operational support measures available as required.

Authorisation

EEAST Clinical Safety Plan Level 4 requires authorisation by the Strategic Commander.

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

Full strategic and tactical command activation.
Strategic Command Cell establishment where system pressures require executive oversight.
Clinical Safety Cell activated with enhanced tactical and strategic interventions.
Consideration of mutual aid and external support arrangements.
Major incident arrangements and business continuity plans enacted as required.
Additional winter command calls and system escalation meetings during festive and extreme pressure periods.

Authorisation

Strategic Commander authorisation required, with escalation through established command and control structures.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Winter demand pressures impact ambulance response times and patient care.

Mitigation: Demand monitoring, CSP escalation, workforce resilience and enhanced operational oversight.

Risk: Hospital handover delays reduce ambulance availability and increase patient safety risk.

Mitigation: HO45/R2R processes, escalation arrangements and system-wide partnership working.

Risk: Workforce sickness reduces service resilience.

Mitigation: Vaccination, wellbeing support, sickness surveillance and workforce planning.

Risk: Limited alternative pathway capacity increases ED conveyance. Mitigation: Expanded UCCH, UCR, CB4YC and community referral pathways.

Risk: Extreme demand creates backlogs and patient safety risks.

Mitigation: Clinical Safety Cell activation, CSP escalation and enhanced command oversight.

Risk: Adverse weather affects staffing and operational capability.

Mitigation: Winter resilience plans, 4x4 support, contingency staffing and tactical oversight.

Risk: Fleet availability impacts operational response capacity.

Mitigation: Fleet resilience measures, extended maintenance cover and contingency vehicle plans.

Risk: IPC outbreaks disrupt staffing and service delivery.

Mitigation: IPC surveillance, PPE assurance, fit testing and outbreak management arrangements.

Risk: Poor system coordination during escalation impacts patient flow.

Mitigation: Integrated LOOC and SCC oversight to maintain system situational awareness.

Minor Injuries Unit – NELFT

OPERATIONNAL READINESS

- Fully staffed seven-day service will be maintained, ensuring sufficient workforce capacity to meet patient care needs and urgent care demand consistently across all days of the week.
- Robust operational and clinical leadership arrangements will be in place to provide effective supervision, support decision-making, manage escalation processes, and ensure the delivery of safe, responsive and high-quality care.
- During periods of increased operational pressure, non-essential planned activity will be reviewed and, where appropriate, deferred, including training events, study leave and internal meetings, to maximise frontline workforce availability and maintain service resilience.
- Daily multidisciplinary flow huddles will be undertaken and regularly updated to support real-time operational oversight, timely decision-making, and strengthen communication and coordination across teams.
- The Directory of Services (DoS) will be proactively maintained and kept up to date, ensuring accurate reflection of, access arrangements and operating status

SYSTEM INTEGRATION

- Seven-day participation in the Essex ICB Situation Awareness Meetings will be maintained, providing real-time operational oversight and supporting the proactive management of system pressures, patient flow, capacity, and service delivery across the health and care system.
- Close working relationships will be maintained with acute, community, primary care and wider system partners to ensure aligned service delivery, timely information sharing, and a coordinated response to emerging operational pressures throughout the winter period.
- Escalation, capacity and demand information will be shared routinely across system partners to support collective decision-making, optimise patient flow, and enable a whole-system approach to managing periods of increased demand.
- Mutual support arrangements will be utilised where appropriate, ensuring services can respond flexibly to fluctuations in demand and maintain continuity of care across organisational boundaries.

PATIENT FLOW, DISCHARGE & CAPACITY

- All patients attending the Minor Injuries Unit (MIU) will be clinically streamed on arrival to ensure timely assessment and direction to the most appropriate care pathway. Daily pre-opening safety and operational handovers will be undertaken to review expected demand, capacity and any service pressures.
- Patient flow will be actively managed throughout the day by the Nurse in Charge, who will oversee streaming and, where appropriate, redirect patients to alternative services to ensure they receive the right care, in the right place, at the right time.
- Effective coordination with system partners will be maintained to support patient flow and timely access to care, ensuring patients are managed within the most appropriate setting and unnecessary delays are minimised.
- Real-time monitoring of demand, capacity and patient waiting times will be undertaken to enable proactive operational management, support escalation processes, and maintain safe and effective service delivery during periods of increased demand.

Minor Injuries Unit – NELFT

WORKFORCE

- Service coverage will be maintained across a seven-day working model, supported by rosters that ensure appropriate skill mix and operational resilience. Festive period rotas have been planned and will be shared system-wide to support coordinated delivery. Business Continuity Plans (BCPs) are in place to mitigate the impact of extreme sickness levels, with staff actively encouraged to receive flu vaccinations. Daily flow huddles will continue to be updated to support real-time operational oversight and responsiveness.
- Staff wellbeing will be prioritised through proactive leadership, access to supervision, and escalation pathways to ensure teams feel supported and safe throughout periods of increased demand.
- Annual leave will be managed effectively, including over the festive period, to ensure service continuity.

DIGITAL & DATA

- Daily operational flow huddles will be maintained and updated with activity from the previous 24 hours, current demand and capacity positions, and any service escalations, ensuring timely operational oversight and informed decision-making.
- IT system disruption will be escalated in accordance with escalation processes. Business Continuity Plans will be enacted where required, including the use of manual documentation processes to ensure continuity of patient care, accurate record keeping, and the safe management of referrals, diagnostics and follow-up actions until system functionality is restored.
- Contingency communication arrangements are in place to maintain operational resilience during system outages. Dedicated mobile phone access is available to support essential communication and coordination in the event of failure of primary communication systems.
- Data quality and timely information sharing will be maintained to support patient flow, service performance monitoring, escalation management and system-wide operational decision-making.

INFECTION PREVENTION CONTROL & VACCINATION

- Infection Prevention and Control (IPC) arrangements will be maintained throughout the winter period to minimise the risk of healthcare-associated infections and support safe patient care during periods of increased demand.
- Staff will receive regular IPC refresher training, including the correct use of personal protective equipment (PPE), hand hygiene, respiratory infection control measures, and outbreak management procedures, ensuring continued compliance with best practice standards.
- IPC champions and clinical leaders will provide ongoing support and assurance, reinforcing good practice, promoting adherence to IPC standards, and supporting teams in the management of infection risks and outbreaks.
- Staff wellbeing and resilience will be prioritised throughout periods of winter pressure and outbreak response, with proactive leadership support, access to supervision, wellbeing resources, and established escalation processes to ensure staff feel supported and able to deliver safe, high-quality care.
- Seasonal vaccination programmes will be actively promoted, with staff encouraged to receive influenza and COVID-19 vaccinations in line with national guidance, supporting workforce resilience and reducing the risk of service disruption during the winter period.

Minor Injuries Unit – NELFT

INCREASE CAPACITY & CAPABILITY:
OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

Additional staffing resources will be requested during periods of exceptional operational pressure, significant staff absence, or sustained demand surges. Where feasible, capacity will be supplemented through redeployment within local teams and NELFT services, aligned to clinical skill mix and service requirements (for example, wound care support).

Bank staffing will be utilised as the first option to maintain safe service delivery. Where bank cover is unavailable and there is an identified risk to patient safety, service continuity, or staff wellbeing, agency staff will be deployed in line with organisational controls and escalation processes.

Mutual aid arrangements will be activated where appropriate, enabling the provision or receipt of support across Emergency Departments, Urgent Treatment Centres, Walk-in Centres and community services to maintain safe patient flow and service resilience.

INCREASE CAPACITY & CAPABILITY:
EXTREMIST

Example

- Additional clinical and diagnostic capacity will be sought through the activation of agreed surge arrangements across partner sites. This may include the use of Community Diagnostic Centre (CDC) facilities and other available clinic space to support service continuity, maintain patient flow, and manage exceptional demand pressures.

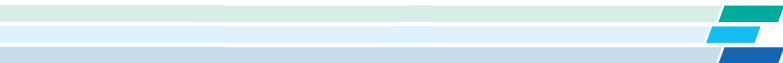
WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Demand consistently exceeds available service capacity, resulting in delays to assessment, treatment and patient flow, with increased operational pressure on teams.

Mitigation: Caseloads are proactively reviewed and prioritised to ensure patients with the greatest clinical need are managed appropriately. Flexible workforce deployment, escalation arrangements and capacity management processes are utilised to respond to periods of sustained or surge demand.

Risk: Misalignment between X-ray operating hours and Minor Injuries Unit (MIU) opening times may impact timely access to diagnostics, patient experience and service flow.

Mitigation: Continued work is underway with MSEFT partners to align diagnostic provision more closely with MIU operating hours. The planned relocation alongside the Community Diagnostic Centre (CDC) will further support improved access to imaging services and strengthen operational integration.



Hospital – Colchester Hospital

OPERATIONAL READINESS

- Bed modelling: forecast deficit of approx. 110 beds per month between January and March 2027, peaking at 123 beds in March, based on 92% occupancy, including an average loss of 13 beds due to IPC constraints.
- A winter mitigation programme is in development to address the forecast bed deficit through additional capacity (subject to funding), expanded Hospital at Home provision, strengthened community pathways, reduced length of stay, optimisation of SDEC and frailty services, and protection of elective activity.
- An organisation-wide **"Are We Ready for Winter?"** assurance session on 18/09/26 with all clinical divisions to demonstrate winter preparedness and identify any additional mitigating actions.
- Elective and Diagnostic Recovery Plan in place to support continued elective recovery alongside delivery of urgent emergency care standards throughout winter.
- Delivery of the winter programme will be overseen by the UEC Improvement and Resilience Programme, providing governance, oversight and management of winter risks/mitigations.

SYSTEM INTEGRATION

- Patient flow and escalation meetings are held three times daily to provide system-wide oversight of demand, capacity and patient flow, enabling a coordinated response in line with the OPEL framework.
- The Transfer of Care Hub acts as the operational link between acute, community and system partners, supporting timely and effective Pathway 1-3 discharges.
- Site leadership teams work collaboratively with community services, EEAST and NHS 111 to support appropriate care navigation, reduce avoidable admissions and facilitate safe redirection from the Emergency Department where appropriate.
- Site leadership teams work closely with system partners to coordinate complex discharge pathways and expedite onward care arrangements.
- Collaborative working with Non-Emergency Patient Transport Services supports timely patient transfers and efficient flow from hospital to community settings.

PATIENT FLOW, DISCHARGE & CAPACITY

- SDEC capacity will be protected to maximise ambulatory care pathways, ensuring patients remain un-bedded where clinically appropriate and supporting 24/7 patient flow.
- The discharge pathway model will be reinforced through effective multidisciplinary board rounds, with a continued focus on early discharge, "tomorrow's work today", Estimated Dates of Discharge (EDD), Criteria Led Discharge (CLD) and Criteria to Reside (C2R) to reduce length of stay and improve flow.
- Long length of stay reviews are in place to address internal and external delays, supported by a weekly complex patient panel chaired by the site leadership team, with escalation where required.
- Clinical professional standards and delays exceeding 24 hours are reviewed through daily capacity and flow meetings to support timely intervention and decision-making.
- A **Criteria to Admit (CTA)** audit on 7 September will identify further opportunities to strengthen admission decision-making, optimise patient pathways and improve urgent and emergency care flow.
- Elective inpatient capacity will be protected wherever operationally possible to support delivery of planned care alongside winter pressures.
- A Reset Week commencing 12 October will support improvement initiatives, test-of-change methodologies and enhanced visible senior leadership across the UEC Improvement Programme.

Hospital – Colchester Hospital

WORKFORCE

- Clinical Divisions will maintain oversight of medical, nursing, AHP and operational workforce capacity through established rostering processes, ensuring seven-day service delivery and access to senior clinical decision-makers during periods of increased demand.
- Daily cross-divisional workforce reviews provide assurance that safe staffing levels are maintained across inpatient wards and key clinical services.
- Robust operational, tactical and strategic on-call arrangements are in place, supported by site and divisional leadership teams to ensure effective escalation and response to winter pressures.
- The Patient Flow and Escalation Policy, supported by OPEL action cards, provides a clear framework for managing operational pressures and escalation.
- Staff flu, COVID-19 and RSV vaccination programmes are delivered through Occupational Health to support workforce resilience throughout the winter period.

DIGITAL & DATA

- SHREWD is embedded within daily patient flow and escalation meetings, providing real-time oversight of demand, capacity, patient flow and operational pressures.
- Epic EPR dashboards are fully utilised to support proactive management of capacity, flow, performance and escalation risks across the site.
- Operational teams use real-time data and reporting tools to support timely decision-making, risk mitigation and effective escalation management.
- National, regional and system reporting requirements are coordinated through the Site Operational Leadership Team, ensuring timely performance oversight and situational awareness.

INFECTION PREVENTION CONTROL & VACCINATION

- IPC governance arrangements, outbreak management policies and daily IPC oversight processes are in place to support safe service delivery throughout winter.
- Winter planning has been developed in conjunction with IPC teams and is aligned to the Trust's IPC strategy and organisational resilience arrangements.
- An agreed patient cohorting plan is in place and can be activated during outbreaks or periods of increased demand to maintain capacity and minimise transmission risks.
- Enhanced cleaning, drainage management and environmental risk mitigation measures are established to reduce infection risks and support operational resilience.
- In-house fit testing, PPE stock management and agreed escalation processes are in place to support staff safety and effective infection prevention and control.
- Staff vaccination programmes are actively promoted, with ongoing monitoring of uptake to maximise workforce protection and resilience throughout the winter period.

Hospital – Colchester Hospital

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- Additional surge capacity will be activated in response to clinical demand, risk assessment and workforce availability through established escalation and authorisation processes.
- Up to **23 General and Acute (G&A) beds at Colchester Hospital** and **26 beds at Clacton Community Hospital** can be opened or repurposed to support system capacity pressures.
- Closed beds may be reopened in partnership with Infection Prevention and Control (IPC) teams and the on-call Microbiologist, ensuring compliance with IPC requirements and safe utilisation of capacity.
- Activation of additional capacity is subject to the availability of supporting workforce, facilities and operational resources, and associated funding approval for staffing, utilities and medical and surgical supplies.
- All escalation capacity will be subject to ongoing operational review to ensure safe, effective and sustainable deployment during periods of heightened demand.

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

- Extreme surge capacity will be activated in response to exceptional demand, subject to clinical need, risk assessment, workforce availability and executive authorisation.
- Closed beds may be reopened in collaboration with Infection Prevention and Control (IPC) teams and the on-call Microbiologist, ensuring compliance with IPC requirements and safe deployment of capacity.
- Elective activity will be reduced where required to release inpatient capacity, including closure of surgical activity within Elmstead Theatres and conversion of the Day Unit to provide up to **24 general inpatient beds**.
- Additional escalation capacity may be created through repurposing of clinical areas, including:
 - **24 beds** within the Day Unit.
 - **9 beds** within the Elective Care Centre.
 - **6 beds** within the Young People's Unit.
 - **11 rooms** within the Pre-Admission Unit.
- Workforce, facilities and operational resources will be redeployed to support the safe operation of escalation capacity and maintenance of critical services.
- Activation of extreme escalation capacity remains subject to funding approval for workforce, utilities and medical and surgical supplies.
- All extreme escalation measures will be coordinated through established command and control arrangements, with ongoing executive review of capacity, demand, risk and workforce sustainability.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Forecast bed deficit reduces available capacity and impacts patient flow.

Mitigation: Additional bed capacity plans are being developed through the Seasonal Variation Planning Group, while the UEC Improvement and Resilience Board oversees admission avoidance, length of stay reduction and bed occupancy improvement initiatives.

Risk: Ambulance handover delays arising from capacity constraints and flow pressures.

Mitigation: Temporary escalation areas and additional capacity measures are being progressed through the Seasonal Variation Programme to support patient flow and reduce handover delays.

Risk: IPC outbreaks and infection control constraints reduce bed availability and disrupt patient flow.

Mitigation: Robust IPC governance, outbreak management arrangements, cohorting plans and environmental risk controls are in place to minimise operational disruption and maintain safe patient flow.

Risk: Workforce pressures, including sickness absence and staffing shortfalls, impact service resilience and escalation capacity.

Mitigation: Additional staffing plans, workforce oversight arrangements and escalation staffing models will support safe staffing levels, patient flow and operational resilience during periods of increased demand.

Hospital – Colchester Hospital

	Core Winter Capacity	Additional Capacity	Extremist Capacity	Total
G&A Beds	591	23	50	664
Paediatric Beds	20	0	0	20
Critical Care Beds	14	0	0	14
Additional Community Beds	0	26	0	26
Hospital at Home	96	0	0	96
Total	721	49	50	820

	Current	Winter Target (1 Dec – 31 Mar 27)
Average occupancy	95.1%	92.0% ²
Length of stay >7 days	176.4	150.4 ²
Length of stay >14 days	102.7	87.7 ²
Length of stay >21 days	63.4	54.1 ²

1 – Requires left shift funding

2 – Dependent upon Community beds funding

Hospital – Mid & South Essex Foundation Trust

OPERATIONAL READINESS

- Executive winter lead in place, with operational accountability at Site Chief Executive level.
- Daily OPEL meetings feed into the System Coordination Centre, providing oversight of capacity, patient flow, operational pressures and escalation requirements.
- Robust 24/7 executive and operational on-call arrangements support timely decision-making and system oversight.
- Local UEC winter plans, including bed models, support operational resilience and patient flow across all acute sites.
- Tactical bed management arrangements operate during weekends and the festive period to maximise capacity.
- Two-hourly Emergency Department huddles, supported by refreshed streaming criteria, optimise flow and appropriate use of primary care services.
- Seven-day SDEC is protected where possible to support admission avoidance and ED flow.
- ED performance and ambulance handover delays are actively monitored and escalated through established reporting routes.
- Neighbourhood summits have strengthened local ownership, accountability and collaborative action to improve patient flow and winter resilience.

SYSTEM INTEGRATION

- Daily participation in the Essex ICB coordination arrangements provides whole-system oversight and escalation management
- Close daily working with community, mental health, social care, and Intermediate Care Team Hub (ICTH) partners to support patient flow, discharge, and admission avoidance
- Neighbourhood summits and local partnerships to ensure local system ownership and accountability for patient flow and discharge across the system
- Established ED redirection pathways ensure patients access the most appropriate service first time
- Ambulance demand and handover performance monitored through operational huddles and escalation processes, enabling timely intervention and flow management.
- Cross-site escalation and mutual aid arrangements activated as required to respond to workforce, capacity, and operational pressures across the acute hospital group.

PATIENT FLOW, DISCHARGE & CAPACITY

- SDEC capacity will be protected wherever operationally possible to maximise admission avoidance and support timely patient flow from the Emergency Department.
- The Integrated Care Transfer Hub (ICTH) provides seven-day support, with daily escalation and resolution of discharge barriers.
- The UEC Improvement Programme continues to drive improvements in patient flow, with a focus on early discharge planning, daily board rounds, EDD/CCD compliance, and Red-to-Green principles.
- Pre-emptive discharge planning is embedded through daily monitoring of EDD/ CDD and Red to Green principles
- 'Home for Lunch' and early discharge initiatives continue to support timely discharge and bed availability
- Length of stay remains a priority with focused reviews of patients staying more than 7,,14 and 21 days
- Elective and cancer capacity will be protected wherever possible to maintain planned care delivery through out winter pressures
- Working closely with the system Integrated Care Transfer Hub each site will optimise patient flow, discharge and capacity across acute, community, mental health, local authority and wider out-of-hospital services to maximise system capacity, reduce delays in care, and support timely access to the most appropriate setting
- The Trust is committed to Zero Tolerance to Corridor Care through improved patient flow, timely discharge and proactive escalation management
- The Trust bed model continues to evolve which will allow for the mitigations to be described and put in place for the winter months
- The Integrated Care Transfer Hub will be the operational bridge between acute services and system partners, facilitating and supporting the management of complex discharges and delays. This will enhance discharge efficiency, reduce length of stay, and improve coordination across care settings during winter pressures.

Hospital – Mid & South Essex Foundation Trust

WORKFORCE

- Senior medical and nursing decision-makers rostered seven days a week to support timely assessment, admission avoidance and patient flow
- Comprehensive on-call arrangements maintained to ensure operational resilience.
- Workforce risks relating to sickness,, vacancies and staffing pressures are actively managed through daily reviews, flexible deployment and mutual support arrangements
- Dedicated workforce capacity for elective and cancer services protected wherever operationally possible to maintain delivery of planned care alongside winter pressures.
- The site Hospital Chief Executives will ensure plans are in place to ensure we have resilient workforce capacity through robust staffing, annual leave and festive period planning, while strengthening operational leadership, executive vaccination leadership, oversight and to support safe and effective winter delivery.
- The Trust remains committed to maximising staff vaccination programme through divisional champions, roving vaccinator and dedicated site vaccination hubs

DIGITAL & DATA

- Daily operational oversight maintained through site status meetings, providing real-time visibility of capacity, flow, and escalation pressures.
- Patient flow, bed capacity, and discharge activity monitored in real time through TeleTracking and SHREWD to support operational decision-making and escalation management.
- Routine performance reporting and statutory data submissions provide ongoing assurance, enabling performance oversight, trend analysis, and system-wide monitoring throughout the winter period.

INFECTION PREVENTION CONTROL & VACCINATION

Executive leadership and oversight are in place for delivery of the seasonal vaccination programme.

- Daily infection prevention surveillance, outbreak management and isolation-capacity monitoring support early identification and mitigation of risks.
- Established IPC escalation arrangements support operational, tactical and strategic responses to winter infections.
- Adequate PPE, consumables and enhanced cleaning arrangements will be maintained throughout winter.
- Mortuary resilience arrangements and contingency capacity have been reviewed and remain in place.

Hospital – Mid & South Essex Foundation Trust

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

When OPEL 4 conditions are declared, the Trust will:

- Implement enhanced operational command and control arrangements.
- Maximise use of SDEC and ambulatory pathways to avoid unnecessary admissions.
- Ensure senior clinical review supports timely decision-making and patient flow.
- Activate ward-level executive sponsorship to expedite discharge barriers
- Review elective activity where patient safety is at risk.
- Suspend non-essential activity where operationally required.
- Work with ICTH and system partners to maximise community capacity and alternative pathways.
- Business as usual daily site internal capacity meetings will be increased if needed
- System Coordination Centre twice daily system capacity meetings
- Mutual aid support across the sites with particular focus on support for ambulance divers.
- Site escalation capacity identified and activated during periods of operational pressure following risk assessments

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

All actions as in Opel 4 with addition of:

- Formal command and control structures activated.
- EPRR support and Critical Incident consideration where required.
- All available capacity options reviewed and risk assessed.
- System discharge delays escalated through ICTH for urgent resolution
- Pause to routine elective surgery, cancer surgery protected.
- Therapy and pharmacy increase to hours

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Demand exceeds available capacity.

Mitigation: Length of stay reduction, discharge optimisation, SDEC utilisation and capacity management.

Risk: Ambulance surges impact ED flow.

Mitigation: Enhanced flow arrangements, operational huddles, mutual aid and escalation processes.

Risk: Mental health pathway delays.

Mitigation: System-wide improvement programmes and escalation support.

Risk: Inability to safely staff escalation capacity.

Mitigation: Executive oversight and workforce-led approval processes.

Risk: Corridor care.

Mitigation: Full Capacity Protocols, proactive discharge management and protected SDEC capacity.

Risk: Severe weather disruption.

Mitigation: Established adverse weather and winter resilience plans.

Risk: Orsett Hospital estates issues

Mitigation: Business continuity planning to ensure any immediate service retraction required is considered alongside UEC flow impact.

Hospital – Mid & South Essex Foundation Trust

	Core Winter Capacity	Additional Capacity	Extremist Capacity	Total
G&A Beds	1540	Southend – 10 Basildon – 8, funding TBC	Southend – 6 Broomfield - 25 Basildon - TBC	1589
Paediatric Beds	56	Basildon – 6 Broomfield to flex capacity on paediatric surgical DSU – Max 11 NB Opportunity removed if used for adults in extremis.		73
Critical Care Beds	Up to (depending on levels) 23 HDU 33 ITU (56 total)	2-4 recovery beds per site. NB can respond to higher acuity through adjustment to staff on shift		62
SDEC	57	NA	NA	57
Hospital at Home	90 visits per day	NA	NA	90 visits per day

	Current	Winter Target (1 Dec – 31 Mar 27)
Average occupancy	97%	95%
Length of stay >7 days	821 (49%)	40%
Length of stay >14 days	458 (27.5%)	20%
Length of stay >21 days	262 (15.7%)	9%
Discharge before noon	11.7% WE 30th August 26	20%
Discharge before 3pm	29.4% WE 30th August 26	50%
SDEC Utilisation	6.8% of adult ED attendances to Medical SDEC WE 30th August 26	10% of adult attendances to Medical SDEC

Hospital – Princess Alexandra Hospital Trust

OPERATIONAL READINESS

- Winter Plan 2026/27 agreed, informed by evaluation of previous successful winter initiatives.
- Winter funding agreed, with recruitment to key winter initiatives underway.
- Nominated Winter Executive Lead (Chief Operating Officer), supported by established tactical, operational and strategic command arrangements.
- Trust Surge Plan in place, with clear escalation processes for periods of increased demand and operational pressure.
- Daily Executive-led huddles support delivery of the 'A to E for a Better Winter, not A&E' programme, focusing on Assessment, Base Wards, Conditions, Discharge and Emergency Department flow.
- Year-round flow and discharge improvement programmes continue, including testing with EMSDEC to improve minors pathway flow.
- EPRR and surge arrangements are regularly tested through exercises and table-top simulations to assure organisational readiness preparedness.

SYSTEM INTEGRATION

- Collaborative winter initiatives are being delivered with primary care, community, hospice and ambulance partners to support system resilience and patient flow.
- A programme of MADE events is planned before October half-term, Christmas and post-Christmas to coordinate acute and community winter preparedness and response.
- Integrated pathways and pilots are in place or being tested, including the DVT pathway via UTC, enhanced CB4C, CATU, and EMSDEC GP support, to reduce avoidable admissions and improve patient access.
- Discussions are underway with partners to enhance community capacity over winter, including Hospice at Home provision and flexible community bed admission criteria during periods of escalation.
- The Care Coordination Centre, hosted by EPUT, provides system-wide oversight of complex discharges, supporting timely patient flow and discharge planning.

PATIENT FLOW, DISCHARGE & CAPACITY

- The Care Coordination Centre (CCC), commissioned to deliver the Transfer of Care Hub function for the West Essex Health and Care Partnership, provides an integrated multi-agency approach to discharge planning and patient flow, bringing together acute, community, mental health, social care, hospice and voluntary sector partners.
- The System Head for Integrated Transfer of Care provides system-wide leadership and oversight of discharge arrangements and all Discharge to Assess (D2A) pathways, ensuring alignment with national discharge guidance and winter demand requirements.
- The CCC acts as the single point of access and triage for community referrals and works collaboratively with Hertfordshire partners to support timely discharge and patient flow across system boundaries.
- Daily multidisciplinary board rounds and system flow meetings review complex discharges, Expected Dates of Discharge (EDD) and Criteria to Reside, supporting proactive discharge planning and reducing delays.
- Coordinated escalation and capacity management arrangements operate through the Trust Surge Plan, supported by 24/7 tactical and strategic on-call command arrangements.
- A range of targeted winter initiatives are in place to reduce discharge delays and improve flow, including additional ward-based medical resource, enhanced SDEC and ED senior clinical support, weekend discharge leadership and extended OPAL service hours.
- Pathway capacity requirements are being reviewed and refreshed for winter to ensure sufficient discharge and community capacity is available across all D2A pathways.
- West Essex maintains a dedicated D2A complex care ward with an integrated multidisciplinary team, supporting timely assessment and onward discharge to home or longer-term care where required.

Hospital – Princess Alexandra Hospital Trust

WORKFORCE

- Daily Safer Staffing huddles in place, supported by established processes to flex workforce deployment in response to patient demand and acuity.
- Additional winter-funded workforce capacity will provide resilience across urgent and emergency care pathways, building on initiatives successfully implemented during Winter 2025/26. Daily Executive-led 8:59 huddles provide operational oversight and support rapid response to emerging workforce and flow pressures.
- A well-established Trust Surge Plan supports the management of demand peaks and workforce escalation requirements.
- Staffing levels are proactively managed through routine workforce processes, including six-week roster reviews and early mitigation of identified gaps.
- Additional nursing, medical and pharmacy resource will be deployed across urgent and emergency care pathways to support flow and discharge over the winter period.
- Community workforce initiatives, including the CATU pilot and enhanced CB4C model, will provide additional system resilience.
- Three additional Pharmacy Prescribers will be in post from 1 October for six months to support timely prescribing, TTA completion and discharge optimisation.

DIGITAL & DATA

- Daily operational oversight through Executive-led 8:59 huddles and a dedicated Winter performance scorecard.
- Real-time monitoring of patient flow, capacity and discharge activity through Oracle Health EPR (Capman) and SHREWD. SHREWD supports system-wide visibility, escalation and operational decision-making.
- Routine performance reporting and statutory data submissions provide ongoing assurance and oversight.
- Transfer of Care Hub-led daily escalation reviews use operational intelligence to support timely discharge and patient flow.

INFECTION PREVENTION CONTROL & VACCINATION

- Executive oversight of the vaccination programme is provided by the Interim Chief Nurse, with delivery plans in place to achieve staff vaccination uptake targets.
- Peer vaccinators are being trained alongside the Occupational Health team, with robust processes in place for vaccine administration and recording.
- Inpatient vaccination services are available for eligible long-stay and care home patients, subject to vaccine supply.
- The IPC Team leads winter preparedness through established governance arrangements, including the IPC Steering Group and Winter Planning Group.
- Established IPC protocols, outbreak management arrangements and Surge Plan escalation processes support safe operational, tactical and strategic responses to winter infections.
- IPC governance supports patient cohorting, isolation arrangements and the safe reconfiguration of clinical areas to maintain capacity during periods of increased demand and infectious disease transmission.
- Adequate PPE and essential consumable stock levels are maintained, supported by enhanced cleaning arrangements.
- Comprehensive fit-testing arrangements are in place for frontline staff, with additional capacity being implemented to support winter preparedness and compliance.
- Plans are being progressed to introduce 24/7 on-site Cepheid testing from October 2026, providing rapid diagnostics to support patient flow, infection control and clinical decision-making.
- Site capacity constraints are recognised within winter planning, with all available escalation and cohorting spaces identified within the Trust Surge Plan.

Hospital – Princess Alexandra Hospital Trust

INCREASE CAPACITY & CAPABILITY: OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

Follow Trust Surge Plan:

Actions can include:

- On-call consultants in all clinical specialties in a declared Surge Incident must be available to attend the Emergency Department (ED) to review patients prior to admission to ensure they are reviewed quickly and are only admitted where an admission is absolutely clinically required.
- Patients must only be admitted following a consultant review.
- GPs, OPD, and specialty teams must not advise patients to attend ED directly.
- Specialty teams should maximise use of SDEC services for patients suitable for same-day assessment and care.
- Strategic commander to consider elective cancellations
- Cancellations of non-clinical activity
- Consideration to consultants changing SPA to DCC to support with Surge.
- Opel 4 – Divisional Representative at Site Meetings, plus Strategic Commander/Chief Operating Officer (COO) or Deputy COO, plus IPC/Comms as required.
- Enact Flex Pathways for Community
- Sweep of all wards to expedite discharge
- Transfer of Care Hub to lead review of all patients without a discharge plan.
- Long length of stay panels mobilised.

INCREASE CAPACITY & CAPABILITY: EXTREMIST

Follow Trust Surge Plan:

Actions can include:

- On-call consultants in all clinical specialties in a declared Surge Incident must be available to attend the ED to review patients prior to admission to ensure they are reviewed quickly and are only admitted where an admission is absolutely clinically required.
- Patients must only be admitted following a consultant review.
- GPs, OPD, and specialty teams must not advise patients to attend ED directly.
- Specialty teams should maximise use of SDEC services for patients suitable for same-day assessment and care.
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- Enact Flex Pathways for Community
- Sweep of all wards to expedite discharge
- Transfer of Care Hub to lead review of all patients without a discharge plan.
- Long length of stay panels mobilised.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Emergency demand exceeds available capacity, resulting in bed pressures, flow delays and prolonged waits.

Mitigation: Delivery of the Trust's 'A to E for a Better Winter, not A&E' approach, focused on assessment, ward capacity, key clinical conditions, discharge and Emergency Department flow, supported by system-wide partnership working.

Risk: Emergency Department overcrowding and increased ambulance arrivals lead to delays, poor patient experience and handover pressures.

Mitigation: Enhanced patient flow, discharge optimisation, escalation processes and coordination with community and ambulance partners.

Risk: Workforce shortages, including sickness absence and unfilled winter posts, impact service delivery during periods of sustained pressure.

Mitigation: Workforce resilience plans, proactive absence management, bank and agency staffing arrangements, and substantive recruitment to key winter roles.

Risk: Critical care demand exceeds available ITU capacity, increasing the risk of elective cancellations and treatment delays.

Mitigation: Ongoing monitoring of ITU occupancy, escalation of surge capacity and progression of plans for additional commissioned ITU beds.

Risk: Extreme winter pressures impact patient safety, operational performance and service continuity.

Mitigation: Robust business continuity arrangements, OPEL escalation processes and close collaboration with system partners to maintain safe and effective services.

Hospital – Princess Alexandra Hospital Trust

	Core Winter Capacity	Additional Capacity	Extremist Capacity	Total
G&A Beds	405	56 + 18 = 74	10	489
Paediatric Beds	16 Paed & 16 neonatal = 32	5	0	37
Critical Care Beds	10	3	0	13
SDEC	Medical/Surgical SDEC – 55 (including cubicles/waiting area).	0	0	55
Hospital at Home	HCT 215 EPUT 106	0	0	321

	Current	Winter Target (1 Dec – 31 Mar 27)
Average occupancy*	95.5% (G&A beds)	89%
Length of stay >7 days**	43%	Maintain
Length of stay >14 days**	26.1%	Maintain
Length of stay >21 days**	15.8%	Maintain
Discharge before noon*	11.86%	33%
Discharge before 3pm*	29.9%	70%
SDEC Utilisation*	41.58%	80%

* Average for period 1 Dec 25 – 31 March 26

** based on July 26

Integrated Care Transfer Hub

OPERATIONAL READINESS

Winter Lead: Deputy Director of Operations, Integrated Care Transfer Hub (ICTH), supported by the System Integrated Care Pathway Director.

Hospital Coordination Centre Arrangements: ICTH attend the daily site operational meetings and system escalation calls, providing oversight of medically optimised patients, discharge delays and pathway capacity to support patient flow. Supported through the Intensive Recovery Programme and Home First model.

Escalation and Incident Management: Daily review of discharge delays across acute, community, Hospital @ Home, D2A and Mental Health pathways, with escalation through provider, community and local authority routes as required. Real-time identification and resolution of barriers impacting flow and quality of care.

Operational Resilience, Capacity and Demand: Seven-day oversight of discharge pathways, Hospital @ Home, D2A capacity, care home placements and community bed utilisation. Daily monitoring of demand and capacity, with escalation processes activated during periods of sustained pressure

SYSTEM INTEGRATION

SCC Participation and Escalation: Daily engagement with Local Authorities through operational and escalation processes to support discharge planning and mitigate delays.

Integration with UCCH: Joint working arrangements supporting admission avoidance, repatriations, community capacity management and patient flow.

Integration with NHS Essex TOCH / ICTH:

- Single-system coordination of discharge management, capacity oversight and escalation across acute, community, mental health and local authority services.
- Collaborative working with EEASt through UCCH/UCRT to support admission avoidance.
- Oversight of D2A pathways, care home capacity, Hospital @ Home, Virtual Wards and other community alternatives to admission.
- Delivery of the Intensive Recovery Programme and Care Home Task and Finish Group.
- Support for mental health discharge pathways across acute and community settings
- Integration with voluntary sector and fire service partners to enhance patient support and independence.

PATIENT FLOW, DISCHARGE & CAPACITY

Integration with UCCH and Community Services

Ongoing collaboration with community providers to support timely discharge, admission avoidance, repatriation and a reduction in avoidable admissions. Joint operational management of pathways maximises community capacity and system flow.

Integration with NHS Essex TOCH / ICTH

The ICTH provides a single system coordination point for complex discharges, D2A pathways, care home placements, repatriations and discharge escalation across Mid and South Essex. As part of NHS Essex, arrangements are aligned with North and West Essex to support a coordinated countywide approach throughout winter.

EDDs / Clinical Criteria for Discharge

Attendance at, and support for, Length of Stay (LOS) reviews, with daily oversight of medically optimised patients and weekly multidisciplinary reviews for patients exceeding 21 days LOS. Escalation through provider and system partners supports timely discharge planning and resolution of delays.

A seven-day discharge model remains in place, supported by seven-day coordination and escalation across health, local authority and community partners to maximise weekend discharges and reduce Monday bed pressures.

Key Priorities

- Embed Home First principles across all pathways.
- Reduce medically optimised delays and long length of stay cohorts.
- Maximise utilisation of Hospital @ Home and Virtual Ward capacity.
- Maintain oversight of care home admissions and timely patient returns.

Pathway Oversight and Development

- Weekly neurology pathway reviews with Neuro Navigators.
- Identification and development of new Hospital @ Home pathways.

Integrated Care Transfer Hub

WORKFORCE

Gaps and Vacancies: Regular workforce reviews to maintain safe staffing levels and operational resilience throughout winter.

Staff Wellbeing: Access to wellbeing support, regular team meetings and 1:1s, with a focus on supporting staff during periods of sustained pressure.

Annual Leave Management: Proactive winter planning to maintain safe staffing levels and manage annual leave across the winter and festive period.

Seven-Day Working: Senior operational leadership available seven days a week, supported by weekend and bank holiday escalation arrangements.

Additional Actions: Cross-training, flexible staff deployment, and ongoing recruitment and retention oversight to strengthen workforce resilience.

DIGITAL & DATA

- Daily oversight of medically optimised patients, delayed discharges, length of stay, D2A utilisation, Hospital @ Home activity and community bed capacity.
- Use of SHREWD, TeleTracking and shared care systems to support situational awareness, patient flow, discharge planning and care co-ordination.
- Regular reporting on delayed discharges, long length of stay, Home First performance, D2A activity, repatriations and Hospital @ Home utilisation.

INFECTION PREVENTION CONTROL & VACCINATION

Staff Vaccination Programme: All ICTH staff actively encouraged to participate in Trust winter vaccination programmes.

Winter Outbreak Management: ICTH to work closely with community, care home and local authority partners to mitigate impacts of outbreaks on discharge pathways and placement capacity.

Care Home Capacity Oversight: Monitoring of care home outbreaks and associated impacts on pathway availability, with escalation where required to maintain patient flow.

Integrated Care Transfer Hub

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- A strengthened seven-day discharge and transfer approach will operate across health and social care services to support continuous patient flow.
- Senior clinical and operational decision-makers will oversee and expedite delays across Pathways 1, 2 and 3, with complex discharges escalated through a single system process and agreed response times.
- Real-time visibility of community and social care capacity will support timely decision-making, while regular reviews of community and mental health bed utilisation will address barriers to discharge.
- Greater focus will be placed on same-day discharge opportunities and discharge directly from assessment areas where clinically appropriate
- Enhanced executive oversight will ensure collective accountability for resolving discharge delays, reducing corridor care, and supporting patients who no longer meet the criteria to reside.
- Additional tactical oversight arrangements across NHS Essex will support the timely discharge and repatriation of Mid and South Essex patients receiving care in neighbouring systems.

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

- Executive-led discharge command and control arrangements will be established, with system performance and risks reviewed through two-hourly escalation processes.
- An enhanced seven-day discharge model will be implemented, subject to funding approval, with additional weekend capacity and senior decision-maker availability across health and social care.
- Delays across Pathways 1, 2 and 3 will be escalated and managed in line with agreed system response standards to support timely discharge and patient flow.
- Community, Discharge to Assess (D2A) and care home capacity will be flexed through surge arrangements and mutual aid agreements, where available, to respond to periods of exceptional demand.
- A system-wide Home First approach will be maintained, supporting timely discharge, maximising acute bed availability and reducing the risk of corridor care.
- Subject to funding approval, Integrated Community Support Team (ICST) capacity will be increased to support the timely resolution of Pathway 1 delays *and improve patient flow.*

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Limited Sunday social work cover in Thurrock resulting in assessment delays.

Mitigation: The Integrated Discharge Team (IDT) continues to support completion of assessments on Sundays.

Risk: Delays in equipment provision impacting timely discharge.

Mitigation: Ongoing monitoring with escalation to the relevant lead where delays are identified.

Risk: Care home closures or outbreaks reducing discharge pathway capacity.

Mitigation: Active monitoring, outbreak management arrangements and escalation through care home provider forums.

Risk: Discharge failures due to process issues, including TTAs, documentation delays and discharge cut-off times.

Mitigation: Early identification and escalation of delays, supported by weekly site performance reviews to drive improvement.

Risk: Workforce pressures across health and social care services.

Mitigation: Winter workforce planning, flexible deployment and established escalation arrangements.

Risk: Delays in social care assessments or availability of care packages.

Mitigation: Daily review and escalation through system operational processes.

Risk: Increased long lengths of stay and medically optimised patients impacting acute flow.

Mitigation: Intensive Recovery Programme, Home First initiatives, daily escalation and executive oversight.

Integrated Care Transfer Hub

	Core Winter Capacity	Additional Capacity	Extremist Capacity	Total
Hospital at Home	30 visits Basildon 30 visits Broomfield 30 visits Southend	Opportunity discussed as required	Opportunity discussed as required	90 visits
OPAT	10 hours Basildon 10 hours Southend	Opportunity discussed as required	Opportunity discussed as required	20 Hours
ICST	56 hours per week	Opportunity discussed as required	Opportunity discussed as required	56 Hours

Neighbourhood Health

OPERATIONAL READINESS

- Plans are focused on maintaining access to key community services, including Urgent Community Response, Virtual Wards, intermediate care, community nursing, and end-of-life care during periods of increased demand.
- Place teams will work closely with providers to identify emerging capacity pressures, agreeing escalation and mutual aid arrangements where appropriate and within agreed local governance frameworks.
- Targeted proactive support will be provided to people with frailty, complex needs, and those at increased risk of hospital admission, including health promotion, winter wellbeing initiatives, and community-based preventative interventions.
- Risk stratification within Integrated Neighbourhood Teams will continue to be developed and utilised to proactively identify and support individuals at greatest risk of deterioration, unplanned hospital attendance, or admission, including those living with frailty, long-term conditions, and complex needs.

SYSTEM INTEGRATION

- Multi-Neighbourhood Partnerships and Integrated Neighbourhood Teams (INTs) will support coordinated, place-based responses for individuals with complex health and care needs, promoting proactive and integrated care.
- Better Care Fund (BCF) arrangements will continue to support integrated health and social care services, including intermediate care, reablement, carers' support, and community-based provision.
- Place-based escalation processes will be utilised to identify emerging operational pressures early, enabling system partners to coordinate timely interventions and collective action.
- Strong partnership working across health, social care, voluntary sector, and community providers will support system resilience, patient flow, and delivery of the Home First approach throughout the winter period.

PATIENT FLOW, DISCHARGE & CAPACITY

- The Zero Tolerance for Corridor Care programme will be supported through delivery of agreed system actions, including targeted interventions for individuals who frequently attend Emergency Departments with mental health needs, helping to reduce overcrowding and improve patient experience.
- System partners will continue to strengthen Pathways 0, 1 and 2, supporting a consistent Home First approach, reducing length of stay, addressing unwarranted variation, and further developing community and intermediate care capacity.
- Urgent Community Response, Virtual Wards, and other admission avoidance services will support people to remain safely at home wherever clinically appropriate, reducing avoidable admissions and supporting system flow.
- Community services will work in partnership with acute discharge teams to facilitate timely assessment, discharge planning, and decision-making, reducing delays, failed starts, and avoidable readmissions.

Neighbourhood Health

NFECTION PREVENTION CONTROL & VACCINATION

- Place teams are working collaboratively with health inequalities and screening teams to support practices with lower vaccination uptake, using targeted interventions to improve coverage amongst eligible populations.
- Cardiovascular Disease (CVD) Hypertension Detect and Perfect (MSE only) programme continues to support the identification and optimisation of patients with hypertension, reducing the risk of heart attack and stroke, particularly during the higher-risk winter period.
- Vaccination uptake and prevention programmes are monitored throughout the winter period, supporting population health, reducing avoidable illness, and helping to minimise demand on health and care services.

DIGITAL & DATA

- Population health, primary care, and risk stratification data will be utilised to identify individuals at increased risk of deterioration, admission, or escalation of need, including those living with frailty, enabling proactive intervention and support.
- Shared care records and digital referral processes will support information sharing and coordination across health and care partners, improving continuity of care and decision-making, whilst recognising further development is required to maximise system-wide integration and functionality.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Increased winter demand exceeds available community, intermediate care, and domiciliary care capacity, impacting patient flow and timely access to services.

Mitigation: Place-level escalation processes, mutual aid arrangements, and regular system oversight will be utilised to optimise capacity and maintain service delivery.

Risk: Workforce pressures affect service resilience and the ability to provide timely seven-day support.

Mitigation: Providers will maintain workforce and business continuity plans, actively manage staffing risks, and escalate emerging gaps through established governance routes.

Risk: Variation in pathways and service availability across Essex leads to inconsistent patient flow and outcomes.

Mitigation: Place-level operational plans and performance will be monitored alongside the wider system position to identify variation and implement corrective actions where required.

Risk: Delays in accessing equipment, care packages, or onward care provision increase patient length of stay and delayed discharges.

Mitigation: Health and local authority partners will monitor and address constraints through integrated discharge arrangements and coordinated escalation processes.

Risk: System pressures are transferred from acute services into community provision without sufficient capacity, affecting service quality and patient safety.

Mitigation: Escalation decisions will be made on a whole-pathway basis, with consideration of capacity, operational impact, and patient safety across the wider system.

Community - Community Collaborative (Mid & South Essex)

OPERATIONNAL READINESS

- Executive Winter Lead in place, with representation at the Essex Winter Strategic Group and MSE System Situation Awareness meetings.
- Single point of contact established for community services, supporting system coordination and escalation.
- Daily operational huddles, bed management meetings, sitrep reporting and escalation processes provide oversight of demand, capacity and patient flow.
- Clear governance, MDT, board round and escalation arrangements support coordinated management of winter pressures.
- Business Continuity Plans in place to mitigate operational pressures, outbreaks, workforce shortages and service disruption.
- Robust IPC arrangements include surge huddles, cohorting and isolation measures, enhanced cleaning, PPE assurance and ventilation oversight.

SYSTEM INTEGRATION

- Community Collaborative services are represented through a single operational point of contact, supporting system coordination and escalation arrangements.
- Active participation in MSE System Situation Awareness meetings and escalation calls supports a coordinated response across health and care partners.
- Community services work collaboratively to flex capacity, share workload and utilise mutual aid arrangements where required.
- UCRT works closely with NHS 111 and Primary Care to support direct referrals, reduce unnecessary conveyance and avoid hospital admission.
- Attendance at INT, PCN and specialist MDTs supports coordinated care planning and patient management.
- Respiratory, specialist and Virtual Ward teams work closely with acute, palliative care and community partners to support admission avoidance, timely discharge and continuity of care.

PATIENT FLOW, DISCHARGE & CAPACITY

- Focused board rounds, MDT reviews and proactive care planning support timely discharge, optimise patient flow and reduce length of stay.
- Red to Green principles are embedded to challenge delays, promote earlier discharge and maximise patient progression.
- Discharge planning begins early, with proactive identification and escalation of barriers, including engagement with families where appropriate to facilitate onward care arrangements.
- Daily monitoring of transfers to and from acute providers, alongside a specific focus on discharges before lunchtime and identification of patients suitable for earlier discharge.
- D2A capacity is available across sites, supported by accelerated assessment processes to minimise discharge delays.
- Community bed capacity is optimised through flexible admission criteria, step-up pathways, regular admission reviews and direct admissions from UCCH where capacity permits.
- Weekly MDTs across community units, supported by weekly Long Length of Stay reviews and monthly Operational Discharge and Quality Governance meetings, provide oversight of patient flow and discharge performance.
- Community Nursing services support admission avoidance and timely discharge through risk stratification, caseload reviews, self-care pathways, community clinics and multidisciplinary working.
- UCRT and Frailty Virtual Ward teams maintain enhanced daily collaboration to improve patient flow and reduce avoidable ED attendance.
- Virtual Wards prioritise step-up patients, support discharge from acute hospitals, undertake daily flow huddles, board rounds and MDT reviews, and proactively manage high-risk patients to prevent deterioration and admission.
- Early Supported Discharge services prioritise acute discharge, utilise risk stratification and increase MDT frequency to maximise flow and capacity.
- Specialist services undertake regular caseload reviews and discharge planning to maximise capacity across community services.

Community - Community Collaborative (Mid & South Essex)

WORKFORCE

- Robust annual leave management and workforce planning processes in place to maintain service resilience throughout winter.
- Workforce rostering and deployment arrangements support safe staffing levels, workforce wellbeing and appropriate rest periods.
- Flexible workforce deployment across Community Nursing, Specialist Services, Virtual Wards and UCRT to prioritise urgent care demand and maintain essential services.
- Staff pooling, mutual aid and redeployment arrangements available across the Community Collaborative to respond to operational pressures.
- Business continuity arrangements established to mitigate the impact of significant workforce absence.
- Non-essential training, meetings and study leave reviewed during periods of escalation to maximise frontline capacity.
- Daily safety huddles and staff wellbeing support arrangements in place.

DIGITAL & DATA

- Regular sitrep reporting through SHREWD to support operational oversight and escalation.
- Increased use of digital technology including AVT and remote monitoring solutions.
- Launch of Doccla across respiratory services to enhance virtual monitoring and support admission avoidance.
- Use of auto-planner functionality within Community Nursing to manage activity and prioritisation during periods of increased demand.
- Utilisation of devices and prompts to support medication adherence and self-management where appropriate.

INFECTION PREVENTION CONTROL & VACCINATION

The Community Collaborative Winter Plan promotes staff flu vaccination, supports vaccination of eligible inpatients, and delivers winter respiratory prevention initiatives through patient education and winter wellness activity

- IPC protocols reviewed and daily IPC huddles implemented during winter surge periods.
- Zoning and cohorting arrangements to separate infectious patients where advised by IPC teams.
- Enhanced cleaning schedules for high-touch areas and shared equipment.
- Adequate PPE stock management and replenishment arrangements maintained.
- Refresher training in PPE use, hand hygiene and respiratory etiquette.
- IPC champions available across services.
- Review of ventilation systems and isolation room availability.
- Flu vaccination programme promoted for staff and delivered to inpatients in line with organisational policy. Uptake monitored and targeted actions implemented where required.
- Winter respiratory initiatives include patient education, winter wellness events and proactive management of high-risk patients.
- Staff actively encouraged to receive seasonal flu vaccination.
- IPC specialist advice available to support risk assessment, outbreak management and operational decision-making.

Community - Community Collaborative (Mid & South Essex)

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- Increase frequency of board rounds, MDTs and flow huddles to strengthen operational oversight.
- Maximise utilisation of community capacity through flexible admission criteria, Virtual Wards, UCRT, remote monitoring and community beds.
- Prioritise urgent, high-risk and discharge-support patients across all services.
- Redeploy workforce and defer lower-priority activity, where clinically appropriate, to increase frontline capacity.
- Utilise mutual aid arrangements across the Community Collaborative to manage surges in demand.
- Pause non-urgent services and activities to release maximum workforce capacity.
- Implement enhanced command, control and escalation arrangements through increased huddles, escalation calls and whole-system coordination.
- Realign workforce and resources to prioritise urgent and emergency care.
- Maximise discharge and admission avoidance support through UCRT, Virtual Wards, Early Supported Discharge (ESD) and community bed capacity.
- Utilise Business Continuity Plans (BCPs) for workforce, estates, IT and operational pressures.

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

- Open additional capacity within community hospitals using day rooms, subject to Executive approval, staffing and equipment availability.
- Utilise full mutual aid arrangements across Community Collaborative providers.
- Restrict activity to essential services and highest clinical priority pathways only.
- Deploy all available workforce flexibilities and Business Continuity Plan (BCP) measures to maintain patient safety and flow.
- Maintain enhanced system command, control and escalation arrangements through collaborative representation and whole-system coordination.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Transport provision impacting patient discharge

Mitigation: Utilise community transport, family support and voluntary sector transport options where appropriate.

Risk: Community demand exceeding available capacity

Mitigation: Regular caseload review, prioritisation, escalation, workforce redeployment and mutual aid arrangements.:

Risk: Safe staffing levels not achievable

Mitigation: Business Continuity Plan (BCP) implementation, workforce redeployment and mutual aid support.

Risk: Children's service pressures impacting routine clinics

Mitigation: Prioritise urgent activity and temporarily reduce or defer routine activity during periods of surge demand.

Risk: Estates issues impacting bed capacity and service delivery

Mitigation: Local contingency arrangements, infection prevention and control measures, and site-specific mitigations to maintain operational capacity.

Risk: Infectious disease outbreaks

Mitigation: Local outbreak management procedures, IPC controls and BCP arrangements.

Risk: D2A delays and long lengths of stay affecting patient flow

Mitigation: Ongoing review with D2A teams, escalation processes and proactive discharge management.

Risk: Delays in the provision of equipment may impact timely discharge and admission avoidance.

Mitigation: Equipment capacity is monitored routinely, with escalation processes and contingency arrangements in place to support timely provision.

Community - Community Collaborative (Mid & South Essex)

CAPACITY AVAILABLE	Core Winter Capacity	Additional Capacity	Extremist Capacity	Total
Intermediate care beds	40	0	0	40
Stroke beds	14	0	0	14
Virtual wards beds	106	0	0	106
UCRT Slots	20	6	0	26
Community Assessment & Treatment Unit (CATU)	22	0	0	22

PATINET FLOW AND DISCHARGE	Current	Winter Target (1 Dec – 31 Mar 27)
Average occupancy	85-90%	95%
Length of stay >7 days	39%	<35%
Length of stay >14 days	33%	<30%
Length of stay >21 days	20%	<18%
Discharge before noon	Not available	
Discharge before 3pm	Not available	

Community – EPUT (West Essex)

OPERATIONAL READINESS

- Maintain an integrated out-of-hospital model comprising Community Inpatient Beds, Virtual Hospital and UCRT, supported by daily operational oversight and escalation arrangements.
- Daily review of demand, capacity, referrals and discharge performance to support patient flow and operational decision-making.
- Seven-day service delivery supports admission avoidance, accelerated discharge and Home First principles.
- Operational leadership will maintain oversight of capacity, patient safety, workforce resilience and system pressures through established flow and escalation processes.
- Flexible workforce deployment, mutual aid and business continuity arrangements will support service resilience during periods of sustained demand.
- Winter escalation arrangements support rapid deployment of additional capacity and prioritisation of urgent services. Business Continuity Plans have been reviewed and refreshed, with mitigations in place for workforce, digital, estates and supplier risks.
- Senior manager and Trust Director on-call arrangements provide leadership and decision-making outside normal working hours.

SYSTEM INTEGRATION

- System integration and oversight is led by the Deputy Director for Care Coordination and Flow through established Essex-wide and West Essex escalation arrangements.
- Integrated working with community, acute, primary care, local authority, EEA and voluntary sector partners supports coordinated discharge, admission avoidance and patient flow.
- UCRT, Virtual Hospital and Community Inpatient services operate as a single community pathway to maximise out-of-hospital capacity and support system flow.
- Joint discharge, transfer and mutual aid arrangements enable seamless care across acute, virtual and community settings during periods of increased demand.
- Winter escalation communications are coordinated through established Trust and system forums to ensure timely and consistent information sharing.

PATIENT FLOW, DISCHARGE & CAPACITY

- Community Inpatient Beds, Virtual Hospital and UCRT operate as an integrated pathway supporting admission avoidance, early supported discharge and optimised patient flow across West Essex.
- Home First and Discharge to Assess principles are embedded to ensure patients receive care in the most appropriate setting and minimise unnecessary hospital stays.
- Daily board rounds, MDT reviews and discharge planning support effective utilisation of capacity, timely patient progression and reduced length of stay.
- UCRT provides rapid assessment and intervention to prevent avoidable admissions and support same-day discharge, while Virtual Hospital capacity delivers acute-level care in patients' own homes.
- Community Inpatient Beds are prioritised for patients requiring rehabilitation, reconditioning or ongoing inpatient support where home-based care is not appropriate.
- Integrated working and established escalation processes across acute, community, local authority and neighbourhood teams support timely transfers of care, discharge arrangements and patient flow.
- Patients at increased risk of deterioration are proactively identified and monitored, with welfare and escalation support implemented where required.
- Outbreak management arrangements are incorporated within patient flow processes to maintain safe admissions, transfers and discharges during periods of increased infection prevalence.
- Daily oversight of discharge performance, delayed discharges and long lengths of stay, supported by pre-Christmas occupancy reduction plans, helps maximise capacity throughout winter.

Community – EPUT (West Essex)

WORKFORCE

- Seven-day service models are maintained across Community Inpatient Services, the Virtual Hospital and Urgent Community Response Teams (UCRT), supported by operational and clinical leadership oversight.
- Extended workforce and rota planning is in place through March 2027, with annual leave and festive period arrangements proactively managed to maintain safe staffing levels.
- Workforce resilience plans include active vacancy management, targeted recruitment, bank workforce utilisation, flexible deployment, redeployment and mutual aid arrangements.
- Staff wellbeing, supervision and psychological support services are available throughout the winter period.
- Flu, COVID-19 and RSV vaccination uptake is actively promoted across all staff groups.
- Escalation and command arrangements provide oversight of workforce risks, workforce pressures, business continuity incidents and severe weather disruption, with timely mitigation actions implemented as required.

DIGITAL & DATA

- Daily monitoring of capacity, demand, patient flow and escalation indicators across Urgent Community Response Teams (UCRT), Virtual Hospital and Community Inpatient Services.
- Real-time oversight of occupancy, virtual bed utilisation, referral activity and discharge performance informs operational decision-making and resource deployment.
- SHREWD and other system reporting platforms provide real-time visibility of operational performance, incidents and emerging pressures.
- Capacity, flow and escalation information is routinely shared with the ICB and system partners through daily operational coordination calls.
- Discharge monitoring arrangements support effective discharge planning and patient flow across community inpatient settings.
- Real-time monitoring of demand, capacity and escalation triggers supports business continuity management and the early identification of pressures requiring tactical or strategic escalation.

INFECTION PREVENTION CONTROL & VACCINATION

- Robust IPC arrangements are in place across Community Inpatient Services, the Virtual Hospital and Urgent Community Response Teams (UCRT), supported by strengthened surveillance, escalation and outbreak management processes following learning from winter 2025/26.
- Enhanced surveillance is maintained throughout winter for COVID-19, influenza, RSV, norovirus and other respiratory and gastrointestinal infections, with escalation aligned to Trust IPC, EPRR and Business Continuity arrangements.
- Community inpatient wards maintain established arrangements for patient isolation, cohort nursing, zoning and admission restrictions where clinically required to minimise transmission and protect vulnerable patients.
- Winter respiratory virus plans include outbreak management processes, dedicated isolation and cohort capacity, outbreak control meetings and multidisciplinary review arrangements.
- Daily monitoring of outbreaks, transmission risks, staffing impacts and bed capacity supports timely escalation through operational, tactical and strategic command structures where patient flow or service delivery is affected.
- PPE assurance, fit testing, stock monitoring and enhanced cleaning arrangements remain in place throughout the winter period in line with Trust requirements and national guidance.
- Business Continuity Plans will be enacted where outbreaks significantly affect staffing, capacity or service delivery, ensuring continuity of priority clinical services and safe risk escalation.
- Seasonal vaccination programmes for staff and eligible patients will be actively promoted and monitored, with particular focus on frontline staff, vulnerable patients and high-risk cohorts.

Community – EPUT (West Essex)

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- OPEL 4 responses will be coordinated across Community Inpatient Services, the Virtual Hospital and Urgent Community Response Teams (UCRT) through a single out-of-hospital escalation framework.
- Daily operational and executive reviews of capacity, demand and escalation requirements will be undertaken through established command structures.
- Community operational leaders have authority to escalate capacity and resource requirements through Silver and Gold command arrangements where required.
- UCRT resources will be prioritised to support admission avoidance, urgent deterioration responses and timely discharge from acute and community settings.
- Virtual Hospital capacity will be flexed, where clinically appropriate, to support admission avoidance and facilitate earlier discharge from acute hospitals.
- Flexible deployment of clinical and operational teams across services will be utilised to manage system pressures and maintain patient flow.
- Additional community inpatient escalation capacity may be opened, subject to operational demand, workforce availability and executive authorisation.
- Additional bed capacity, workforce deployment, virtual capacity expansion and discharge acceleration measures will be authorised through established command arrangements and reviewed daily.
- Non-urgent activity may be reviewed and temporarily reduced where necessary to release capacity for urgent care and discharge pathways.

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

- Full activation of community escalation arrangements across Community Inpatient Services, the Virtual Hospital and Urgent Community Response Teams (UCRT).
- Executive oversight maintained through incident management and command structures, with enhanced operational reporting and frequent review of capacity, demand and system risks.
- Close coordination with acute providers, the ICB and system partners to manage whole-system pressures, maintain patient flow and support safe service delivery.
- In-reach support to acute hospitals intensified to maximise discharge opportunities, reduce delays and support surge management.
- Urgent clinical activity, admission avoidance interventions and discharge pathways prioritised to optimise available capacity across the system.
- Virtual Hospital capacity expanded to the maximum clinically safe operating level to support admission avoidance and earlier discharge from hospital.
- Agreed escalation bed capacity fully utilised, with community inpatient accommodation flexed in accordance with approved escalation procedures.
- Workforce redeployment, mutual aid arrangements and flexible deployment of resources enacted to maintain critical services and respond to sustained operational pressures.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Demand exceeds available out-of-hospital capacity across Community Inpatient Services, the Virtual Hospital and UCRT, resulting in reduced flow and increased system pressure.

Mitigation: Daily review of bed occupancy, virtual capacity utilisation and UCRT demand, with escalation capacity, admission avoidance measures and urgent pathways prioritised as required.

Risk: Workforce shortages arising from vacancies, sickness, severe weather or sustained operational pressures affect service delivery.

Mitigation: Workforce resilience and business continuity plans, including bank utilisation, flexible deployment, targeted recruitment, mutual aid arrangements and alternative workforce deployment where required.

Risk: Delayed discharges due to transport constraints, social care availability or delays in onward placement reduce capacity and patient flow.

Mitigation: Active discharge management through daily escalation processes, partnership working with local authority services and system discharge forums and focus on Home First principles.

Risk: Infectious disease outbreaks, including influenza, RSV, COVID-19 and norovirus, reduce bed capacity, increase staff absence and adversely affect patient flow.

Mitigation: Enhanced IPC surveillance, vaccination programmes, early outbreak identification, isolation and cohorting arrangements, outbreak control processes and daily review of operational impacts.

Community – EPUT (West Essex)

CAPACITY AVAILABLE	Core Winter Capacity	Additional Capacity	Extremist Capacity	Total
Intermediate care beds	40	0	0	40
Stroke beds	14	0	0	14
Virtual wards beds	106	0	0	106
UCRT Slots	20	6	0	26
Community Assessment & Treatment Unit (CATU)	22	0	0	22

PATINET FLOW AND DISCHARGE	Current	Winter Target (1 Dec – 31 Mar 27)
Average occupancy	85-90%	95%
Length of stay >7 days	39%	<35%
Length of stay >14 days	33%	<30%
Length of stay >21 days	20%	<18%
Discharge before noon	Not available	
Discharge before 3pm	Not available	

NELFT: CAMHS Crisis

OPERATIONAL READINESS

- The SET-CAMHS Crisis Team operates a 24/7 service throughout the winter period, supported by robust staffing rotas and established escalation arrangements to maintain safe service delivery.
- Twice-daily MDT reviews, including senior clinical and psychiatry input, provide oversight of caseloads, risk and operational priorities, supported by out-of-hours on-call psychiatry rota.
- NELFT weekend management huddles provide oversight of children and young people (CYP) presenting to Emergency Departments.
- The Crisis Team manages out-of-hours NHS 111 mental health referrals, providing rapid triage, assessment and intervention to support admission avoidance and reduce unnecessary Emergency Department attendance.
- Community-based assessments are utilised wherever clinically appropriate to deliver timely support in the most appropriate setting.
- Established partnership arrangements with Essex Police support safe diversion from Emergency Departments and facilitate access to appropriate mental health services.

SYSTEM INTEGRATION

- Close collaboration with the Provider Collaborative supports timely identification of inpatient mental health beds and effective management of patient flow across the system.
- Strong partnership working with social care services facilitates timely discharge planning and ensures safe and appropriate onward care arrangements.
- Ongoing engagement with Acute Hospital Mental Health Liaison Teams supports coordinated multidisciplinary decision-making, patient flow and oversight of complex care pathways.
- Weekly system-wide meetings, involving senior leaders and partner organisations, provide oversight of discharge barriers and enable timely resolution of issues impacting patient flow and capacity.
- Integrated working across health, social care and provider partners supports safe admission avoidance, timely discharge and effective management of winter pressures across CAMHS pathways.

PATIENT FLOW, DISCHARGE & CAPACITY

- Children and young people (CYP) presenting to the Emergency Department in mental health crisis are referred to the SET-CAMHS Crisis Team following medical clearance.
- The SET-CAMHS Crisis Team provides timely assessment, with face-to-face review undertaken within four hours of the CYP being deemed medically fit, supporting rapid clinical decision-making and flow through acute pathways.
- Following assessment, CYP are discharged where clinically appropriate, with safeguarding concerns managed in partnership with social care to ensure safe discharge arrangements and suitable onward placement.
- Where discharge is not clinically appropriate due to assessed mental health needs or risk, the Crisis Team works closely with acute hospital teams and the Provider Collaborative to secure appropriate inpatient CAMHS provision and maintain patient safety.
- Discharge planning meetings are convened as required to coordinate complex discharges, support safe transitions of care and minimise avoidable delays.
- Close working between SET-CAMHS, acute hospitals, social care and inpatient providers supports timely assessment, admission avoidance where appropriate, effective discharge planning and management of winter demand and capacity pressures.

NELFT: CAMHS Crisis

WORKFORCE

- The SET-CAMHS Crisis Team operates a 24/7 rota, supported by staff training in acute hospital processes to ensure an effective response within acute settings.
- Robust escalation arrangements are in place, providing access to senior practitioners, operational management and clinical leadership during core and out-of-hours periods to support timely decision-making and risk management.
- An on-call management structure operates across evenings, weekends and bank holidays, ensuring continuous operational oversight and senior escalation support.
- Workforce resilience is supported through clear escalation pathways, defined leadership accountability and access to senior clinical advice when managing complex presentations and periods of increased demand.
- The NELFT staff vaccination programme promotes uptake of seasonal flu and other relevant vaccinations, with trained peer vaccinators improving accessibility, supporting compliance and enhancing workforce resilience throughout the winter period.

DIGITAL & DATA

- SHREWD reporting is utilised to provide system-wide visibility of children and young people (CYP) awaiting assessment or admission within Emergency Department and ward settings.
- Data is routinely submitted to the SCC to support oversight of demand, capacity, patient flow and operational pressures across CAMHS services.
- Real-time reporting supports the identification and escalation of staffing concerns, capacity constraints and delays, enabling timely operational intervention and risk management.
- Information is used to support system-wide situational awareness, escalation processes and coordinated decision-making throughout the winter period.

INFECTION PREVENTION CONTROL & VACCINATION

- SET-CAMHS services operate in line with NELFT Infection Prevention and Control policies and escalation arrangements to support safe service delivery throughout the winter period.
- Community-based assessments are utilised where clinically appropriate, reducing unnecessary Emergency Department attendance and supporting management of infection risks.
- Close working with acute hospitals ensures appropriate management of children and young people presenting with mental health needs alongside respiratory or infectious illnesses.
- Escalation routes are in place to manage operational pressures arising from infectious disease outbreaks, including impacts on staffing capacity and service delivery.
- The NELFT staff vaccination programme actively promotes uptake of seasonal flu and other recommended vaccinations, supported by trained peer vaccinators to maximise workforce protection and resilience.
- Staff are supported to maintain compliance with infection prevention and control requirements, helping to protect patients, families and staff during periods of increased winter illness.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Increased winter-related sickness absence impacts workforce capacity and the ability to maintain timely CAMHS crisis response.

Mitigation: Staffing rotas are planned up to six weeks in advance, with contingency arrangements including bank staff utilisation and mutual support from other CAMHS Crisis locality teams to maintain safe staffing levels and service continuity across acute hospital settings.

NELFT: CAMHS Eating Disorder

OPERATIONNAL READINESS

- The SET-CAMHS Eating Disorders Service, comprising the Core Eating Disorders Pathway, Enhanced Treatment Pathway and Day Programme, will remain fully operational throughout the winter period.
- The service operates Monday to Friday, 09:00-17:00, with established staffing arrangements to maintain safe and effective service delivery during periods of increased winter demand.
- Proactive workforce planning, including management of annual leave and sickness absence, supports service resilience and continuity of care throughout the winter period.
- Established clinical pathways and operational oversight arrangements ensure timely assessment, treatment and risk management for children and young people with eating disorders.
- Service capacity and operational pressures will be routinely monitored to support early identification of risks and implementation of appropriate mitigations where required.
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SYSTEM INTEGRATION

- Close collaboration with the Provider Collaborative ensures service pressures are communicated effectively and supports timely identification of inpatient CAMHS beds when required.
- Joint working with social care services facilitates early intervention, coordinated care planning and the provision of additional support packages to reduce the risk of admission.
- Integrated partnership arrangements across health and social care support timely decision-making, effective patient flow and safe management of children and young people with complex needs.
- Multi-agency working enables coordinated admission avoidance, discharge planning and ongoing support, helping to maintain capacity and service resilience throughout the winter period.

PATIENT FLOW, DISCHARGE & CAPACITY

- Referrals are received via the Single Point of Access and triaged by the Clinician of the Day, with patients prioritised in line with MEED guidance. Urgent referrals are assessed within five working days and routine referrals within 28 calendar days.
- Assessments are delivered across Chelmsford, Clacton, Colchester, Basildon and Harlow, with hospital-based assessments available for inpatients where required.
- Following assessment, all patients are reviewed through a Post-Assessment Discussion (PAD) and multidisciplinary team (MDT) process to confirm diagnosis, risk and treatment pathway.
- Eligible patients are allocated to the most appropriate treatment pathway, including the Core Team, Intensive Support Pathway (ISP) or Day Hospital, ensuring care is delivered according to clinical need.
- Children and young people at increased medical risk are actively monitored, with re-feeding plans implemented where required and escalation to Emergency Department or inpatient care undertaken when clinically indicated.
- The Intensive Support Pathway provides enhanced support for patients at risk of admission, while the Day Hospital, including a virtual bed model, supports admission avoidance and management of higher-risk patients in the community.
- Treatment capacity is maximised through delivery of evidence-based interventions, including Family-Based Treatment (FBT), Cognitive Behavioural Therapy (CBT), meal support, dietetic input and psychiatric review, with frequency tailored to clinical risk.
- Close working with acute hospitals, the Provider Collaborative and community partners supports timely access to specialist care, effective management of demand and capacity, and avoidance of unnecessary admissions wherever clinically appropriate.

NELFT: CAMHS Eating Disorder

WORKFORCE

- The service operates Monday to Friday, 08:00-18:00, with out-of-hours support provided through NELFT services, including the SET-CAMHS Crisis Team.
- Established administrative and clinical teams are in place, including dedicated capacity to support winter pressures and maintain service continuity.
- Workforce resilience is supported through robust staffing arrangements and access to wider NELFT services to maintain safe and effective care throughout the winter period.
- The NELFT staff vaccination programme actively promotes seasonal flu vaccination, supported by trained peer vaccinators to improve uptake, protect staff wellbeing and strengthen workforce resilience during periods of increased winter illness.

INFECTION PREVENTION CONTROL & VACCINATION

- Services operate in line with NELFT Infection Prevention and Control policies and procedures to support safe service delivery throughout the winter period.
- Virtual appointments are utilised where clinically appropriate to maintain access to care and reduce infection transmission risks during periods of increased winter illness.
- Real-time operational reporting supports early identification and escalation of staffing pressures that may arise from infectious disease outbreaks or seasonal illness.
- Established staffing and service continuity arrangements support maintenance of safe service delivery during periods of increased winter-related absence.
- The NELFT staff vaccination programme actively promotes seasonal flu vaccination, with trained peer vaccinators supporting uptake, workforce resilience and the reduction of winter virus transmission.
- Vaccination uptake is monitored routinely to support staff wellbeing, patient safety and continuity of services throughout the winter period.

DIGITAL & DATA

- SHREWD reporting provides system-wide visibility of children and young people (CYP) awaiting assessment or admission within Emergency Department and ward settings.
- Data is routinely submitted to the System Coordination Centre (SCC) to support oversight of demand, capacity, patient flow and operational pressures across CAMHS services.
- Real-time reporting supports the early identification and escalation of staffing pressures, capacity constraints and delays, enabling timely operational intervention.
- Data and reporting are used to support system-wide situational awareness, escalation management and coordinated operational decision-making throughout the winter period.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

- Risk:** CYP with eating disorders experience physical deterioration during winter.
Mitigation: High-risk patients are monitored in line with MEED guidance, with regular reviews, enhanced physical health monitoring and escalation to acute services where required.
- Risk:** Winter-related sickness absence reduces workforce capacity and service resilience.
Mitigation: Forward-planned rotas, leave management, business continuity arrangements, bank staffing and cross-cover processes maintain safe service delivery.
- Risk:** Workforce pressures affect timely follow-up and management of high-risk patients.
Mitigation: Continuity processes and access to the Close Monitoring Clinic (CMC) provide enhanced oversight and short-term risk management.
- Risk:** Increased winter demand impacts access to routine appointments.
Mitigation: Virtual appointments and physical health monitoring through GP and urgent care services support continuity of care.

Adult Mental Health – EPUT

OPERATIONNAL READINESS

- Operational resilience plans are in place for all-age urgent mental health services, including NHS 111 Mental Health, Crisis Resolution and Home Treatment Teams, liaison psychiatry, crisis alternatives and Section 136 pathways.
- Tailored crisis and relapse plans are maintained for high-risk individuals and frequent users of urgent mental health services.
- Locality-based flow and capacity management arrangements provide twice-daily oversight of demand, occupancy, delays and escalation requirements.
- A Trust-wide Flow Improvement Programme, co-chaired with the ICB, is driving improvements in patient flow, demand and capacity modelling, crisis alternatives and discharge pathways.
- Daily operational sitreps, escalation huddles and system calls provide oversight of bed occupancy, demand, delays and operational risks.
- Community OPEL escalation arrangements support early identification and management of pressures across mental health services.

SYSTEM INTEGRATION

- Integrated working is supported through partnership arrangements with the ICB, local authorities, housing providers, acute trusts, police, social care and voluntary sector organisations.
- Community and locality oversight meetings provide multidisciplinary review of admissions, delayed discharges and out-of-area placements.
- Mental health services are integrated within neighbourhood and system escalation arrangements to support whole-system situational awareness and coordinated responses.
- Crisis Concordat arrangements, Section 136 partnerships and collaboration with police and Approved Mental Health Professionals (AMHPs) support delivery of urgent mental health pathways.
- Weekend and rapid multi-agency MDT arrangements support complex patients, discharge planning and admission avoidance.

PATIENT FLOW, DISCHARGE & CAPACITY

- Home First remains the default discharge model, with discharge planning commencing on admission and expected discharge dates established early in the inpatient pathway.
- Daily board rounds, Red to Green reviews, weekly inpatient MDTs and system delay meetings provide operational grip on flow, length of stay and discharge performance.
- Intensive focus is maintained on reducing delayed discharges, reducing length of stay and improving flow from acute, community and mental health inpatient settings.
- Enhanced oversight of out-of-area placements supports timely repatriation and discharge planning.
- Mental Health Assessment Centres, crisis alternatives, Crisis Assessment and Treatment Units (CATU) and community-based services support admission avoidance and ED diversion.
- Community teams provide proactive support for discharge planning through in-reach, named practitioner allocation and transition support arrangements.
- Daily monitoring of demand, capacity, occupancy and escalation status supports timely operational decision-making and escalation where required.

Adult Mental Health – EPUT

WORKFORCE

- A pool of bank staff is maintained to support 24/7 crisis response and assessment services during periods of increased demand.
- Workforce plans include extended rota and roster management through winter, with seven-day senior clinical and operational leadership cover across key services.
- Appropriate skill mix, senior clinical decision-maker availability and workforce deployment are regularly reviewed to maintain safe services.
- Mutual aid arrangements and joint workforce models with system partners support resilience during periods of workforce pressure.
- Staff wellbeing, welfare and Occupational Health support are actively promoted throughout the winter period.
- Senior clinical huddles and operational escalation processes provide oversight of staffing risks and workforce mitigations.

DIGITAL & DATA

- Demand dashboards, Power BI reporting and live flow tools provide real-time oversight of demand, capacity, escalation pressures and operational performance.
- Locality teams utilise urgent care and flow dashboards to support discharge management, patient tracking and operational decision-making.
- Real-time OPEL monitoring supports escalation management and executive oversight when thresholds are reached.
- Twice-daily sitreps and system reporting provide visibility of occupancy, demand, delays, out-of-area placements and escalation actions.
- MaST predictive analytics tools are utilised to identify individuals at risk of deterioration and those requiring enhanced community support.

INFECTION PREVENTION CONTROL & VACCINATION

- IPC arrangements are in place across mental health inpatient and community services, with escalation and outbreak management processes aligned to Trust IPC requirements.
- Enhanced surveillance, patient testing, isolation and cohort management arrangements support the management of respiratory and gastrointestinal outbreaks.
- Agreed cleaning protocols, enhanced cleaning measures and PPE assurance arrangements are maintained throughout the winter period.
- Staff flu, COVID-19 and RSV vaccination programmes are actively promoted, monitored and supported through dedicated governance arrangements.
- Vaccination planning includes long-stay inpatients and patients discharged to care home settings.
- Ventilation compliance, fit testing and outbreak escalation processes support infection prevention and service resilience.

Adult Mental Health – EPUT

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- Full activation of mental health escalation arrangements, supported by enhanced operational oversight and increased frequency of escalation reviews
- Expansion of Mental Health Assessment Centre utilisation and crisis alternatives to maximise ED diversion and admission avoidance
- Flexible deployment of workforce, bank staff utilisation and mutual aid arrangements implemented to maintain critical services
- Additional senior clinical and operational support deployed to manage flow, capacity and discharge pressures
- Prioritisation of urgent mental health activity, discharge pathways and reduction of delayed discharges to maximise available capacity
- Daily executive, operational and system escalation calls provide oversight and authorisation of escalation actions.

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

- Full activation of command and control arrangements with executive oversight of mental health demand, capacity and system pressures
- Surge deployment of bank staff, senior clinical leaders and operational management resources to maintain essential services
- Maximum utilisation of crisis alternatives, Mental Health Assessment Centres, home treatment services and community pathways to avoid admission wherever clinically appropriate
- Intensive management of inpatient flow, out-of-area placements, delayed discharges and length of stay to release capacity
- Enhanced collaboration with acute providers, police, local authorities, housing partners, social care and system partners to manage significant escalation pressures
- Escalation decisions authorised through established Gold, Silver and operational command structures, with continuous monitoring of demand, capacity, staffing and risk.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Demand for urgent and emergency mental health services exceeds available community, crisis or inpatient capacity.

Mitigation: Twice-daily capacity reviews, OPEL monitoring, demand dashboards, crisis alternatives and escalation arrangements support capacity management.

Risk: Delayed discharges and extended lengths of stay reduce inpatient capacity and increase out-of-area placements.

Mitigation: Home First principles, daily discharge oversight, MDT reviews and flow improvement arrangements.

Risk: Workforce shortages arising from vacancies, sickness or sustained winter pressures impact service resilience.

Mitigation: Bank workforce, seven-day senior clinical cover, workforce escalation processes, mutual aid and wellbeing support.

Risk: System pressures across acute, social care, housing and community services impact mental health pathways and discharge.

Mitigation: Multi-agency escalation arrangements and partnership working across health, local authority, housing, police and voluntary sector partners.

Risk: Infectious disease outbreaks reduce bed availability, increase staff absence and disrupt service delivery.

Mitigation: Enhanced IPC surveillance, testing, isolation and cohorting arrangements, PPE assurance, enhanced cleaning and vaccination programmes.

Risk: Limited operational visibility delays escalation and response to emerging pressures.

Mitigation: Real-time demand and capacity dashboards, OPEL monitoring, regular sitreps and executive oversight support timely decision-making.

Adult Mental Health – EPUT

	Core Winter Capacity	Additional Capacity	Extremist Capacity	Total
136 suites	6	0	0	6
Urgent Care Department	8	0	0	8
Crisis House	5	0	0	5
Assessment Units	32	0	0	32
Adult Acute Beds	197	Out of area placements	Out of area placements	197
Older Adult Beds	143	0	0	143

In Patient Bed / Flow	Current	Winter Target (1 Dec – 31 Mar 27)
Average occupancy – Adult Acute Pathway	97.4%	97.4%
Length of stay < 60 days (NOF standard) – Adult Acute	64.9	<60

Essex County Council

OPERATIONAL READINESS

- Management oversight and escalation protocols will continue to inform the setting of the Local Authority Pressure Escalation Level (LAPEL), guiding the activation and de-escalation of infrastructure, system response arrangements, reporting requirements and the frequency of coordination calls.
- Senior leaders will convene weekly through the Priority Review Meeting (PRM) to determine the LAPEL status, review the Situation Report (SITREP) and consider locality position statements, providing strategic oversight of operational pressures and coordinating Essex County Council's winter response.
- Adult Social Care will participate in countywide System Assurance Meetings every Monday, Wednesday and Friday to provide operational updates, monitor pressures and escalate risks where required.
- The Safe and Settle service within ECL Reablement will continue to support effective utilisation of Intermediate Care capacity by facilitating timely transitions and maximising service throughput.

SYSTEM INTEGRATION

Countywide Delivery

- A centralised carers support model with a single point of contact, proactive carer identification and targeted wellbeing interventions to strengthen resilience.
- System-wide schemes, including Dementia Community Support, ARC and ECL Reablement capacity, and flexible surge arrangements to support discharge, recovery and patient flow.
- TOCH Team will utilise targeted spot purchasing to address capacity pressures and maintain patient flow during periods of increased winter demand.

Locality-Level Actions

- Falls prevention initiatives, including slipper swap schemes, exercise guidance and links to social care services, will help reduce avoidable admissions and support independence.
- Voluntary, Community and Social Enterprise partners to provide resettlement support following hospital discharge to promote recovery and reduce readmission risk.
- Integrated therapy support within reablement will maximise rehabilitation outcomes, improve independence and enhance service effectiveness.

PATIENT FLOW, DISCHARGE & CAPACITY

Intermediate Care Programme

- Delivery of a system-wide Intermediate Care model in partnership with providers and system partners to strengthen support for people to remain at home, increase the use of care technology and reduce demand for long-term care.
- The programme will improve operational flow and efficiency, prioritise outcomes-based support, integrate services under a unified specification, maintain admission avoidance capacity and drive continuous improvement across care pathways.
- Pathway 1 capacity and utilisation are monitored daily to support operational oversight, flow management and timely escalation where required.

Operational Delivery

- Primary Reablement contracts have been recommissioned with enhanced objectives focused on improving outcomes, flow and service effectiveness.
- The Home to Assess service is now embedded as an alternative to Reablement where an individual's needs remain unclear following medical optimisation, supporting timely discharge, assessment in the most appropriate setting and improved patient flow.

Essex County Council

WORKFORCE

- Delivery of a seven-day operating model to maintain service continuity, support timely discharges and optimise patient flow throughout the winter period.
- Proactive management of annual leave and workforce capacity to maintain safe staffing levels and operational resilience during periods of increased demand.
- Continued use of the Local Authority Pressure Escalation Level (LAPEL) framework to coordinate the response to system pressures, including the activation and deactivation of infrastructure, escalation arrangements, reporting requirements and the frequency of system coordination calls.
- Senior leaders will convene weekly through the Priority Review Meeting (PRM) to determine the LAPEL status, review the Situation Report (SITREP) and consider locality position statements, providing strategic oversight and coordinated management of operational pressures across Essex.

DIGITAL & DATA

- Essex County Council's Intermediate Care Dashboard provides real-time oversight of service utilisation, capacity, length of stay, spot purchasing, inpatient activity and key outcome measures, including failed starts, restarts, readmissions and ongoing care needs.
- The Care Technology Programme will continue to expand support for individuals, promoting independence, improving quality of life and reducing demand on health and social care services. Care technology provides a preventative approach and, where appropriate, offers an alternative to commissioned services by enabling individuals to manage their needs more independently.

INFECTION PREVENTION CONTROL & VACCINATION

- Frontline Adult Social Care staff will be supported to access seasonal flu vaccinations through community pharmacies.
- Essex County Council will work with Care Homes, Supported Living and Extra Care providers to maximise vaccination uptake amongst eligible residents.
- Robust Infection Prevention and Control (IPC) measures, guidance and communications will continue to be implemented throughout the winter period to protect residents, staff and service continuity.

Essex County Council

INCREASE CAPACITY & CAPABILITY:
OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- At OPEL 4, Essex County Council will maximise available capacity and capability across the social care system to support patient flow and maintain service resilience during periods of severe and sustained pressure. Pathway 1 capacity can be flexed above contracted block levels to accommodate increased demand, with additional contingency capacity available where required. Essex continues to benefit from a strong residential and nursing care market, providing flexibility to respond rapidly to surges in activity.
- The Local Authority Pressure Escalation Level (LAPEL) framework will remain the mechanism for managing and coordinating the Local Authority response to system pressures. The framework provides clear governance for the activation and deactivation of additional infrastructure, escalation measures, reporting requirements and the frequency of system-wide coordination calls.
- Senior leaders meet weekly through the Priority Review Meeting (PRM) to determine the current LAPEL status, review the Situation Report (SITREP) and consider locality position statements. The PRM provides strategic oversight of operational pressures and is critical to coordinating Essex County Council's winter response, enabling timely decision-making, resource deployment and system-wide partnership working during periods of escalation.

INCREASE CAPACITY & CAPABILITY:
EXTREMIST

- Where sustained system pressures exceed available in-county capacity, out-of-county residential and nursing care placements may be utilised as a last resort to support discharge and maintain patient flow. All placements will be subject to individual consent, assessed care needs, and appropriate financial authorisation.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

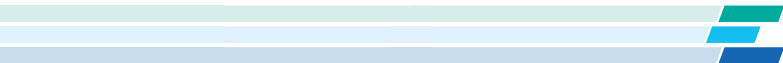
Risk: Adults failing to start Intermediate Care as planned, or being readmitted shortly after admission, reduce capacity, impede flow and create avoidable void costs.
Mitigation: Strengthen admission oversight and provider coordination to maximise occupancy, minimise delays and reduce readmissions.

Risk: Referral surges can quickly consume Intermediate Care capacity, restricting patient flow and responsiveness to demand.
Mitigation: Maintain consistent seven-day flow across the system, reducing peaks and troughs in referrals and discharges.

Risk: Gaps in community services, including therapy, neighbourhood wellbeing pathways, equipment and adaptations, CHC and End of Life services, can increase pressure on Intermediate Care and delay discharge.
Mitigation: Ensure robust multidisciplinary decision-making and prioritisation based on assessed need.

Risk: Escalations outside agreed processes can delay decision-making, duplicate effort and reduce operational effectiveness.
Mitigation: Adhere to agreed SOPs and escalation routes to ensure a coordinated and timely response.

Risk: Misunderstanding that Intermediate Care provides a fixed period of “six weeks free care” can create bottlenecks and delay progression when individuals are ready to move on.
Mitigation: Deliver clear, consistent messaging that Intermediate Care is needs-led, with no fixed duration applied to placements or discharge arrangements.



Southend City Council

OPERATIONAL READINESS

Winter Leadership and Governance: Director of Commissioning, Head of Adult Social Care and leadership team will lead winter. Escalation routes across Adult Social Care, Health and Provider Services, with representation at Essex ICB winter strategic and operational forums.

Escalation and Incident Management

- LAPEL framework and established partner escalation processes will support identification, oversight and management of winter pressures and emerging risks.
- Senior leaders daily review of intelligence and performance information to coordinate responses and support operational decision-making.

Operational Capacity and Demand

- Realtime monitoring discharge demand and capacity to support patient flow and resilience.
- Close working with SEDS, Reablement and commissioned providers, supported by contingency capacity arrangements, will enable a flexible response to increased demand.
- Regular provider engagement will monitor capacity, performance and risks.

Quality and IPC: The Quality Assurance Team will maintain provider oversight to support safe and effective Infection Prevention and Control (IPC) arrangements throughout winter.

SYSTEM INTEGRATION

- Southend City Council will maintain active participation in system-wide winter planning, operational and escalation arrangements, with Adult Social Care represented through relevant resilience and control structures.
- Continued partnership working with TOCH/ICTH, health partners and care providers will support integrated discharge planning, community-based support and joint decision-making through shared intelligence and performance information.
- Established escalation arrangements will support the identification and coordinated management of capacity pressures across the system, including access to mutual aid where required.
- VCSE partners will continue to support Pathway 0 discharges, while a focus on prevention, early intervention, digital and assistive technology will help reduce avoidable admissions and readmissions, promote independence and support people in the most appropriate setting.

PATIENT FLOW, DISCHARGE & CAPACITY

- Commissioners, operational teams and the Southend City Council Recovery Team support early discharge planning through MDT participation, live discharge tracking and the timely identification of care requirements to minimise delays.
- Pathway 1 remains the default discharge model where appropriate, with SEDS and Reablement supporting individuals to return home, maximise independence and reduce reliance on long-term care.
- The Recovery Team plays a key role in coordinating discharges, managing complex cases through the Transfer of Care Hub (TOCH), and working with health partners, providers and families to resolve barriers and maintain patient flow.
- SEDS operates seven days a week, including weekends and bank holidays, ensuring discharge pathways remain available throughout the week.
- Access to Brook Meadows Assessment Beds is actively managed to support individuals with more complex needs, providing assessment in the most appropriate setting, promoting independence and avoiding premature long-term placements.
- Ongoing reviews ensure care arrangements remain proportionate, outcomes-focused and aligned to assessed need.
- Daily monitoring of discharge pathways, SEDS, Reablement, Homecare, residential and nursing care capacity provides oversight of demand, commissioned capacity and system flow, enabling timely escalation where required.

Southend City Council

WORKFORCE

- Workforce planning and annual leave management will maintain appropriate staffing levels across peak winter periods, with leave requests managed in line with service requirements and business continuity arrangements.
- Workforce capacity across operational teams and commissioned services will be monitored throughout winter, supported by regular provider engagement to identify and mitigate staffing challenges at an early stage.
- Providers will maintain workforce contingency arrangements to support service resilience and continuity during periods of increased demand.
- Staff wellbeing, supervision and management support will remain available throughout the winter period, with ongoing oversight of workforce pressures.
- Key discharge services will continue to operate on a seven-day basis, supporting timely discharge activity across weekends and bank holidays.
- Established senior management on-call arrangements and clear escalation routes will support timely operational decision-making throughout the winter and festive period.

DIGITAL & DATA

- Daily monitoring of discharge activity, SEDS, Reablement, residential care, short-term beds, homecare capacity and operational pressures will provide real-time oversight of demand and system performance.
- Daily intelligence reports and established performance reporting arrangements will support senior leaders to proactively identify, manage and respond to emerging winter pressures.
- Real-time dashboards, provider reporting and information sharing across health and social care partners will support integrated working, operational oversight and improved patient flow.

INFECTION PREVENTION CONTROL & VACCINATION

- The Health Protection Operations Manager and Strategic Commissioning Officer will provide oversight and coordination of vaccination, infection prevention and outbreak management arrangements throughout the winter period.
- Seasonal vaccination programmes, including flu and RSV vaccines, will be promoted across Adult Social Care staff, commissioned services and care providers, with uptake monitored through provider engagement.
- Providers will maintain outbreak management and business continuity plans, supported by established escalation procedures to minimise service disruption arising from infectious disease outbreaks.
- Providers will maintain appropriate arrangements for isolation, cohorting, PPE stock management and compliance with relevant infection prevention and control requirements.
- Quality assurance activity will continue to monitor IPC standards, enhanced cleaning arrangements and compliance with national guidance, including FIT testing requirements where applicable.

Southend City Council

INCREASE CAPACITY & CAPABILITY:
OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- Flexible commissioned capacity within SEDS, alongside Reablement and Homecare services, will support increased discharge activity, maximise independence and reduce reliance on long-term care.
- Established escalation processes and senior leadership oversight enable the rapid authorisation and deployment of additional capacity during periods of heightened demand.
- System partners will work collaboratively to identify and implement capacity solutions where pressures emerge, including the use of mutual aid arrangements where required.
- Strong provider relationships and Better Care Fund investment continue to strengthen sector capacity, resilience and the ability to mobilise additional support at pace.

INCREASE CAPACITY & CAPABILITY:
EXTREMIST

- Block-contracted provision will be flexed where possible to respond to exceptional demand and maintain patient flow.
- Enhanced escalation arrangements, including daily case tracking and senior operational oversight, will be implemented to support timely decision-making and resource allocation.
- Additional support will be provided to care homes to enable residents to remain in their usual place of residence wherever clinically appropriate, reducing avoidable admissions and transfers.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Increased hospital discharge demand may exceed available community capacity, impacting flow and timely discharge.

Mitigation: Daily monitoring of discharge activity and capacity, seven-day discharge arrangements, and flexible commissioned capacity within SEDS to respond to increased demand.

Risk: Workforce pressures across social care providers may affect service delivery and resilience.

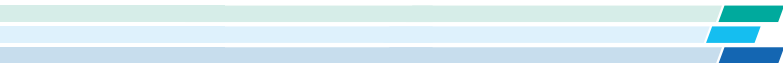
Mitigation: Regular provider engagement, workforce monitoring, wellbeing support and management oversight.

Risk: Winter illness and infectious disease outbreaks may reduce workforce availability and increase demand for services.

Mitigation: Promotion of vaccination programmes, robust Infection Prevention and Control (IPC) arrangements, and established business continuity and outbreak management plans.

Risk: Community capacity pressures may limit the ability to respond to rising demand and support timely discharge.

Mitigation: Regular provider capacity reviews, Better Care Fund investment, and established escalation processes to enable rapid system-wide coordination and response.



Thurrock Council

OPERATIONAL READINESS

- Management oversight and established escalation protocols will continue to inform LAPEL assessment and activation, ensuring a proportionate response and effective prioritisation of resources.
- Senior Pressure and Urgent Response (SPUR) meetings provide system-wide oversight, bringing together senior leaders from Adult Social Care, key operational functions (including hospital teams, brokerage, UCRT and HR), and community health partners. Meeting frequency is determined by senior leadership and escalated in line with system pressures and LAPEL status. SPUR meetings review demand, capacity and workforce resilience, resolve operational issues, coordinate the system response, and direct resources to areas of greatest need.
- Established winter resilience measures remain in place to support seasonal demand, including reablement and interim bed capacity, falls prevention initiatives, and infection prevention and control (IPC) support, enabling timely interventions and maintaining system flow.

SYSTEM INTEGRATION

- Delivering patient-centred care and improved outcomes through a Home First approach:
- **Information Sharing and System Coordination:** The Senior Pressure and Urgent Response (SPUR) meeting serves as the primary forum for sharing intelligence, reviewing system pressures, and coordinating a timely and proportionate multi-agency response.
 - **Joint Planning and Resource Prioritisation:** Active participation in the Mid and South Essex Winter Strategic Group supports the development, alignment and sharing of contingency plans. System-wide planning, escalation management and resource prioritisation are coordinated through Better Care Fund (BCF) Delivery Group and Integrated Care Board (ICB) governance arrangements.
 - **Collaborative Integrated Working:** Health and social care services in Thurrock operate through established integrated and aligned arrangements, including joint director-level leadership roles. Integrated Locality Teams (ILTs) provide coordinated, neighbourhood-based services that support prevention, independence and person-centred care, ensuring residents receive the right support at the right time.

PATIENT FLOW, DISCHARGE & CAPACITY

Operational Delivery: The actions outlined below are in addition to established business-as-usual services, including intermediate care, unpaid carer support and domiciliary care provision.

- New domiciliary care contracts implemented during summer 2025 are now embedded across three of the four localities, with revised arrangements in place within the remaining locality following a provider transition. These changes have strengthened market capacity and resilience, supporting timely hospital discharge.
- The reablement service redesign, including the integration of the former bridging service, has been fully implemented. Capacity and throughput have increased by more than 100% compared with the previous winter, improving patient outcomes and providing enhanced discharge support.
- Fee negotiations with the older people's care home sector are underway to maintain market sustainability, support provider resilience and maximise available discharge capacity over the winter period.
- The Home from Hospital voluntary sector resettlement and follow-up service has received increased funding and capacity for 2025/26, including expansion to seven-day working and an all-age offer. This supports both hospital discharge and admission avoidance through ongoing community-based support.
- A Falls Prevention Test and Learn programme is operating within Integrated Locality Team (ILT) 4, supporting early intervention and reducing avoidable admissions.
- A Respiratory Test and Learn programme is operating within ILT 3, including enhanced respiratory care training for domiciliary care staff ahead of winter, to support early identification and management of deterioration and reduce admissions.
- Enhanced payment arrangements for care workers during the festive period are under consideration to support workforce availability, maintain service continuity and minimise discharge delays during periods of peak demand.

Thurrock Council

WORKFORCE

- **Management Oversight and Escalation:** The Senior Pressure and Urgent Response (SPUR) meeting determines the appropriate LAPEL level and coordinates the system response, resource deployment and escalation arrangements. Attendance includes senior Adult Social Care leaders and system partners, ensuring a coordinated approach to winter pressures.
- **Workforce Sustainability:** Changes to immigration legislation present a potential risk to care sector workforce capacity. Thurrock is reviewing reliance on internationally recruited staff and working with providers to strengthen domestic recruitment and retention, supported by transitional arrangements.
- **Vaccination and Infection Prevention and Control (IPC):** Vaccination remains a key measure to protect the health and social care workforce, maintain service capacity and reduce transmission of seasonal infections. Employers will continue to promote and facilitate staff vaccination, alongside reinforcing IPC requirements and best practice across health and social care settings.

DIGITAL & DATA

- Care home market capacity is monitored three times weekly, with bed availability reviewed through SPUR arrangements. Capacity intelligence is shared across partners and, where required, mitigating actions are implemented to secure additional provision, including out-of-area placements and block-booked capacity.
- Real-time care home bed availability and discharge data are shared with NHS partners through the SHREWD Resilience platform, providing a system-wide view of capacity, demand and patient flow. Daily updates support proactive operational planning, timely discharge coordination, resource allocation and the reduction of avoidable delays across health and social care services.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

- **Risk:** Workforce Capacity - Workforce capacity remains the principal risk within Adult Social Care. The sector continues to experience recruitment and retention challenges, compounded by the potential impact of changes to immigration legislation on the availability of internationally recruited staff. In addition, widespread winter illness could significantly affect workforce availability and service delivery.
- **Mitigation:** An Integrated Workforce Strategy has been developed to strengthen recruitment and retention across the sector, with dedicated leadership being established to oversee implementation. Thurrock continues to review workforce risks, support domestic recruitment initiatives, and promote vaccination uptake across the health and social care workforce to reduce the impact of seasonal illness.
- **Risk:** Resource Constraints -Adult Social Care has statutory responsibilities that extend beyond hospital discharge and admission avoidance. Increasing demand and finite financial resources may limit the capacity to deliver additional winter resilience measures alongside core Care Act duties.
- **Mitigation:** Delivery of winter initiatives will be closely monitored through established governance and escalation arrangements, with resources prioritised according to system pressures and statutory responsibilities to maximise available capacity within existing funding allocations.
- **Risk:** Impact of Health System Changes - System-wide efficiency and transformation programmes within health services may have unintended consequences for Adult Social Care and the sustainability of the external care market. This could increase demand for social care support and contribute to avoidable hospital admissions and discharge delays.
- **Mitigation:** Ongoing engagement with NHS partners through SPUR and wider system governance arrangements will support early identification of emerging pressures, coordinated planning, and collaborative management of risks affecting service capacity and patient flow.

Non Emergency Patient Transport (EEAST: West Essex)

OPERATIONNAL READINESS

- A clear escalation process will be maintained and communicated across the service, ensuring timely identification, management and escalation of operational pressures in line with agreed system and organisational procedures.
- Microsoft Teams will be utilised as the primary platform for real-time operational communications, enabling the rapid sharing of service updates, capacity information, escalation status and key operational decisions.
- Transport Coordination Officers (TCOs) will continue to be deployed within HWE acute sites, providing on-site operational coordination, supporting patient flow, and facilitating effective communication between transport providers and system partners.
- Workforce and resource deployment will be aligned to forecast and modelled demand profiles, ensuring capacity is optimised to meet anticipated activity levels and maintain service resilience throughout periods of increased winter demand.

SYSTEM INTEGRATION

- The service will maintain active engagement with the SCC, ensuring timely escalation of operational pressures and alignment with system-wide response arrangements throughout the winter period.
- Established escalation processes with the East of England Ambulance Service Trust (EEAST) will be utilised to support coordinated operational management, facilitate timely communication, and maintain continuity of patient transport services during periods of increased demand.
- The Patient Transport Service SOP is being updated in collaboration with the Essex Care Experience Integrated Care Board (CE ICB) to strengthen operational consistency, clarify escalation arrangements, and support effective system working.
- Patient transport journey activity will be monitored in SHREWD, with journey data refreshed every 15 minutes, providing near real-time visibility of operational performance, supporting proactive management of demand and capacity, and enabling system decision-making.

PATIENT FLOW, DISCHARGE & CAPACITY

- TCOs will be embedded across all HWE acute sites, providing on-site operational coordination, supporting timely patient discharges, and facilitating effective communication between providers and system partners.
- Demand management arrangements are in place through an agreed activity cap, enabling available capacity to be prioritised appropriately and resources deployed effectively during periods of sustained operational pressure.
- A proportion of transport capacity will remain unallocated within routine booking schedules to maintain flexibility and support same-day and on-the-day hospital discharges, helping to minimise discharge delays and improve patient flow.
- Patient Transport Service (PTS) capacity will be delivered in line with commissioned activity levels across HWE. Ongoing monitoring of demand and utilisation will be undertaken to identify and escalate any capacity pressures associated with the existing unfunded demand gap, ensuring system visibility and appropriate mitigation where required.

Non Emergency Patient Transport (EEAST: West Essex)

WORKFORCE

- Bank staff will be utilised to support the filling of substantive vacancies across the HWE contract, ensuring service continuity and maintaining safe staffing levels throughout the winter period.
- Recruitment activity will continue throughout winter, supported by a rolling programme of Associate Ambulance Practitioner (ACA) training courses to strengthen workforce capacity and address recruitment gaps.
- Annual leave will be managed in accordance with EEAST Annual Leave Policy, balancing staff wellbeing with the need to maintain appropriate workforce availability during periods of increased operational demand.
- Vacant shifts will be proactively managed and, where required, covered through overtime arrangements, enabling flexibility within the existing workforce and supporting the delivery of commissioned services and patient care requirements.

DIGITAL & DATA

- Service activity will be monitored daily against the agreed activity cap, providing oversight of demand, capacity and utilisation, and enabling timely operational interventions where pressures are identified.
- Performance and activity data will be reported through Power BI and shared with commissioners monthly, supporting transparency, performance monitoring and informed decision-making throughout the winter period.
- A live SHREWD data feed, refreshed every 15 minutes, will provide near real-time visibility of patient transport activity and operational performance, enabling proactive management of capacity, supporting escalation processes, and facilitating system-wide coordination during periods of increased demand.

INFECTION PREVENTION CONTROL & VACCINATION

- The Trust will actively promote seasonal influenza vaccination across the workforce, with delivery plans in place to achieve the organisational uptake target of 57%, representing a 5% increase on the previous year.
- Appropriate Personal Protective Equipment (PPE) will be maintained and readily available on all Trust vehicles, ensuring staff can comply with infection prevention and control requirements and respond safely to patients with suspected or confirmed infectious conditions.
- All infection prevention and control practices will be delivered in accordance with EEAST Infection Prevention and Control policies and procedures, supporting the reduction of healthcare-associated infections and maintaining safe care environments.
- Routine IPC assurance processes will be maintained throughout the winter period, including monthly audits of vehicles, stations and staff uniform compliance undertaken by local managers. Findings will be reviewed and addressed through established governance processes to ensure continued adherence to IPC standards.

Non Emergency Patient Transport (EEAST: West Essex)

INCREASE CAPACITY & CAPABILITY:
OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

Capacity will be maintained in line with contracted activity levels wherever possible, supported by escalation processes, flexible workforce deployment, and system coordination to ensure safe and sustainable service delivery during periods of exceptional demand.

INCREASE CAPACITY & CAPABILITY:
EXTREMIST

In agreement with commissioners, transport resources will be prioritised for essential activity only during periods of extreme operational pressure, including hospital discharges and access to critical services such as cancer treatment and renal dialysis, to maintain patient safety and service continuity.

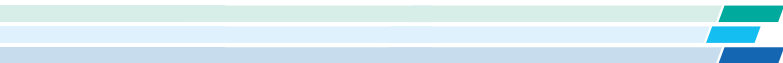
WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Activity levels exceed commissioned and funded capacity, creating financial and operational pressures on the service.

Mitigation: Demand is actively managed through an agreed daily activity cap, with ongoing monitoring of capacity and utilisation to ensure safe and sustainable service delivery.

Risk: Same-day transport bookings may limit operational flexibility and impact the ability to accommodate all requests.

Mitigation: Regular communication is maintained with service users and referring organisations regarding booking requirements. For out-of-area (HWE) journeys, a minimum of 24 hours' notice is required to support effective planning and resource allocation.



Non Emergency Patient Transport (EEAST: West Essex)

	Core Winter Capacity	Additional Capacity	Extremist Capacity	Total
Capacity – Monday – Friday	551 (HWE total)	0	0	551 (HWE total(
Capacity – Saturday	262 (HWE Total)	0	0	262 (HWE Total)
Capacity – Sunday	59 (HWE Total)	0	0	59 (HWE Total)

Non Emergency Patient Transport (HTG - North, Mid, South Essex)

OPERATIONNAL READINESS

- A seven-day workforce model is in place to support both planned journeys and patient discharge transport, ensuring continuity of service throughout the week.
- HTG UK has submitted proposals to the ICB outlining adjustments to daily operations and resource configuration. These plans are designed to support all patient cohorts through winter and beyond, while remaining within existing contractual resource parameters.
- The proposals prioritise pre-planned discharges, introducing measures to optimise vehicle utilisation and establish a dedicated pool of resources for unplanned, same-day demand. This approach safeguards scheduled patient journeys and enhances visibility of available capacity.
- Effective collaboration with acute sites is essential to agree discharge priorities, aligning hospital flow with transport logistics and maximising vehicle deployment efficiency.

SYSTEM INTEGRATION

- SHREWD Resilience has been enhanced to reflect the current capacity of transport services, ensuring that scheduled demand is aligned with available resources.
- Direct electronic and telephone booking of patient transport from acute and community hospitals.
- Consistent weekday coordination touchpoints are established with acute care teams, enabling collaborative prioritisation and early identification of daily operational risks.

PATIENT FLOW, DISCHARGE & CAPACITY

- HTG has proposed allocating a limited number of daily resources specifically to respond to On the Day transport demand. These resources have been strategically mapped in terms of operational hours and geographic coverage to reflect current demand patterns.
- Enhanced early discharge planning, including transport coordination, is critical to maintaining flow and avoiding delays.
- Particular attention is required for Pathway 2 and Pathway 3 discharges from both acute and community settings. Timely alignment of transport with package of care arrangements and cut-off times is essential to ensure safe and efficient discharge.

Non Emergency Patient Transport (HTG - North, Mid, South Essex)

WORKFORCE

- A workforce rota review will optimise resource deployment during peak demand periods, ensuring appropriate coverage across all patient cohorts.
- Agency staffing arrangements are in place to maintain contracted workforce levels and strengthen resilience throughout winter.
- A comprehensive Employee Assistance Programme (EAP) provides staff wellbeing, welfare and resilience support.

DIGITAL & DATA

- SHREWD Resilience is maintained to provide accurate visibility of transport capacity, ensuring scheduled demand is aligned to available resources.
- PTS Online is available across all sites, supporting efficient transport booking management and real-time tracking.

INFECTION PREVENTION CONTROL & VACCINATION

- Annual staff flu and vaccination programmes are promoted to maximise workforce resilience, supported by vaccination reimbursement schemes.
- PPE stock levels are routinely monitored to ensure availability throughout periods of increased demand.
- Enhanced cleaning arrangements are implemented to support infection prevention and control during periods of increased infection prevalence.

Non Emergency Patient Transport (HTG - North, Mid, South Essex)

INCREASE CAPACITY & CAPABILITY:

OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

- Additional capacity can be mobilised through internal overtime and third-party provider support, subject to the availability of ICB funding and approval.

INCREASE CAPACITY & CAPABILITY:

EXTREMIST

- Additional capacity can be mobilised through internal overtime and third-party provider support, subject to the availability of ICB funding and approval.

WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

- **Risk:** Overdemand on NEPTS driven by renal dialysis growth
Mitigation: HTG has submitted a proposal to the ICB to increase resources. Timely review and approval are essential to ensure service continuity.
- **Risk:** Inability to expand evening and weekend NEPTS coverage
Mitigation: Resource uplift is contingent on ICB approval. Interim scheduling adjustments and prioritisation of critical journeys may be required.
- **Risk:** Potential shortfall in NEPTS capacity if system adopts full 7-day discharge model
Mitigation: Scenario planning and phased implementation of 7-day discharge, aligned with transport capacity reviews, will help manage risk.
- **Risk:** Surge in demand during predictable peaks (e.g. pre-Festive period)
Mitigation: Early forecasting and temporary resource scaling, including agency support and flexible rota planning, will ensure readiness

Non Emergency Patient Transport (HTG - North, Mid, South Essex)

	Core Winter Capacity	Additional Capacity	Extremist Capacity	Total
Capacity – Monday – Friday	1066	0	3 rd party if authorised by ICB	1066 + any 3 rd party if requested
Capacity – Saturday	550	0	3 rd party if authorised by the ICB	550 + any 3 rd party requested
Capacity – Sunday	196	0	3 rd party if authorised by the ICB	196 + any 3 rd party requested

Mortuary Service

OPERATIONNAL READINESS

Mortuary capacity plays a key role in maintaining operational resilience during the winter period, when seasonal illness, adverse weather and increased demand can place additional pressures on health and care services. To support the safe and effective management of mortuary services throughout the winter, the following arrangements are in place:

- Daily monitoring of mortuary occupancy levels, available fridge and freezer capacity, and workforce resilience across all sites.
- Timely escalation of capacity concerns through established operational and senior leadership governance routes.
- Prioritisation of post-mortem activity in line with available capacity and operational requirements.

SYSTEM INTEGRATION

To enhance mortuary resilience and maintain sufficient capacity during periods of increased demand, a range of contingency, mutual aid and escalation arrangements have been established:

- Cross-site workforce support arrangements are in place, including the temporary redeployment of staff across MSEFT sites where required. Mutual aid between mortuary sites will be coordinated in line with operational demand, available capacity and workforce availability.
- Additional Coroner cases may be accommodated by external providers, subject to agreement with the Coroner.
- Mortuary capacity pressures will be escalated promptly to the Essex ICB System Coordination Centre (SCC) to support system-wide situational awareness, coordination and, where necessary, engagement with Essex Resilience partners.

PATIENT FLOW, DISCHARGE & CAPACITY

To optimise available mortuary capacity and maintain service continuity throughout periods of sustained winter pressure, a number of operational arrangements have been established:

- Southend Hospital will serve as the primary receiving site for community deaths across Mid and South Essex.
- Mortuary capacity at Basildon and Broomfield Hospitals will be prioritised to support acute hospital demand and maintain operational flow within the acute sector.
- During periods of sustained pressure, capacity management requirements may take precedence over routine post-mortem activity to ensure the safe and effective operation of mortuary services.
- Where demand exceeds available capacity, escalation measures including activity prioritisation, mutual aid arrangements and off-site contingency provision will be implemented to maintain system resilience and continuity of service.

This approach will support the effective management of mortuary capacity across the system while ensuring services remain safe, responsive and operationally sustainable during periods of increased demand.

Mortuary Service

WORKFORCE

To ensure service continuity and support staff wellbeing during periods of increased seasonal demand, mortuary services will adopt a proactive and flexible workforce approach:

- Workforce resilience will be monitored throughout the winter period alongside mortuary capacity and activity levels.
- Staff sickness and absence may impact workforce resilience and reduce the ability to sustain extended operational activity.
- Cross-site workforce support arrangements are available, including the temporary redeployment of staff to Southend Hospital where community activity is concentrated.
- Workforce availability will be a key consideration in activity prioritisation and decisions relating to the use of off-site contingency storage.
- The provision of cross-site support may affect local resilience and the capacity to undertake routine post-mortem activity at individual sites.

DIGITAL & DATA

Robust digital infrastructure and data-driven decision-making are essential during the winter period. To support operational resilience and situational awareness, the following arrangements are in place:

- Data and trend analysis will be used to forecast demand, monitor occupancy levels and inform contingency and surge capacity planning.
- Mortuary reporting will align with wider NHS operational reporting arrangements to support oversight of patient flow, system pressures and discharge performance.
- Capacity, occupancy levels and workforce resilience will be monitored through established escalation processes and winter planning arrangements.
- A live overview of capacity across Basildon, Broomfield and Southend mortuary sites will be maintained to support operational decision-making.
- Emerging risks and constraints, including infrastructure or equipment will be identified and escalated promptly.

INFECTION PREVENTION CONTROL & VACCINATION

- Existing infection prevention and control procedures remain in place across mortuary services.
- Staff vaccination is managed through provider winter vaccination programmes.

Mortuary Service

INCREASE CAPACITY & CAPABILITY:
OPEL 4 CAPACITY, CAPABILITY & AUTHORISATION

In response to increasing demand and capacity pressures, cross-site workforce and capacity support arrangements will be implemented as required to maintain service resilience.

Essential hospital, forensic and Coroner-related activity will be prioritised in line with operational demand, while community deaths may be directed to Southend Hospital, where appropriate, to optimise available capacity across the system.

Coroner-appointed providers will be utilised where agreed and operationally necessary and contracted off-site contingency storage arrangements will be activated if local capacity thresholds are reached.

Any emerging or sustained capacity pressures will be escalated through established Operational, Tactical and senior leadership governance routes to support timely decision-making and coordinated system action.

INCREASE CAPACITY & CAPABILITY:
EXTREMIST

If capacity pressures continue to escalate, the Southend contingency body store will be utilised to its maximum safe operating capacity, subject to access arrangements and workforce availability.

Formal off-site contingency storage arrangements will be activated to provide additional surge capacity, and further support from external providers will be sought where operationally necessary and agreed with the Coroner.

To preserve essential capacity and maintain service continuity, routine post-mortem activity may be reduced or temporarily suspended, with priority given to capacity management and critical operational activity.

System-wide mutual aid arrangements will be coordinated as required, with senior-level authorisation sought for the implementation of escalation measures and additional contingency actions.

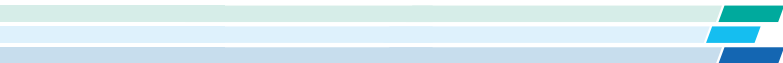
WINTER PLAN RISKS IDENTIFIED & MITIGATIONS

Risk: Broomfield Hospital reduced storage capacity and no freezer provision available
Mitigation: Includes equipment repair or replacement programmes, completion of Pluto compliance works, redirection of activity where appropriate, and access to external storage arrangements.

Risk: Southend Hospital faces increased demand and workforce pressures as the primary receiving site for community deaths across Mid and South Essex
Mitigation: Includes cross-site workforce support, activity prioritisation and the utilisation of external providers where required.

Risk: Planned basement works at Southend Hospital may impact access to contingency storage areas
Mitigation: Includes close coordination with Estates teams and the availability of off-site contingency storage arrangements.

Risk: Sustained periods of increased winter mortality may place demand on mortuary capacity beyond normal operating level
Mitigation: Includes daily monitoring of capacity and activity, timely escalation of emerging pressures, and the activation of formal contingency storage arrangements when required.

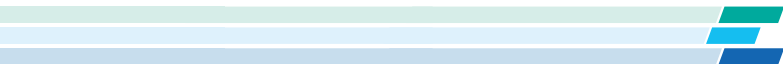


Mortuary Service

Location	Core Winter Capacity	Additional Capacity	Extremist Capacity	Total
Colchester Hospital	98 12 bariatric 9 freezer bariatric	84 12 fridge bariatric	0	215
MSEFT: Basildon Hospital	110	0	100 fridge 10 freezer	220
MSEFT: Broomfield Hospital	65	0	100 fridge 10 freezer	175
MSEFT: Southend Hospital	195	63 basement contingency spaces	0	258
Princess Alexandra Hospital	147 2 bariatric 6 Deep freezer	15 extra spaces at contractual funeral directors	0	170
Total	644	174	220	1038

Thank you

For more information, please contact:
Samantha Goldberg
Executive Director of Commissioning
samantha.goldberg@nhs.net



To: • All NHS trust:

- chairs
- chief executives
- chief operating officers
- medical directors
- chief nurses

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

17 July 2026

• ICB:

- chairs
- chief executives
- chief operating officers
- medical directors
- chief nurses

- Primary care networks
- Local government chief executives
- Directors of Adult Social Services
- Directors of Public Health

cc. • Regional:

- directors
- chief operating officers
- medical directors
- chief nurses
- directors of commissioning
- chairs

Dear colleagues

Winter planning 2026/27 – expectations and assurance

Last winter was the best in 3 years for 4-hour performance and ambulance response times, despite an early flu season, a January norovirus peak and industrial action. That was the result of early planning and strong collaboration across health and care, for which we thank you. This letter sets out the national approach to winter 2026/27 and the actions we need every part of the NHS and local government to take, starting now.

Every local area must have a robust, clinically led and deliverable winter plan. The core expectations are:

- draft winter plans completed by the end of August, developed jointly by all local partners: acute, ambulance, community, mental health, primary care, local authorities, social care and the third sector
- a named Executive Winter Lead in every ICB and provider, accountable for preparedness and response
- plans tested at the NHS England regional stress test exercises in September
- plans signed off by boards using the attached Board Assurance Statements (BAS), submitted to england.eecpmo@nhs.net by 30 September 2026

Responsibilities for winter reflect the new operating model set out in the Model ICB and Model Region Blueprints: ICBs commission, providers deliver, and regions oversee. The BAS templates set out in full what boards will be asked to assure; use them now to shape your plans rather than as a retrospective checklist. In summary:

ICBs

ICBs are responsible for the winter plan for their area, agreed with all partners and signed off by their board. Plans must be built on a whole-area demand and capacity analysis with robust planning assumptions, tested against surge and extreme surge scenarios. As strategic commissioners, ICBs must lead prevention now – vaccination uptake (particularly maximising uptake in children to help reduce spread), and proactive support for people most at risk from winter viruses and cold weather – and commission the right level of activity for winter so that people are treated closer to home wherever possible. That means sufficient commissioned capacity across:

- primary care: same day urgent appointments, enhanced access, NHS 111 direct booking, community pharmacy and out-of-hours provision including during holidays and over Christmas, alongside delivery of the seasonal vaccination campaigns
- community services: urgent community response, virtual wards and Hospital at Home, with senior clinical decision-making accessible through a single point of access at least 12 hours a day, 7 days a week
- mental health: resilient all-age crisis services, including urgent mental health helplines via NHS 111, crisis alternatives and liaison psychiatry, with crisis plans in place ahead of winter for high-risk patients and frequent attenders
- social care and intermediate care: commissioned jointly with local authorities, with discharge planned together, sufficient capacity through winter and agreed plans to reduce hospital occupancy ahead of Christmas
- infection prevention and control (IPC): commissioning safe IPC practice in care homes and the wider care sector

ICBs must also co-ordinate the winter response day-to-day through their co-ordination centre, operating 7 days a week and using the OPEL framework, with tested escalation, surge and mutual aid arrangements agreed by all partners.

NHS trusts and foundation trusts

Providers are accountable for operational delivery through winter. Trusts must:

- complete an organisational winter plan by the end of August, with staff flu vaccination programmes ready to launch and preparatory actions under way now
- implement the [Model Emergency Department](#), [Model Acute Pathway](#) and [Model discharge pathway](#) requirements ahead of winter, with the elimination of corridor care

treated as a patient safety priority, while maintaining elective capacity throughout the winter period

- assure tested arrangements for escalation, infection prevention and control, on-call leadership and staff welfare, and protect delivery of agreed 2026/27 trajectories

Ambulance services

- Plan to deliver the 2026/27 Category 2 response time trajectory, maximising hear and treat, see and treat and referral into alternatives to ED, to reduce conveyance rates.
- Work with acute partners to deliver 15-minute handovers, with none exceeding the 45-minute maximum.

Regional teams

In line with the Model Region Blueprint, regional teams will oversee winter preparedness and performance across providers and ICBs, arrange the September stress test exercises, assure plans across their geographies and co-ordinate mutual aid across ICB boundaries where needed, including specialised services and pathways commissioned outside of ICB arrangements.

Support available

We will share performance data to support planning by the end of July via NHS Futures, run online sessions in July on improving vaccination uptake, and publish further guidance on Urgent Community Response and community beds shortly. We will continue to work with ICBs and providers to support communication on 111, Pharmacy First, vaccination, and alternatives to ED.

Thank you for everything you and your teams are doing to prepare. Early, collaborative planning delivered a better winter for patients last year; together we can do so again.

Yours sincerely

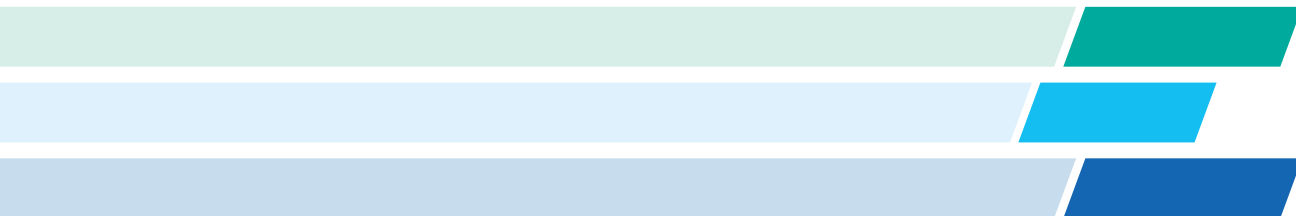


Sarah-Jane Marsh CBE

NHS England Chief Operating Officer

Strategic Assurance Framework Report

15 October 2026



4. Financially and clinically sustainable services across Essex which are safe and high quality

Risk Narrative:

Datix Risk Ref:
165, 167, 168, 169, 178, 182,
183, 184, 188, 190, 197, 198,
199, 200, 201, 226, 228

Risk Owner/Lead:

Jennifer Kearton, Executive Director of Finance and Commercial
Dr Giles Thorpe, Executive Chief Nursing Officer

PHIP Deliverables and RAG Status:

Develop Neighbourhood Health service model ● MC▶
Community Services Review & Perinatal services quality review ● HC / ● MC▶
Development of Estates strategy ● HC▶
Approach to commissioning Integrated Urgent Care ● HC▶
Reduce unwarranted variation in delivery and cost of AACC services ● MC▶
Data driven, value-based approach to commissioning decisions ● MC▶

**Current Risk Score:
(impact x likelihood)**

Target Score

Risk Appetite Category

**Directorate:
Board Committee:**

**Overall Assurance Level:
Trend:
Risk Appetite Position:**

4 x 4 = 16 (Red) ●▶S

4 x 3 = 12 (Amber)

**Financial: 4 (Seek)
Quality: 4 (Seek)**

Assessment:

● M
●▶S
Outside Appetite

**Finance / Nursing
Commissioning, Quality and Resource
Committee**

Alert (Strategic issues or external factors)

- Remaining risks to the financial position, sit across All Age Continuing Health Care and specific areas of Mental Health spend. Plans are in place to mitigate and remediate.
- Expected imminently National Quality of Care Dashboard for all providers, data driven and metric focused which will provide indicators for ICB oversight in Quality & Safety.

Advise (Gaps in control or assurance)

- Productivity opportunities and benchmarking required continued focus.
- Service review activities may lead to unknown quality risks being surfaced leading to enhanced scrutiny and reputational impact as well as public confidence in services.
- Ability of the system to mobilise the requirements of new quality strategy and framework, in addition to national directives for service change

Assure (Controls and Assurance)

- Delivery of financial accounts, clean audit offers positive assurance on financial controls.
- All key contracts agreed for 2026/27.
- Successful transition of strengthened governance of contract management into Board sub-committees across Essex providers with Quality oversight (27/28)
- PHIP Quality enabling plan meeting agreed delivery timescales.

Celebrate (Controls and Assurance)

- Establishment of Executive Resource Review meetings, include finance and contracts.
- Local Quality Requirements agreed across all providers through Contract Variation aligned to Quality Account priorities.
- Estates engagement and leadership in recent Neighbourhood Health Centre submission

Leading Indicators	Target	RAG	Assurance
Delivery of the financial plan Quality and Safety Delivery of PHIP transformation benefits Workforce sustainability / vacancy rate Service sustainability – provider and service resilience	Financial Balance In development Pending evaluations 0 TBC	● HC▶ ● MC▲ ● MC▶ ● MC▲ ● LC▶	Moderate assurance is provided through established financial governance, quality oversight and structured transformation programmes. Long-term sustainability remains dependent on successful delivery of productivity improvements, service redesign and workforce stabilisation. Meeting Pack Page 196

Essex ICB Part I Board Meeting

15 October 2026

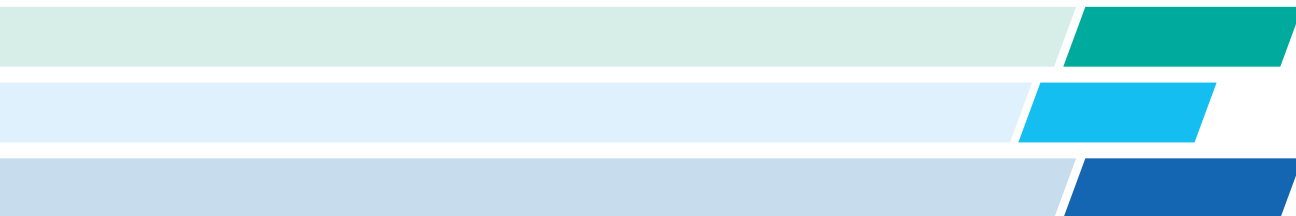
Agenda Item No:	14																		
Report Title:	Commissioning, Quality and Resource Report																		
Purpose of Report: 'Check' (x) relevant box(es).	<table style="width: 100%; border: none;"> <tr> <td>Approval</td><td>☐</td> <td>Endorsement</td><td>☐</td> <td>Discussion</td><td>☐</td> </tr> <tr> <td>Alert</td><td>☐</td> <td>Advise</td><td>☐</td> <td>Assure</td><td>☒</td> </tr> <tr> <td>Celebrate</td><td>☐</td> <td colspan="4"></td> </tr> </table> Assurance Rating: ● M	Approval	☐	Endorsement	☐	Discussion	☐	Alert	☐	Advise	☐	Assure	☒	Celebrate	☐				
Approval	☐	Endorsement	☐	Discussion	☐														
Alert	☐	Advise	☐	Assure	☒														
Celebrate	☐																		
Confidentiality Status:	General – no additional protection																		
Executive Director Sponsor:	Jennifer Kearton – Executive Director of Finance and Commercial Natalie Hammond – Interim Chief Nursing Officer Sam Goldberg – Executive Director of Commissioning																		
Report Author / Presenter:	As above																		
Previously considered by:	Commissioning, Quality and Resource Committee 6 October 2026																		
Subject of Report:	This report provides the Board with an overview of the Commissioning, Quality and Resource position across Essex ICB and the principal matters considered by the Commissioning, Quality and Resource Committee (CQRC). The ICB continues to forecast delivery of its breakeven financial plan, with identified mitigations supporting management of residual financial risks. Contracting and procurement programmes are progressing as planned, with no significant issues requiring escalation and all NHS contracts agreed. Capital and estates programmes remain on track, including progression of neighbourhood health estates priorities and the active management of Section 106 funding opportunities. Quality oversight continues through established governance arrangements, with particular focus on provider regulatory concerns, quality improvement actions and implementation of national requirements arising from the Thirlwall Inquiry. No matters require escalation to the Board, and the CQRC is satisfied that appropriate assurance arrangements remain in place.																		
Recommendations:	The Board/Committee is asked to: - Note the assurances provided within the report regarding commissioning, quality and resource performance. - Note the areas requiring continued monitoring and oversight.																		
Strategic Objectives: 'Check' (x) relevant box(es).	<table style="width: 100%; border: none;"> <tr> <td>1. Health inequalities narrowing year on year</td> <td style="text-align: right;">☐</td> </tr> <tr> <td colspan="2">2. A decisive shift towards neighbourhood care delivery</td> </tr> </table>	1. Health inequalities narrowing year on year	☐	2. A decisive shift towards neighbourhood care delivery															
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	and prevention ☐ 3. Timely access and excellent outcomes across services ☒ 4. Financially and clinically sustainable services across Essex which are safe and high quality ☒ 5. An organisation that is up to the job, good to work for and good to partner with ☐
Impact Assessments (IA):	QEHIA ☐ DPIA/DTAC ☐ Sustainability ☐ Primary care ☐ Not Applicable ☒
Financial Implications:	There are no direct financial implications arising from this report. The report provides an overview of ICB financial management.
Details of patient or public engagement or consultation:	Engagement is not required; this is an assurance report.
Conflicts of Interest:	None identified
Related risks / new risks:	The CQRC has reviewed the principal risks associated with commissioning, quality and resource delivery. Areas requiring ongoing oversight include financial pressures within Continuing Healthcare and mental health services, provider quality and regulatory concerns, and risks associated with the delivery of key transformation, contracting and capital programmes. Whilst these risks remain under active management, the Committee is satisfied that appropriate mitigations, governance arrangements and escalation processes are in place, and no additional matters require escalation to the Board at this time.
Internal Engagement:	Finance ☒ Procurement ☒ Contracting ☒ Quality ☐ IG Team ☐ Delivery Unit ☐ Governance ☐ Comms ☐ Clinical ☐

Commissioning, Quality and Resource Committee.

Executive Director Report to the Board

October 15th, 2026



Sam Goldberg	– Executive Director of Commissioning
Natalie Hammond	– Interim Executive Director of Nursing
Jen Kearton	– Executive Director of Finance and Commercial

1. Introduction

The following report presents a summary of the Commissioning, Quality and Resource position across Essex ICB, providing a position against revenue, capital and contracting plans for the 2026/27 financial year. As well as an overview of the system quality position and any national escalations.

The dashboard for the National Oversight Framework, is currently being developed and will be presented to the Commissioning, Quality and Resource Committee and the Board in quarter 3.

Escalations from the CQRC Chair

Mark Bailham (*Non-Executive Member*)

There are no escalations from the Chair at Month 5.

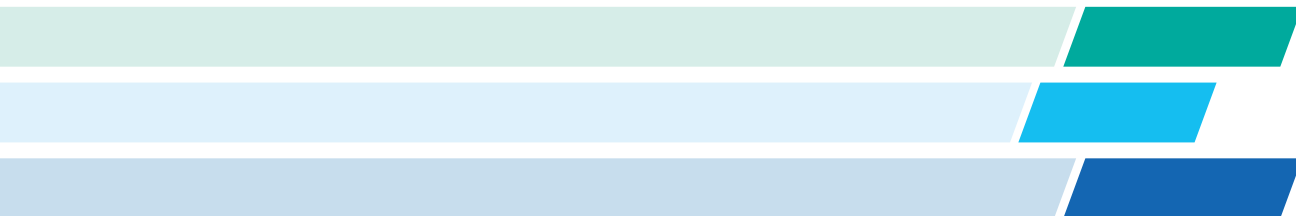
Following endorsement by the CQRC, it was recommended that the Board approve the Joint Capital Resource Use Plan and the Strategic Commissioning and Decision-Making Framework.

1a. Recommendation

The Board are asked to:

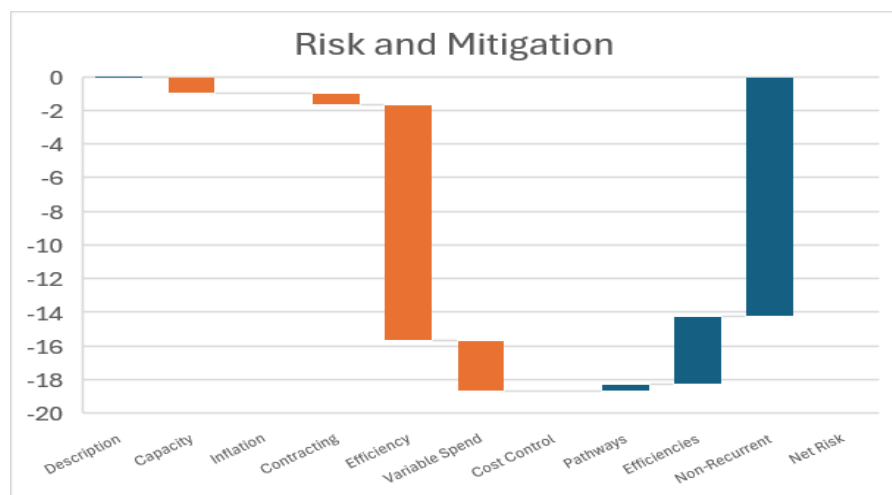
- *Note the assurances provided within the report regarding commissioning, quality and resource performance,*
- *Note the areas requiring continued monitoring and oversight.*

CQR Update – Finance and Activity Month 5



2. Key Financials and Activity

Summary financial position	Month 5			Forecast outturn		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Acute	1,049.7	1,047.9	1.8	2,548.2	2,547.0	1.2
Mental Health	197.1	201.5	(4.4)	472.0	477.2	(5.2)
Community Health Services	163.7	164.0	(0.3)	392.3	392.9	(0.6)
Continuing Care	110.5	113.0	(2.4)	265.2	269.7	(4.5)
Primary Care Including Delegated	440.3	440.6	(0.3)	1,056.7	1,057.4	(0.7)
Other	34.1	29.2	4.9	81.8	72.7	9.1
Specialised Commissioning	228.3	228.3	0.0	542.0	542.0	(0.0)
Corporate	13.0	12.2	0.8	31.3	30.5	0.8
Total	2,236.8	2,236.8	0.0	5,389.5	5,389.5	(0.0)



Net Risk	£m
Plan position	(14)
Current Month	0

Movement	£m
Trend	14

Overall position

The ICB has an agreed breakeven plan and continues to forecast delivery of this position to the year-end. Notable areas of variance are Continuing Health Care, which we anticipate will be a financial pressure throughout the year due to volume and price increases. The ICB is involved in the national pilot reviews and has established an uplift panel to support grip and control in this area.

Mental Health Out-of-area placement demand remains sustained and above planned levels, while demand for Attention Deficit Hyperactivity Disorder (ADHD) and autism assessments continues to significantly exceed available capacity. The ICB is working with system partners to complete demand and capacity modelling, alongside evaluating the impact of Time to Care investment, to support delivery of the mental health strategy and reduce reliance on out-of-area placements. In parallel, the ICB is implementing the national ADHD tariff to improve value for money, strengthening provider accountability for delivery against agreed activity plans, and developing a sustainable Essex-wide ADHD service to improve access and reduce waiting times.

Risk and Mitigations

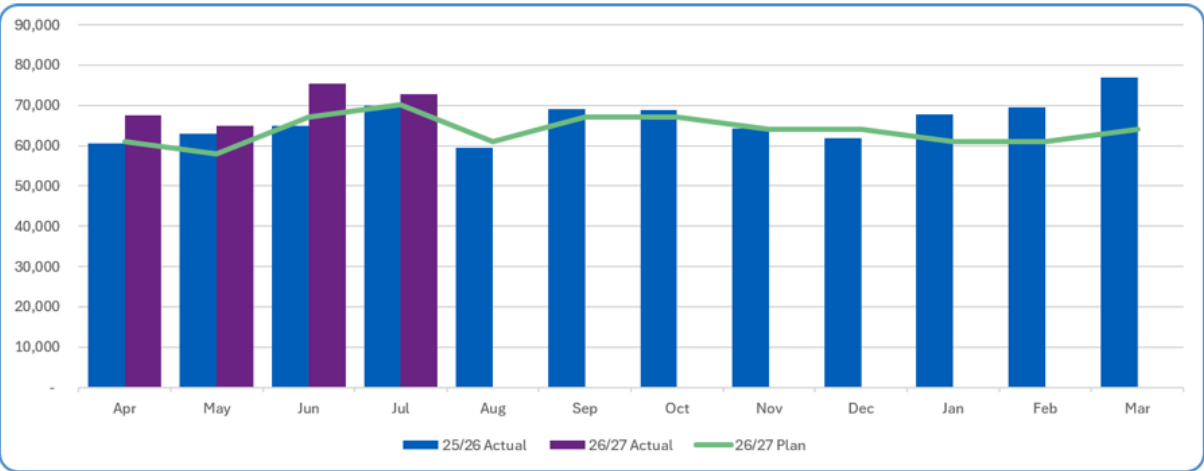
At planning stage, the ICB had an unmitigated risk position of £14m. As we approach Q3, whilst we still have some risk, we have identified mitigation to support the continued delivery of the breakeven plan. An increasing number of contracts have been agreed and signed and the level of risk associated with transition is reducing.

Efficiencies Delivery

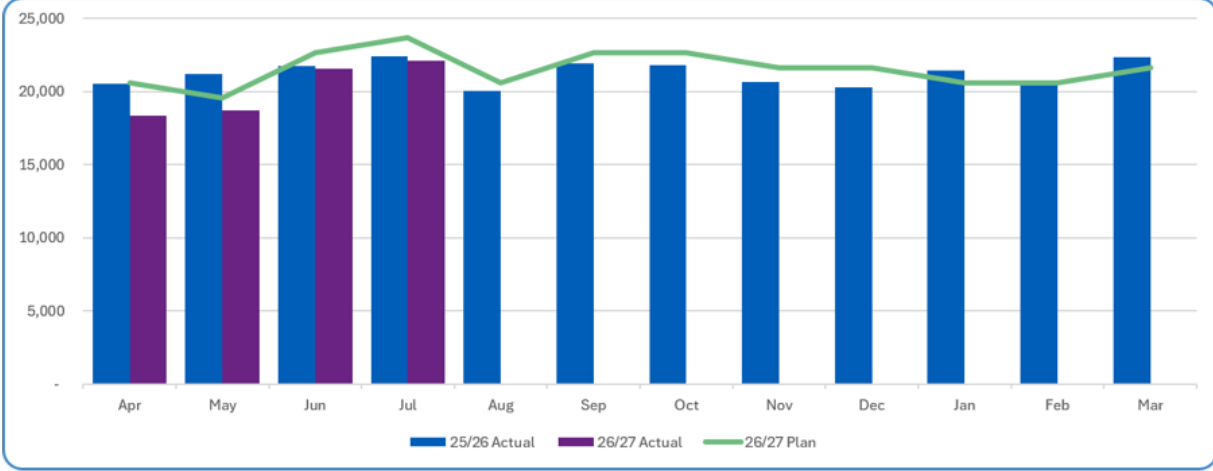
The total efficiency challenge includes the tariff adjustment. At planning stage, there was an unidentified gap of £27m. Budget adjustments have reduced this by £11 million, leaving a remaining gap of £16 million, which is included within the risk position. Work continues to close this gap and avoid using mitigations that could limit the ICB's ability to invest in 2026/27.

Planned Care Activity - All

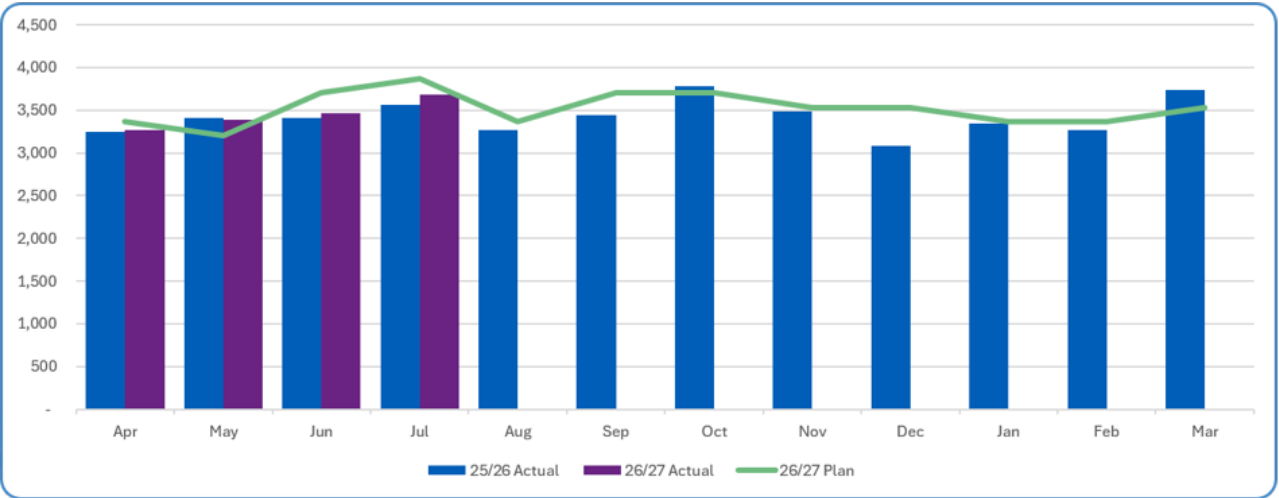
Outpatients



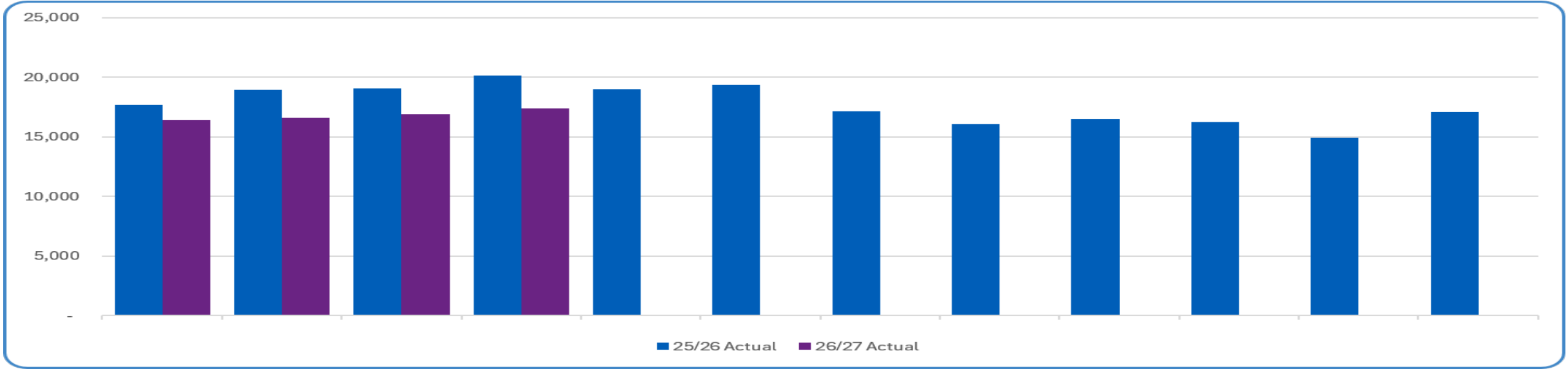
Day cases



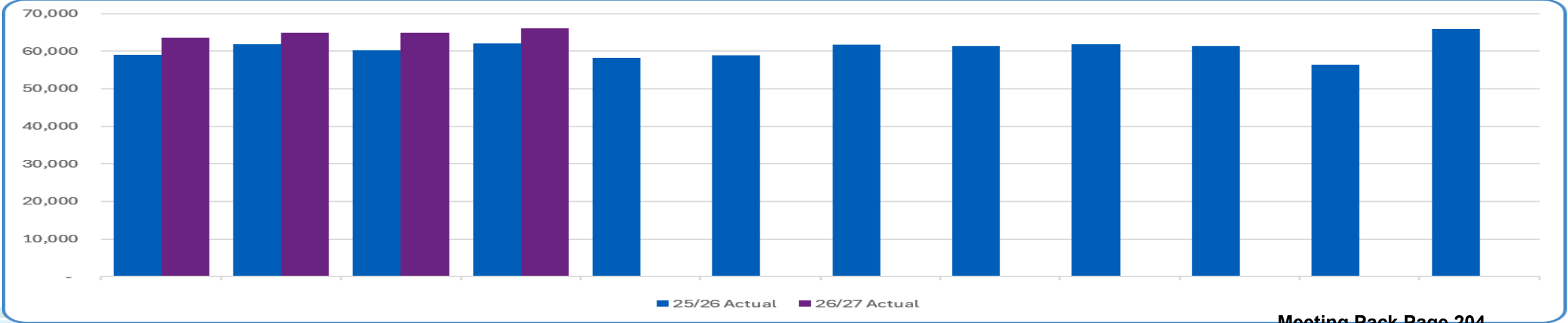
Elective



Non - Elective



A&E Attendances



3. Contracting and Procurement

Procurement Progress

Status	No.
Live	32
Go Live Q1	-
Go Live Q2	-
Go Live Q3	10
Go Live Q4	8
Projects on hold	1
Under review	0
Under Escalation	0

Accreditation status	Number
Requests rec'd Q1 (to date)	4
In progress Q1	6

Procurement plan on track

All procurements progressing as expected or without significant delay.

The procurement progress position is taken on 21 September 2026.

The main procurement activity across the start of the quarter related to Talking Therapies, Adult Autism Spectrum Disorder (ASD)/ADHD, Enteral Feeds, General Medical Services (GMS), Work Well Services and Digital . Other Projects included Integrated Urgent Care and Orthodontics.

Pre-procurement pipeline preparatory work is also being planned for, as several larger potential procurements are in the pipeline for the next 18 months.

A large volume of acute contracts were also agreed in this quarter, prompting a higher volume of [Direct] DAP A awards than seen in previous quarters.
No concerns or issues to escalate.

2026/27 Contract Progress

Awards	No.
Dap A	30
Dap B	2
Dap C	4
PA23	0
Competitive	0
MSPs	0
Framework call offs	1
Urgent Awards	8

Awards cont.	Number
Waivers	9
Status (NHS)	Number
Agreed	35
Signed	10
Escalation	0
Arbitration	0

The 2026/27 contracting programme is progressing as expected, with all contract values agreed and no contracts currently in escalation or arbitration. Whilst only ten contracts have been formally signed to date, the remaining agreements are progressing through final execution. Delays are primarily associated with associate contracts where Essex ICB is reliant on host commissioners to provide signatory details and complete documentation.

This has affected 20 contracts but does not currently present a material risk to contract delivery. Contract award activity has remained high during the quarter, reflecting a significant volume of procurement and commissioning activity across the system, with no issues requiring escalation.

4. Capital and Estates

Strategic Capital and Estates Programme

Projects

Essex ICB capital allocation is held by NHS England as three separate allocations.

- £3.60m Operational (Business As Usual (BAU)) Capital
- £6.00m ICB Strategic Capital
- £1.75m Utilisation & Modernisation Fund (UMF)

Further capital allocations received for Additional Roles Reimbursement (ARRS) General Practice IT (GPIT) (£428k) and MHLDA Crisis Accommodation (£160k) - both fully committed

S106 Progress Update

Focused remains on maximising S106 opportunities, particularly where funding expiry dates are approaching. Drawdown plans are progressing in several areas and funding requests have been submitted for a number of developments.

Neighbourhood Health Estates Progress

Prioritisation of the ICBs preferred sites for Neighbourhood Health Centres requiring national funding support has been completed, the ICB is awaiting confirmation from NHS England to proceed.

Project	Status	Go Live Q	Plan Value £k	Forecast £k	On Track
Shoebury HC	Feasibility	3	3,003	3,003	Yes
Laindon HC	Feasibility	3	3,003	3,003	Yes
GPIT Replacement	In Progress	1	1,879	1,879	Yes
BAU Capital	Various	Various	1,879	1,879	Yes
UMF	Various	Various	1,750	1,750	Yes

Status	Current Qtr	Previous Qtr
Projects in Train		
- EOI	3	3
- PID In Development	12	13
- PID Approved	2	1
- Business Case	1	1
- In Construction	0	0
Under Review	0	1
On Hold	1	0
Under Escalation	0	0
Future Years	28	29

5. Quality Overview – National Update/ System Quality Group Escalations

National Quality Board/Department of Health and Social Care/NHS England

1. The Thirlwall Inquiry Report has been published and includes actions for providers and ICBs. Organisations are required to review and provide assurance regarding their safeguarding, governance and whistleblowing arrangements to ensure alignment with NHS England requirements. An update on the work being undertaken across Essex is provided within the Chief Executive's report.
2. NHS England is seeking assurance that robust controls are in place to prevent inappropriate access to patient records and that organisations have effective processes for identifying and responding to data access incidents.
3. In addition, regional oversight continues regarding the completion of historic cancer harm reviews at provider organisations, with assurance being sought that any review backlogs are addressed and that appropriate governance arrangements are in place to monitor progress.

System Quality Group – Update

1. There were no escalations from the System Quality Group during the reporting period.
2. A forward programme of work has now been agreed through to May 2027, providing a structured approach to system quality oversight and identifying areas for future deep-dive reviews. This represents a continuation of work following the re-establishment of the System Quality Group.
3. The next deep-dive review will focus on assurance relating to Venous Thromboembolism (VTE). The review will consider learning arising from incidents and will provide an overview of system performance, learning, governance arrangements and opportunities for improvement across Essex.

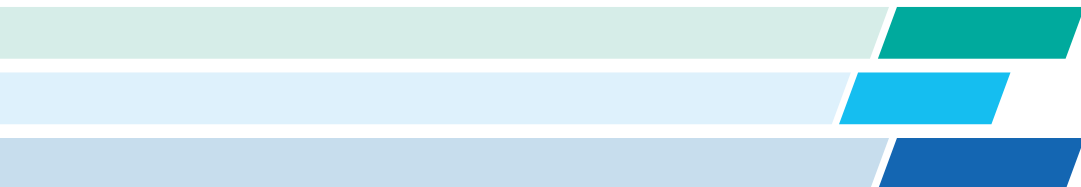
System Quality Position– Quarter 2 (to date) (1 of 2)

NHS Provider Position	
Mid and South Essex NHS Foundation Trust • Remain in NOF 4 • Incident Management Team's (IMT) in place relating to ongoing incidents • Radiology rejection letters • Maternity antenatal screening • Paraprotein • ASI drop off • RTT recovery and data quality • Section 29a in place for Basildon & Broomfield Children & Young People (CYP) • Section 31 in place for Basildon Urgent Emergency Care and Broomfield maternity • CQC rated inadequate overall • Potential number of CQC intention to prosecute notices currently under review • GMC conditions in place for anaesthetics at Basildon	Essex Partnership University NHS Foundation Trust • Increase of inpatient deaths- action plan requested to assure patient safety governance is in place • Section 29a in place for Ipswich Road • NOF 3 • CQC overall rating requires improvement
The Princess Alexandra Hospital NHS Trust • CQC rated requires improvement overall (July 2026) • Medical Care – Good (July 2026) • Surgery – Requires improvement (July 2026) • Urgent and emergency services – Requires improvement (July 2026) • NOF 4 • External review to commence relating to neonatal incidents • Review of potential incidents relating to: • Dermatology Urgent Suspected Cancer pathway • Ophthalmology	East Suffolk and North Essex NHS Foundation Trust (Colchester) • Section 29a remains in place for elderly medicine and UEC • NOF 3 • CQC overall rating requires improvement

System Quality Position– Quarter 2 (to date) (2 of 2)

Collaborative/Primary Care/Independent Sector	
General Practice • 2 practices in West Essex have CQC regulation breach notices • 15 practices across Essex have CQC rating Requires Improvement	Community Optometry • Nil to report
Community Dentistry • 1 dental provider in North East Essex is currently not meeting regulations for CQC domains 'safe' and 'well-led'	Independent Sector Providers/Other • Ramsay Healthcare – CQC inspection in July 2026, reported in August as good overall. • Provide CiC- incident relating to the transfer of CYP patients data to a RTC provider for ADHD assessments • EEAST- unannounced CQC inspection in July 2026, awaiting formal report. • Cora Health - multiple delays in post-op care pathways being escalated by several providers • HTG - 4 satellite bases noted to not be CQC registered (2 of which are in Essex)
Community Collaborative • Nil to report	Risks on Datix 1. Acute Provider -CQC rated Inadequate 2. Acute Provider– sepsis mortality and deteriorating patients concerns 3. Community – concerns with wound care services across Essex 4. Transport provider – concerns from multiple providers regarding cancelled and delaying services 5. Acute provider– CQC section 29a for Medical Care and Urgent and Emergency Care 6. Independent Provider– regional concerns / reputational damage 7. Mental Health regulatory concerns by CQC

Thank you



Reporting route:	Commissioning, Quality and Resource Committee (CQRC) – Meeting held on 6 October 2026 reporting to the ICB Board.
Executive and Committee/Group Sponsor:	Sam Goldberg, Executive Director of Commissioning Natalie Hammond, Acting Chief Nursing Officer Jen Kearton, Executive Director of Finance and Commercial Chair of CQRC – Mark Bailham, Non-Executive Member
Report Author:	Emma Seabrook, Business Manager
Confidentiality and Conflicts of Interest:	There are no confidentiality concerns or conflicts of interest to note.
PHIP Delivery / Risk:	Sustainable Hospital Services - Planned Care Sustainable Hospital Services - Unplanned Care and Flow Mental Health and Neurodiversity - Adult Mental Health Services Complex Care Planned surplus or deficit Variation to plan year-to-date (YTD) Implied productivity growth
Agenda items covered	• Joint Capital Resource Use Plan • Executive Director Report • Update from the Mid-Year Review Meeting on 25 September 2026 • Planning approach 2027/28 • Risk Assurance Report • Updates from Sub-Committees: Capital & Estates Group, Essex Medicines Commissioning Group and System Quality Group • Prevention of Future Deaths • Strategic Commissioning and Decision-Making Framework

	Key discussion points and matters to be escalated from the meeting:
Alert: Matters that need the Boards attention or action	The Essex Joint Capital Resource Use Plan sets out how NHS Essex ICB and its partner providers will invest capital funding in 2026/27. Following endorsement by the Commissioning Quality and Resource Committee, it was recommended that the Board approve the Joint Capital Resource Use Plan for 2026/27.
Advise: Matters the Board should be aware of	The Committee received the Executive Director's Report, providing updates on Commissioning, Quality and Resources. While noting good progress since the last meeting, the Committee recognised that as it was Month 5 it was too early to fully assess performance data, and that the reporting pack would continue to develop as further information became available.
Assure: Positive assurance	The level of risk reduced in Month 5 following agreement of the NHS contracts and an improved understanding of the position inherited from the predecessor ICBs, including greater clarity on the remaining knowledge gaps.
Celebrate Success:	• Successful Essex-wide launch of the Medicines Optimisation Local Enhanced Service prescribing optimisation programme, with all Primary Care Networks engaged and key implementation milestones achieved. • Strong progress in workforce development, with Essex achieving the highest engagement levels in the East of England Clinical Supervision Project. • Continued formulary harmonisation across Essex, supporting greater consistency in prescribing and medicines management. • Positioning Essex as an early adopter of the Single National Formulary, enabling the system to influence national implementation and reduce variation in prescribing
Actions required:	N/A
Date of next meeting:	5 January 2027

Essex ICB Part I Board Meeting

15 October 2026

Agenda Item No:	15
Report Title:	Joint Capital Resource Use Plan 2026/27
Purpose of Report: 'Check' (x) relevant box(es).	Approval ☒ Endorsement ☐ Discussion ☐ Alert ☐ Advise ☐ Assure ☐ Celebrate ☐ Assurance Rating: Not rated – approval of a plan
Confidentiality Status:	General – no additional protection
Executive Director Sponsor:	Jennifer Kearton, Executive Director of Finance and Commercial
Report Author:	Ashley King, Director of Capital and Estates
Previously considered by:	System Investment Group Estates & Capital Group Commissioning, Quality and Resource Committee (CQRC)
Subject of Report:	This paper presents the Joint Capital Resource Use Plan for 2026/27, which sets out how the ICB and its system partner NHS trusts will use available capital resources in line with final financial plans, system priorities and agreed capital governance arrangements. The Plan supports the statutory duty under the National Health Service Act 2006, as amended by the Health and Care Act 2022, to prepare and publish a joint plan for capital resource use. The Joint Capital Resource Use Plan is presented to the ICB Board for approval.
Recommendations:	The Board is asked to approve the Joint Capital Resource Use Plan for 2026/27.
Strategic Objectives: 'Check' (x) relevant box(es).	1. Health inequalities narrowing year on year ☒ 2. A decisive shift towards neighbourhood care delivery and prevention ☒ 3. Timely access and excellent outcomes across services ☒ 4. Financially and clinically sustainable services across Essex which are safe and high quality ☒ 5. An organisation that is up to the job, good to work for and good to partner with ☒
Impact Assessments (IA):	QEHIIA ☐ DPIA/DTAC ☐ Sustainability ☐ Primary care ☐ Not Applicable ☒ No separate impact assessment is required for approval of the plan. Individual schemes will be subject to the appropriate assessments through the relevant business case and governance processes.

Financial Implications:	The plan sets out the system’s planned capital resource use for 2026/27. Approval of the plan does not create expenditure beyond confirmed capital allocations; individual schemes remain subject to affordability, prioritisation, business-case approval and approval through the relevant delegated governance.																		
Details of patient or public engagement or consultation:	No specific patient or public consultation has been undertaken in relation to the approval of this annual plan. Engagement on individual schemes will be undertaken where required through as part of the relevant development and approval processes.																		
Conflicts of Interest:	None identified.																		
Related risks / new risks:	Key risks relate to affordability within confirmed capital limits; changes to national or system funding assumptions; inflationary and other cost pressures; scheme slippage; and delivery capacity. These are managed through organisational capital prioritisation, business-case controls, routine financial monitoring and escalation through the relevant governance arrangements.																		
Internal Engagement:	<table><tr><td>Finance</td><td>☒</td><td>Procurement</td><td>☐</td><td>Contracting</td><td>☐</td></tr><tr><td>Quality</td><td>☒</td><td>IG Team</td><td>☐</td><td>Delivery Unit</td><td>☐</td></tr><tr><td>Governance</td><td>☒</td><td>Comms</td><td>☐</td><td>Clinical</td><td>☐</td></tr></table>	Finance	☒	Procurement	☐	Contracting	☐	Quality	☒	IG Team	☐	Delivery Unit	☐	Governance	☒	Comms	☐	Clinical	☐
Finance	☒	Procurement	☐	Contracting	☐														
Quality	☒	IG Team	☐	Delivery Unit	☐														
Governance	☒	Comms	☐	Clinical	☐														

Joint Capital Resource Use Plan 2026/27

1. Context and Purpose

NHS England requires Integrated Care Boards (ICBs) and their partner NHS Trusts and Foundation Trusts to jointly prepare and publish an annual Joint Capital Resource Use Plan (JCRUP). This requirement is set out within the National Health Service Act 2006, as amended by the Health and Care Act 2022. The JCRUP must describe how capital resources will be used across the system and demonstrate alignment with agreed strategic, operational and financial priorities.

The Essex JCRUP has been developed collaboratively by the ICB and NHS Essex system planning partner organisations. It reflects the outcomes of system capital-planning discussions and sets out the collective approach to prioritising and managing capital investment within available resources during 2026/27. The plan supports delivery of key system objectives, including maintaining safe and compliant infrastructure, addressing estate risks, improving productivity, enabling service transformation and supporting the shift towards more integrated models of care.

NHS England's latest guidance states that JCRUPs should demonstrate alignment with annual capital plans, longer-term strategic planning arrangements and integrated care system infrastructure priorities. The plan has been prepared in accordance with this guidance and reflects the agreed position across partner organisations.

Ref	PHIP Deliverable	Delivery Rating
	Capital investment supports delivery across a range of PHIP deliverables.	● MC

2. Key Issues and Assurance Summary

Alert	None identified.
Advise	Each partner organisation is responsible for monitoring its individual capital schemes, with system-level progress reported through agreed capital governance arrangements.
Assure	Capital monitoring is undertaken within individual organisations, and forms part of regular reporting to NHS England. The JCRUP has been developed in partnership with system partners. Progress against the plan is reported to the System Investment Group and monitored by the Estates and Capital Group.
Celebrate	None identified.

3. Assessment / Analysis

The attached JCRUP provides the Essex system's agreed statement of planned capital resource utilisation for 2026/27. It has been developed jointly with NHS Essex system planning partners and aligns with NHS England's statutory and planning requirements. East Suffolk and North East Essex NHS Foundation Trust and North East London NHS Foundation Trust are not included in this JCRUP because they are not defined as Essex system partners for capital-planning purposes. Their capital plans should instead be included in JCRUPs for their respective planning systems.

Following approval, the JCRUP will be shared with NHS England and published by the ICB.

4. Associated Risks

Individual organisations are responsible for identifying and managing risks relating to their capital allocations, and programmes.

The ICB is currently monitoring its capital risk through Datix, Risk 240: insufficient capital funding for the primary care estate and future neighbourhood estate may require available resources to be prioritised, thereby reducing the ICB's ability to invest in new opportunities and deliver transformational improvements.

5. Financial Implications

There are no direct financial implications identified within the report, with the JCRUP reconciling to the initial planning position of each organisation. Each programme will have direct financial implications that will be considered through the appropriate organisation's governance routes.

6. Recommendations

The Board is asked to approve the Joint Capital Resource Use Plan for 2026/27.

7. Appendices

Appendix A – Joint Capital Resource Use Plan

Joint capital resource use plan 2026/27 template

Integrated care boards (ICBs) can use this non-mandated template to present their information in their published plans.

Region	East of England				
ICB	NHS Essex ICB				
Date published					
Version control	V0.11				
Version	Date issued: 22/07/26	Who/Comment	Updated by Mike Shimmon	Sign off	Approvals
Introduction					
NHS Essex Integrated Care Board (ICB) became the commissioning organisation for the Essex geography from 1 April 2026 and is responsible for planning and commissioning NHS services for approximately 2 million residents across Essex. The ICB works in partnership with NHS providers, local authorities, primary care, voluntary sector organisations and wider system partners to improve population health, reduce health inequalities and deliver sustainable health and care services. Essex is one of the largest Integrated Care Systems in England, covering a diverse geography that includes large urban centres, coastal communities and significant rural populations. The population is growing and ageing, with increasing demand for healthcare services driven by long-term conditions, deprivation, workforce pressures and health inequalities. The providers covered by this Joint Capital Resource Use Plan are: • Mid and South Essex NHS Foundation Trust (MSEFT) • Essex Partnership University NHS Foundation Trust (EPUT) • The Princess Alexandra Hospital NHS Trust (PAH) Whilst East Suffolk and North Essex NHS Foundation Trust (ESNEFT) and North East London NHS Foundation Trust (NELFT) are both named Partners Members they are not					

included within the JCRUP as they are not classified as Essex NHS system partners for capital planning purposes, in accordance with NHS England requirements.

The Joint Capital Resource Use Plan (JCRUP) has been developed in partnership with these organisations and aligns with:

- NHS England Joint Capital Resource Use Plan Guidance 2026/27
- NHS Medium-Term Planning Framework: Delivering Change Together
- NHS 10-Year Health Plan
- Essex Population Health Improvement Plan (PHIP) 2026-2031

The Essex capital programme supports the three national shifts set out within the NHS 10-Year Health Plan:

- Hospital to community
- Analogue to digital
- Treatment to prevention

Capital investment is therefore focused on:

- Delivering neighbourhood health infrastructure
- Expanding diagnostic and elective capacity
- Supporting digital transformation
- Addressing estate safety and backlog maintenance risks
- Improving primary care accommodation
- Supporting mental health transformation
- Delivering environmentally sustainable healthcare infrastructure

The Essex system has established a capital investment group to oversee the prioritisation, planning and delivery of capital investment across the system.



Executive Summary

The Essex Joint Capital Resource Use Plan sets out how NHS Essex ICB and its partner providers will utilise approximately £145.1 million of capital resources during 2026/27.

The programme has been developed within the available Capital Departmental Expenditure Limit (CDEL) and balances statutory safety requirements, critical infrastructure investment, service transformation and long-term sustainability.

Key priorities during 2026/27 include:

- Expansion of Community Diagnostic Centre capacity
- Delivery of the Nova Electronic Patient Record (EPR) programme

- Development of neighbourhood health infrastructure
- Primary care estate modernisation
- Mental health infrastructure development
- Estate safety and backlog maintenance programmes
- Replacement of critical medical equipment
- Digital transformation initiatives

The capital programme supports delivery of the Essex Population Health Improvement Plan and the NHS Medium-Term Planning Framework through a coordinated system-wide approach to investment.

Alignment with the Essex Population Health Improvement Plan

The Joint Capital Resource Use Plan is a key enabling component of the Essex Population Health Improvement Plan.

PHIP Priority	Capital Investment Response
Neighbourhood Health	Primary care developments, Utilisation and Modernisation Fund Schemes, integrated neighbourhood infrastructure
Live Well	Diagnostic capacity, prevention-focused primary care improvements
Feel Well	Mental health estate improvements and digital investment
Age Well	Community Infrastructure and neighbourhood services.
Respond Well	Community Diagnostic Centre developments, urgent care and Elective recovery schemes
Digital Transformation	Nova EPR, General Practice Information Technology (GPIT) and digital infrastructure

This investment programme supports the planned shift towards community-based care, reducing reliance on hospital-based services while improving access, productivity and patient outcomes.

A key focus of the 2026/27 programme is enabling the development of neighbourhood health models across Essex. Capital investment in primary care infrastructure, community-

based diagnostics, mental health facilities and neighbourhood health centre development will support the transition towards more integrated, preventative and community-based care.

Specific priorities across Essex are listed below:

Essex Integrated Care Board

Essex ICB received three Capital allocations in 2026/27 and over the next four years.

The allocations are

1. **Operational (Business as Usual (BAU)) Capital:** For use on primary care investments, including GPIT and premises improvement and ICB capital requirements, as well as IFRS16 leases.
2. **ICB Strategic Capital:** 5% funding shift from provider capital to ICBs not ringfenced and can be transferred back to providers. Intended to enable local hospital-to-community and demand-management initiatives consistent with the 10-Year Health Plan.
3. **Utilisation & Modernisation Fund (UMF):** National Primary Care programme anticipated to fund renovation and repurposing of existing estates to increase primary care capacity.

Table 1

Essex ICB Capital Allocations	2026/27 £'000	2027/28 £'000	2028/29 £'000	2029/30 £'000	Total £'000
Business as Usual	3,758	3,760	3,761	3,761	15,040
Strategic	6,006	6,273	6,396	6,517	25,192
Utilisation & Modernisation Fund (<i>indicative</i>)	1,750	1,750	1,750	1,750	7,000
Annual Total	11,514	11,783	11,907	12,028	

Mid and South Essex Foundation Trust (MSE FT)

MSE FT has a 2026/27 CDEL limit of £86.9m comprising local operational capital, national programme capital, PFI lifecycle expenditure and donated funds, including £250k of lease remeasurement funding.

The programme is dominated by three strategic priorities:

- Pitsea Community Diagnostic Centre
- Nova Electronic Patient Record
- Southend Day Surgery Unit

Remaining funding supports critical medical equipment replacement, digital refresh programmes and estate maintenance requirements.

The trust is actively working with NHSE regarding additional capital funding to help tackle significant backlog and infrastructure risks across its sites.

Princess Alexandra Hospital NHS Trust (PAH)

PAH has a 2026/27 capital programme of £24.3m focused on:

- Community Diagnostic Centre expansion
- De-risking of estate and medical equipment
- Urgent & Emergency Care reconfiguration
- Digital transformation

The programme supports improved diagnostic capacity, productivity and patient flow.

Essex Partnership University NHS foundation Trust (EPUT)

EPUT has a 2026/27 capital programme of £24.1m supporting:

- Electronic Patient Record deployment
- Mental health transformation
- Community and neighbourhood healthcare infrastructure
- Estate safety improvements

The programme supports delivery of neighbourhood health services and improved mental health outcomes.

Private Finance Initiative and Long-Term Estate Commitments

The Essex health system continues to manage several legacy Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) arrangements which remain important components of the estate portfolio.

Scheme	Organisation
Broomfield Hospital	MSEFT
Broomfield Accommodation	MSEFT
Braintree Community Hospital	MSEFT
Brockfield House	EPUT

EMI House - Rawreth Court and Clifton Lodge	EPUT
Brentwood Community Hospital	NHS Property Services (NHSPS)
St Margaret's Hospital	NHSPS
North Road PCC	Community Health Partnerships (CHP)
Valkyrie PCC	CHP
Canvey PCC	CHP
Fryatt Hospital	CHP
Turner Road PCC	CHP
The annual revenue consequences of these arrangements continue to be reflected within organisational financial plans.	

Alignment with the NHS Medium-Term Planning Framework – Delivering Change Together

This Joint Capital Resource Plan has been developed in line with the principles and objectives of NHS England's **Medium-Term Planning Framework – Delivering Change Together (2026/27–2028/29)**, which sets out a three-year approach to improving NHS performance, productivity, financial sustainability and long-term transformation. The Essex capital programme directly supports the ambitions of the framework by:

- Improving access to care through expansion of capacity and modernisation of facilities.
- Reducing waiting times through investment in elective, diagnostic and cancer infrastructure.
- Delivering productivity improvements through technology, digital transformation and estate optimisation.
- Supporting the shift from hospital-based care towards neighbourhood and community-based models of care.
- Improving financial sustainability through targeted, prioritised and value-for-money investment decisions.
- Creating modern, resilient and sustainable healthcare infrastructure capable of supporting future service transformation.
- Through a co-ordinated approach to capital planning, NHS Essex ICB and its partner organisations will maximise the benefit derived from available capital resources, ensuring that investment decisions support improved outcomes for

patients, reduced inequalities, enhanced productivity and the long-term sustainability of health and care services across Essex.

2026/27 CDEL allocations and sources of funding

Below are details of the overall CDEL funding allocations that the ICB and partner trusts are managing as part of their capital expenditure (all figures are in £000's). The table excludes the Utilisation & Modernisation Fund which remained indicative at point of final plan submission.

CDEL	ICB	EPUT	MSE FT	PAH	Total full year plan £'000
Operational Capital – ICB	9,764	0	0	0	9,764
Operational Capital – Provider	0	15,354	42,895	15,665	73,914
Total Operational Capital	9,764	15,354	42,895	15,665	83,678
<i>National Programme Spend:</i>					
Estates safety	0	2,473	3,817	4,006	10,296
NHP	0	0	0	1,560	1,560
National Programme sub total	0	2,473	3,817	5,566	11,856
<i>Constitutional Standards:</i>					
Diagnostics	0	0	15,668	1,600	17,268
Elective recovery	0	0	11,000	0	11,000
MH Digital	0	350	0	0	350
MH Neighbourhood Centres	0	3,000	0	0	3,000
Community	0	2,816	270	0	3,086
UEC	0	0	9,700	1,500	11,200
Constitutional Standards sub-Total	0	6,166	36,638	3,100	45,904
Residual Interest PFI	0	120	3,535	0	3,655
Total CDEL	9,764	24,113	86,885	24,331	145,093

Capital prioritisation

Capital resources across Essex have been prioritised in line with organisational and national programme requirements intended to maximise value from the available operational capital allocation.

The prioritisation considers:

Statutory Compliance and Patient Safety

Schemes required to maintain compliance with statutory requirements, eliminate critical infrastructure risks and address patient safety concerns.

Nationally Mandated Programmes

Nationally funded schemes linked to diagnostics, elective recovery, mental health, community transformation and digital programmes.

Critical Infrastructure and Backlog Maintenance

Investment addressing high and significant backlog maintenance liabilities and maintaining operational resilience.

Digital Transformation

Schemes supporting productivity improvements, Electronic Patient Records, cyber resilience and digital maturity.

Neighbourhood Health and Prevention

Schemes supporting primary care expansion, neighbourhood health models and population health improvement.

Service Transformation and Growth

Schemes supporting capacity expansion, service redesign and future sustainability.

Capital planning

The Essex 2026/27 capital programme has been developed to balance statutory compliance, patient safety, service transformation, productivity improvement and delivery of the Population Health Improvement Plan. Investment priorities reflect both national requirements and local strategic needs and have been developed through a collaborative prioritisation process where appropriate.

Estate Backlog Maintenance

The Essex NHS estate contains a range of backlog maintenance liabilities across acute, community and mental health facilities.

The capital programme prioritises investment in high and significant risk backlog items to ensure patient safety, operational continuity and compliance with statutory obligations.

Consequently, investment has been targeted towards high and significant-risk backlog and critical infrastructure items using a risk-based prioritisation methodology.

Overview of ongoing scheme progression

Pitsea Community Diagnostic Centre (MSE FT)

Capital Value: 26/27: £19.7m, 27/28: £4.7m

Delivery Period: 2025–2027

Purpose: Development of a major community diagnostic centre increasing access to CT, MRI, ultrasound, X-ray, phlebotomy and endoscopy services closer to patients' homes.

Strategic Contribution:

- Supports neighbourhood health models.
- Supports earlier diagnosis.
- Reduces pressure on acute hospital sites.
- Supports elective recovery.

Nova EPR (MSE FT)

Capital Value: 26/27: £11.4m, 27/28: £26.3m, 28/29: £1.6m

Delivery Period: 2027/28

Purpose: Unified EPR scheme in partnership with EPUT.

Strategic Contribution:

- Integrated care – creation of a single patient record across hospitals, mental health and community services.
- Improves patient safety and quality
- Supports neighbourhood and community-based care.
- Enables population health management.

Southend Day Surgery Unit (DSU – MSE FT)

Capital Value: 26/27: £11m, 27/28: £7.5m subject to national approval

Delivery Period: 2027/28

Purpose: Reprovision of two-day surgery theatres and an additional enhanced procedure room.

Strategic Contribution:

- Additional planned surgical capacity
- Elective recovery
- Productivity
- Neighbourhood based care

Nova EPR (EPUT)

Capital Value: 26/27: £6.5m, 27/28: £11m

Delivery Period: 2027/28

Purpose: Unified EPR scheme in partnership with EPUT.

Strategic Contribution:

- Integrated care – creation of a single patient record across hospitals, mental health and community services.
- Improves patient safety and quality
- Supports neighbourhood and community-based care.
- Enables population health management.

MH ED (EPUT)

Capital Value: Planned 26/27 spend £1.5m, £3.9m spent in 25/26

Delivery Period: 2026/27 (completion expected Sept 2026)

Purpose: Support new pathways for our Mental Health patients

Strategic Contribution:

- Creation of two Mental Health Urgent Care Centres, one in North Essex (Kingswood Centre) and one in West Essex (Derwent Centre), increasing diagnostic capacity and supporting earlier detection. The centres will improve access to crisis assessment for patients and support improved performance against Emergency Department (ED) constitutional standards.

Community Diagnostic Centre Phase 2 (PAH)

Capital Value: £5.7m total value, £1.1m spent in 25/26

Delivery Period: 2026/27 (completion expected Dec 2026)

Purpose: New build extension to diagnostic centre.

Strategic Contribution:

- Shift of diagnostics to community with overall increase in both diagnostic capacity and capability, assisting early detection and providing care in a more accessible and pleasant setting.

EPR Phase 2 (PAH)

Capital Value: £4.6m total value, £2.9m spent in 25/26

Delivery Period: 2026/27 (completion expected Mar 2027)

Purpose: Expansion of EPR functionality including build of clinical pathways

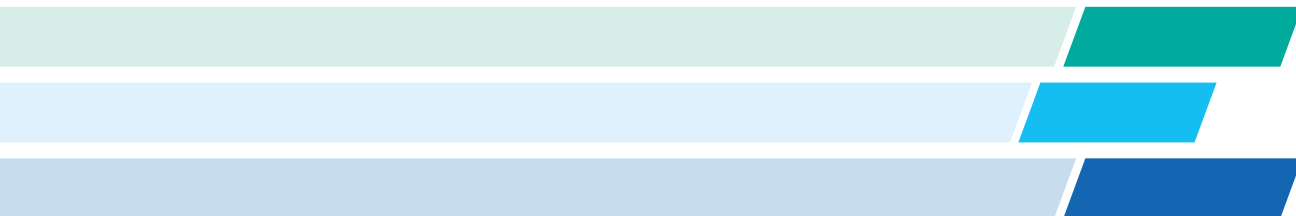
Strategic Contribution:

- Building on EPR system; expanding clinical functionality, increasing automation, enhancing interoperability, and further digitising clinical and operational workflows across the Trust.

The Essex capital programme represents a balanced portfolio of statutory, operational and transformational investment. Collectively, these schemes will improve resilience of the NHS estate, support workforce productivity, expand community services and create the infrastructure required to deliver future models of care.

Strategic Assurance Framework Report

15 October 2026



5. An organisation that is up to the job, good to work for and good to partner with

Risk Narrative: Datix Risk Ref: 157, 159, 160, 161, 171, 172, 173, 174, 176, 177, 178, 182, 229		There is a risk that NHS Essex is not sufficiently capable, resilient and well-connected to deliver its strategic objectives and fulfil its role within the Essex health and care system. This is caused by limitations in organisational capacity, capability, leadership, culture, governance, partnership maturity and organisational development. This could lead to ineffective commissioning, reduced ability to influence system outcomes, failure to deliver the PHIP and corporate objectives, loss of stakeholder confidence, and failure to meet statutory duties.		Current Risk Score: (impact x likelihood) Target Score Risk Appetite Category		4 x 3 = 12 (Amber) ▼ D 4 x 2 = 8 (Amber) People: 5 (Significant) Regulatory: 3 (Open) Reputational: 5 (Significant)	
Risk Owner/Lead:		Michael Watson, Executive Director of Corporate Services		Directorate: Board Committee:		Corporate Services Executive Committee / Audit, Risk and Compliance Committee	
PHIP Deliverables and RAG Status:		Develop approaches to wellbeing, engagement and flexible working ● HC► Implement the NHS Equality, Diversity, and Inclusion strategy ● MC► Development and delivery of Culture & Leadership Programme ● HC► Ensure clear and robust governance arrangements are in place ● HC► Standardised approach to prioritisation and evaluation ● MC► Views and needs of Essex residents are at the heart of the ICBs work ● HC▲		Overall Assurance Level: Trend: Risk Appetite Position:		Assessment: ● M / ● H ● ► S Outside Appetite	
Alert (Strategic issues or external factors)		Advise (Gaps in control or assurance)		Assure (Controls and Assurance)		Celebrate (Controls and Assurance)	
- Need to continue to assess whether the structures during the change process provide sufficient resource in key areas, and whether the organisations workforce has the right skills and capabilities to deliver its objectives. - Whilst progress has been made on establishing the ICBs internal Population Health Management (PHM) and Business Intelligence (BI) function (see assure), challenges remain in establishing a single data architecture across the Essex system.		- Organisational Development plan includes objectives focused on building leadership capacity and skills, and wider strategic commissioning skills in the organisation. - Continued uncertainty about the ICBs role in relation to digital and workforce, generated by uncertainty about the NHS operating model in those areas.		- Evidence of stronger partnership with VCSFE sector (development of convenor model, closer working relationships at senior level with the sector. - ICB partnership with Healthwatch agreed. - Significant progress on Essex digital strategy and agreed system digital governance. Essex ICB Chief Clinical Information Officer appointed. - PHM/BI team should shortly reach full establishment and will be reporting on ICB progress against the National Oversight Framework and PHIP by end of October.		- Values for the organisation agreed. - Received substantive assurance on internal audit of governance arrangements. - Revised delivery arrangements in place. - Vacancies/staff turnover now reaching ‘BAU’ levels.	
Leading Indicators				RAG		Assurance	
Organisational Capability Governance and Accountability effectiveness measures Maturity of commissioning, programme and transformation capability Staff Survey / engagement score Vacancy and turnover rates Public awareness and stakeholder confidence				● MC▲ ● HC ● MC ● HC ● HC ● HC		Moderate to High Assurance is provided through strengthening governance arrangements, improved delivery oversight, workforce stabilisation, stronger partnership working and increased organisational maturity since April. The reduction in the principal risk score reflects greater confidence in organisational capability and resilience. Further work is required to build strategic commissioning capability, embed a single data architecture, and respond to NHS reform. The objective of the position, and the overall trend is improving, but continued focus is required before High Assurance can be concluded.	

Essex ICB Part I Board Meeting

15 October 2026

Agenda Item No:	17
Report Title:	Audit, Risk and Compliance Committee Summary and Escalation Report
Purpose of Report: 'Check' (x) relevant box(es).	Approval ☐ Endorsement ☐ Discussion ☐ Alert ☒ Advise ☒ Assure ☒ Celebrate ☒ Assurance Rating: ● HC
Confidentiality Status:	General – no additional protection
Executive Director Sponsor:	Michael Watson, Executive Director of Corporate Services.
Report Author / Presenter:	Jane King, Assistant Governance Manager
Previously considered by:	Audit, Risk and Compliance Committee.
Subject of Report:	The report provides a summary of key discussions and assurances from the Audit, Risk and Compliance Committee meeting held on 8 September 2026. The Committee considered matters relating to governance, risk management, assurance reporting, health and safety, emergency preparedness, sustainability, information governance, internal audit, counter fraud, procurement and financial governance.
Recommendations:	The Board/Committee is asked to receive the Audit, Risk and Compliance Committee Summary and Escalations Report for assurance.
Strategic Objectives: 'Check' (x) relevant box(es).	1. Health inequalities narrowing year on year ☐ 2. A decisive shift towards neighbourhood care delivery and prevention ☐ 3. Timely access and excellent outcomes across services ☐ 4. Financially and clinically sustainable services across Essex which are safe and high quality ☐ 5. An organisation that is up to the job, good to work for and good to partner with ☒
Impact Assessments (IA):	QEHIA ☐ DPIA/DTAC ☐ Sustainability ☐ Primary care ☐ Not Applicable ☒ This report provides assurance and escalation from the Audit, Risk and Compliance Committee and does not require an impact assessment to be undertaken.

Financial Implications:	Not Applicable. This report provides assurance and escalation from the Audit, Risk and Compliance Committee and does not propose any decisions or service changes or financial commitments.																		
Details of patient or public engagement or consultation:	Not Applicable. This report provides assurance and escalation from the Audit, Risk and Compliance Committee and does not propose any matters requiring patient or public engagement.																		
Conflicts of Interest:	None Identified.																		
Related risks / new risks:	No new risks requiring addition to the Strategic Assurance Framework or Risk Register were escalated by the Committee																		
Internal Engagement:	<table><tr><td>Finance</td><td>☒</td><td>Procurement</td><td>☒</td><td>Contracting</td><td>☐</td></tr><tr><td>Quality</td><td>☒</td><td>IG Team</td><td>☒</td><td>Delivery Unit</td><td>☐</td></tr><tr><td>Governance</td><td>☒</td><td>Comms</td><td>☐</td><td>Clinical</td><td>☐</td></tr></table>	Finance	☒	Procurement	☒	Contracting	☐	Quality	☒	IG Team	☒	Delivery Unit	☐	Governance	☒	Comms	☐	Clinical	☐
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Governance	☒	Comms	☐	Clinical	☐														

Reporting route:	Audit, Risk and Compliance Committee (ARCC) on 8 September 2026, reporting to the Board.
Executive and Committee/Group Sponsor:	Executive Sponsor – Michael Watson, Executive Director of Corporate Services. Chair – Rex Smith, Non-Executive Member.
Report Author:	Jane King, Assistant Governance Manager.
Confidentiality and Conflicts of Interest:	No conflicts of interest or confidentiality concerns to be noted.
PHIP Delivery / Risk:	The ARCC has oversight responsibility for the governance and control frameworks to enable PHIP delivery.

Agenda items covered:	Assurance, Risk, Governance & Compliance Strategic risk and assurance reporting; governance effectiveness; policy oversight; emergency preparedness and resilience; health and safety; sustainability; committee effectiveness; workforce compliance and risk training; information governance; quality and statutory compliance; internal audit; and counter fraud and security matters. Finance Financial governance, including losses and special payments, procurement and contract oversight, waivers, and external audit updates.
Key discussion points and matters to be escalated from the meeting:	
Alert: Matters that need the Boards attention or action	The Committee identified no formal matters for escalation to the Board. Financial sustainability, health and safety compliance, information governance and mandatory learning remained areas requiring continued management attention. Several strategic risks remain outside appetite, and six internal audit actions remain outstanding, including four moderate-priority actions.
Advise: Matters the Board should be aware of	Governance, risk management and Strategic Assurance Framework arrangements continued to mature, with further work required to strengthen risk scoring, mitigation, trend analysis and

	reporting. The Board should also remain aware of legislative uncertainty arising from the Health Bill 2026–27, development of the Green Plan, progress with cyber and AI governance. Ongoing quality risks include Infection Prevention and Control (IPC) outbreak management, safeguarding workforce resilience and Special Educational Needs and Disabilities (SEND) statutory compliance. The Committee also noted increasing Information Governance workload pressures associated with complex information requests.
Assure: Positive assurance	The Committee received positive assurance regarding governance, emergency preparedness, procurement and counter-fraud arrangements. Governance arrangements continue to operate effectively and received a substantial internal audit opinion, although further work is ongoing to embed assurance, performance and risk management arrangements. The Emergency Preparedness, Resilience and Response (EPRR) Core Standards achieved substantial compliance. No losses or special payments were reported, and the predecessor ICB external audit was completed within the required deadline.
Celebrate Success:	The Governance Team was commended for its progress in establishing the new Essex ICB governance framework, supported by improved assurance reporting templates and dashboards. Further positive developments included improved complaints closure activity, successful safeguarding recruitment, a green counter-fraud rating and the absence of urgent internal audit recommendations.
Actions required:	The following actions were noted within the ARCC minutes and action log: • Strengthen future EPRR reporting by clearly setting out areas of partial compliance, associated gaps, planned actions and target completion dates, and consider the inclusion of performance targets within the EPRR dashboard. • Enhance future Health and Safety dashboards by including target figures, explanations for rejected incidents and the actual number of incidents reported.
Date of next meeting:	8 December 2026

ICB Board Meeting (Part I)

15 October 2026

Agenda Item No:	18.1																		
Report Title:	Governance Changes Update Report																		
Purpose of Report: 'Check' (x) relevant box(es).	<table><tr><td>Approval</td><td>☒</td><td>Endorsement</td><td>☐</td><td>Discussion</td><td>☐</td></tr><tr><td>Alert</td><td>☐</td><td>Advise</td><td>☐</td><td>Assure</td><td>☒</td></tr><tr><td>Celebrate</td><td>☐</td><td></td><td></td><td></td><td></td></tr></table> Assurance Rating: ● H	Approval	☒	Endorsement	☐	Discussion	☐	Alert	☐	Advise	☐	Assure	☒	Celebrate	☐				
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Alert	☐	Advise	☐	Assure	☒														
Celebrate	☐																		
Confidentiality Status:	General – no additional protection																		
Executive Director Sponsor:	Michael Watson – Executive Director of Corporate Services																		
Report Author / Presenter:	Nicola Adams – Associate Director of Governance																		
Previously considered by:	Executive Committee – 22 September 2026 Remuneration Committee – 24 September 2026																		
Subject of Report:	This report seeks Board approval for governance amendments arising from changes to Essex ICB’s executive leadership structure and updates to the Executive Committee’s operating arrangements. The changes establish separate Executive Director portfolios for Finance and for Commercial, Estates and Resilience, including the formal delegation of Executive Accountable Officer responsibility for EPRR. The key messages are: • The Scheme of Reservation and Delegation, Executive Committee Terms of Reference, Functions and Decision Map and associated governance documents require amendment to reflect the revised executive portfolios and accountabilities. • The Executive Committee Terms of Reference have also been updated to reflect its revised membership and meeting cadence, and the replacement of the Strategic Delivery Group with the Delivery Coordination and Risk Oversight Group. The detailed operating arrangements of this executive sub-group do not require Board approval. • The changes are intended to strengthen executive accountability, delivery coordination, risk oversight and the management of complex commissioning decisions. Transitional risks, including unclear accountabilities and the continued use of superseded delegations or role titles, will be managed through formal approval, clear implementation arrangements and a coordinated document-review programme.																		

Recommendations:	The Board/Committee is asked to: • Approve the amendments to the Scheme of Reservation and Delegation arising from changes to the Executive Team. • Approve the revised Executive Committee Terms of Reference. • Approve the consequential amendments required to the Functions and Decision Map and supporting governance documents. • Authorise the Chief Executive Officer and Associate Director of Governance to make consequential amendments to governance documents, policies and frameworks arising from these changes.									
Strategic Objectives: 'Check' (x) relevant box(es).	1. Health inequalities narrowing year on year ☐ 2. A decisive shift towards neighbourhood care delivery and prevention ☐ 3. Timely access and excellent outcomes across services ☐ 4. Financially and clinically sustainable services across Essex which are safe and high quality ☐ 5. An organisation that is up to the job, good to work for and good to partner with ☒									
Impact Assessments (IA):	QEHIIA ☐ DPIA/DTAC ☐ Sustainability ☐ Primary care ☐ Not Applicable ☒ <i>Changes reflect minor amendments to governance documents that do not require an impact assessment.</i>									
Financial Implications:	There are no financial implications arising from this paper.									
Details of patient or public engagement or consultation:	There is no requirement to for engagement arising from this paper. Relevant amended governance documents will be published when approved.									
Conflicts of Interest:	None identified.									
Related risks / new risks:										
Internal Engagement:	<table border="0"> <tr> <td>Finance ☐</td> <td>Procurement ☐</td> <td>Contracting ☐</td> </tr> <tr> <td>Quality ☐</td> <td>IG Team ☐</td> <td>Delivery Unit ☐</td> </tr> <tr> <td>Governance ☒</td> <td>Comms ☐</td> <td>Clinical ☐</td> </tr> </table>	Finance ☐	Procurement ☐	Contracting ☐	Quality ☐	IG Team ☐	Delivery Unit ☐	Governance ☒	Comms ☐	Clinical ☐
Finance ☐	Procurement ☐	Contracting ☐								
Quality ☐	IG Team ☐	Delivery Unit ☐								
Governance ☒	Comms ☐	Clinical ☐								

Governance changes update report

1. Context and Purpose

The purpose of this report is to seek Board approval for a series of governance amendments arising from changes to the executive leadership structure of Essex ICB.

The Remuneration Committee recently considered proposals regarding the future executive leadership arrangements for finance, commercial, estates and capital functions and supported the establishment of a dedicated Executive Director of Commercial role.

These changes require amendments to the ICB's governance framework, specifically the Scheme of Reservation and Delegation, Executive Committee Terms of Reference, Functions and Decision Map and associated governance documentation.

Furthermore, the Executive Committee Terms of Reference has also been updated to reflect its reporting cadence and changes to its sub-groups.

2. Key Issues and Assurance Summary

The Remuneration Committee considered proposed changes to the executive leadership arrangements for the ICB's finance, commercial, capital, estates and resilience functions at its meeting on 24 September 2026.

The changes respond to the scale and complexity of the work required across these portfolios, including the development of new approaches to payment and resource allocation, significant future procurement and re-procurement activity, provider market development, and the delivery of major capital and estates programmes.

It is proposed that the existing Executive Director of Finance and Commercial portfolio is divided into two distinct executive portfolios:

Executive Director of Finance

This portfolio will encompass the core financial activities of the ICB, with a particular focus on financial stewardship and the development and implementation of new approaches to resource allocation and payment mechanisms.

Executive Director of Commercial, Estates and Resilience

This portfolio will encompass the ICB's commercial, capital and estates activities and provide executive leadership for major projects in these areas. It will also provide an organisational focus for provider contract management, service planning and the alignment of commercial and capital activity with the ICB's commissioning priorities.

The EPRR function will transfer into the Commercial, Estates and Resilience portfolio, recognising the relationship between the resilience of commissioned health services and the ICB's contractual arrangements with providers. The Chief Executive Officer will formally delegate the Executive Accountable Officer responsibility for EPRR to the Executive Director of Commercial, Estates and Resilience. The Chief Executive will remain ultimately accountable for the ICB's discharge of its statutory responsibilities.

Both Executive Directors will be members of the Executive Committee. The revised Executive Committee Terms of Reference will therefore need to reflect the new membership and portfolio responsibilities.

The overall financial impact of the revised executive structure is expected to be cost neutral, taking account of the planned cessation of the Executive Director of Commissioning role at the end of March 2027.

Executive Committee Terms of Reference

The Executive Committee has reviewed its operating arrangements to ensure they remain aligned to the developing organisational model and support effective delivery of the ICB's strategic objectives. The proposed revisions clarify the membership of the Committee (see changes above), the cadence of the meeting and reflect changes to the Executive Committee sub-groups.

The revised Terms of Reference therefore reflect the replacement of the Strategic Delivery Group (SDG) with the Delivery Coordination and Risk Oversight Group (DCROG). Following a review of the effectiveness and purpose of the SDG, it was concluded that a more focused approach was required to strengthen organisational delivery coordination, programme oversight, prioritisation and risk management.

The Board is not being asked to approve the detailed operating arrangements of DCROG or its supporting groups. These sit within the delegated authority of the Executive Committee. However, members are asked to approve the revised Executive Committee Terms of Reference recognising DCROG as a key governance mechanism supporting delivery oversight and escalation arrangements.

To support this revised model, DCROG has established:

- a GRID process to coordinate communications, engagement, consultation planning and management of politically or publicly sensitive issues; and
- a Difficult Decisions and Disinvestment Sub-Group to support the consistent development and scrutiny of service review, decommissioning and disinvestment proposals in accordance with the Strategic Commissioning and Decision-Making Framework.

These changes are intended to strengthen organisational coordination, improve oversight of delivery risks and provide clearer routes for the escalation and management of complex commissioning and service-change decisions.

Consequential Governance Changes

The following consequential amendments to governance documentation are required:

- Amend the **Scheme of Reservation and Delegation** to replace the Executive Director of Finance and Commercial with the Executive Director of Finance and to introduce delegations for the Executive Director of Commercial, Estates and Resilience.
- Update the **Executive Committee Terms of Reference** to reflect the revised membership, meeting cadence and sub-groups.
- Amend the **Functions and Decision Map** to reflect the revised allocation of executive functions and reflect the changes to the Executive Committee sub-groups.
- Record the Chief Executive's formal delegation of the Executive Accountable Officer responsibility for EPRR.
- Update the **EPRR policy, framework and assurance arrangements** to reflect the revised executive leadership.
- Review financial, procurement, commercial, contracting, capital, estates and business continuity policies for outdated role titles or accountabilities.
- Update committee reporting arrangements, executive lead references, risk ownership records and relevant organisational charts.

Alert	There are no alerts associated with this paper.
Advise	There may be some organisational uncertainty while these changes are enacted.
Assure	The executive team continue to review management arrangements to support the delivery of ICB objectives.
Celebrate	The work of the outgoing Executive Director of Finance and Commercial both with Mid and South Essex ICB and Essex ICB.

3. Assessment / Analysis

Conclusion

The proposed changes strengthen executive leadership capacity, clarify accountability arrangements and ensure governance structures remain aligned to the organisation's operating model. Board approval is therefore sought for the proposed governance amendments and the associated programme of consequential document updates.

4. Associated Risks

The following risks have been considered as part of this change, with supporting mitigation shown below. These are considered transition arrangement risks and are therefore not recorded in Datix.

Risk	Mitigation
Ambiguity regarding executive accountabilities during transition	Approval of revised SoRD, Terms of Reference and supporting documentation
Decisions taken under superseded delegations	Changes implemented on a defined commencement date and communicated organisation-wide
Policies and procedures containing outdated role titles	Coordinated governance review and document refresh programme
EPRR accountability not clearly documented	Formal CEO delegation and update of EPRR governance documentation

5. Financial Implications

There are no financial implications relating to this paper.

6. Recommendations

The Board is asked to:

- Approve the amendments to the Scheme of Reservation and Delegation arising from changes to the Executive Team.
- Approve the revised Executive Committee Terms of Reference.
- Approve the consequential amendments required to the Functions and Decision Map and supporting governance documents.
- Authorise the Chief Executive Officer and Associate Director of Governance to make consequential amendments to governance documents, policies and frameworks arising from these changes.

7. Appendices

Appendix A – Executive Committee Terms of Reference

Other amended documents referred to above are available upon request.

Interpreting this report

Section	Definition
Assurance Assessment	Describes overall assurance level, the trend (movement from the previous meeting), and whether the risk is within or outside the Board risk appetite.
PHIP Deliverables	3-5 delivery programmes linked to the achievement of the objective (as outlined within PHIP and of the nine strategic priorities).
Alert	Action statements describing strategic issues requiring intervention / key threats to delivery of the objective.
Advise	Emerging risks or issues, dependencies or decisions that the Board should be aware of.
Assure	Evidence that controls, governance and delivery arrangements are working.
Celebrate	Notable achievements or milestones
Leading Indicators	3-5 metrics only to track delivery of the objective.
Assurance Narrative	A short paragraph describing the rationale for the assurance rating.

Delivery Rating	RAG	Definition	Typical Characteristics
High Confidence	 H	The objective is highly likely to be achieved within planned timescales and resources	Delivery milestones are on track; performance indicators are favourable; risks are controlled and within appetite; dependencies are being effectively managed
Moderate Confidence	 M	The objective remains achievable , but there are material risks, issues or dependencies that require active management	Some milestones are delayed or under pressure; performance is mixed; certain risks remain outside appetite; corrective actions are in place
Low Confidence	 L	Significant concerns exist regarding achievement of the objective and substantial intervention may be required	Multiple milestones are off track; performance is deteriorating; major risks or dependencies threaten delivery; existing mitigations may be insufficient
Very Low Confidence	 VL	The objective is unlikely to be achieved in its current form without fundamental change, additional resource, or Board intervention	Major delivery failure risk; significant programme slippage; key dependences unresolved; objectives, scope or timescales may need to be reconsidered

Assurance Level	RAG	Definition	Board Interpretation
High Assurance	 H	Strong evidence that the objective will be achieved . Risks are controlled and assurance sources are consistent	Board can be confident delivery is on track
Moderate Assurance	 M	Reasonable confidence , but some significant risks, gaps or dependencies require management attention	Objective remains deliverable but needs monitoring.
Limited Assurance	 L	Significant concerns regarding delivery, controls, performance or assurance	Board intervention or additional oversight may be required.
No Assurance	 N	Insufficient evidence to conclude the objective is likely to be achieved	Immediate action required

Executive Committee

Terms of Reference

Status:	The Committee is an executive committee of the Board.
Accountable to:	The ICB Board.
Purpose:	To provide oversight and assurance to the Board regarding operational management of the ICB and delivery of its strategic objectives, strategies and plans.
Membership:	Chief Executive Officer Executive Director of Finance and Commercial Executive Chief Nursing Officer Executive Medical Director Executive Director of Corporate Services Executive Director of Neighbourhood Health Executive Director of Strategy
Chair:	Chief Executive Officer
Vice Chair:	To be assigned as required
Attendees:	Chief of Staff Senior Business Manager
Frequency of Meetings:	Weekly meetings with Directorate presenting on a regular cycle. Due to the frequency and operational nature of meetings, they will not be minuted formally. However, a decision log will be maintained and decisions reported to the Board via the Chief Executives Report.
Quorum:	Three Members
Delegated Authority:	Financial approval limits between £500k - £15m (budgeted), <£5m (unbudgeted). £2.5m - £5m for capital investments.

	Approving on behalf of the ICB Board or endorsing new and/or significant amendments of policies and procedures within its remit.
Key Performance Indicators:	Delivery of the Population Health Improvement Plan Delivery of ICB Financial Plan Freedom to speak up referrals and outcomes Equality metrics (WRES, WDES, Pay Gap) Delivery of National Oversight Framework (where relevant to ICBs) Corporate Risk Register / Risk Position of the ICB
Intelligent Board Data / Reporting Requirements:	Directorate and Executive KPIs Equality Indicators Compliance data NOF Data
Sub Committees:	Delivery Coordination and Risk Oversight Group Senior Leadership Team Staff Partnership Forum ICB People Inclusion and Belonging Group

Responsibilities of Committee

The Executive Committee is accountable for the delivery of statutory, regulatory and constitutional duties and responsible for providing multi-professional leadership, scrutiny and strategic alignment to ensure the effective operation of the Integrated Care Board (ICB) and the delivery of its objectives. In discharging its delegated authority, the Committee will:

1. Strategic Leadership and Direction

- Establish, shape and oversee the strategic direction of the ICB, ensuring strategies and plans are developed for recommendation to and approval by the Board, including setting strategic commissioning intentions and the Population Health Improvement Plan.
- Provide operational oversight of ICB operations.
- Ensure consistent organisational messaging and alignment to strategic priorities, including the delivery of financial turnaround.

- Ensure the ICB fulfils its statutory requirement to engage with stakeholders and the public; to ensure that system collaboration is effective and that the patient voice is heard.
- Receive reports from Executives on the delivery of organisation objectives, including any escalations in relation to delivery.

2. Delivery Oversight

- Empower and enable staff to deliver programmes and projects that support the achievement of ICB objectives and its Population Health Improvement Programme and improve metrics aligned to National Oversight Framework.
- Provide collective stewardship and early oversight of financial, quality, operational and contractual performance prior to scrutiny by Board sub-committees.
- Oversee the delivery, governance and benefits realisation of major transformation and improvement programmes.

3. Organisational Development and Culture

- Ensure the ICB has a comprehensive and effective organisational development plan that supports capability, culture and change.
- Provide leadership for the ICB's equality, diversity, inclusion and belonging agenda, ensuring compliance with statutory requirements and promotion of an inclusive culture.
- Set expectations and model behaviours for effective matrix working across the organisation.

4. Governance, Assurance and Risk

- Maintain oversight of the corporate risk register, ensuring risks are regularly reviewed, updated and that mitigation actions are actively managed.
- Support the Board and its sub-committees to discharge their duties by providing clear, timely and accurate information, assurance and recommendations.
- Provide advice, guidance and decision-making support to the Senior Leadership Team

5. Financial Sustainability

- Support financial sustainability through robust decision-making within delegated authority as set out in the Scheme of Reservation and Delegation (SoRD).
- Ensure collective executive ownership of financial stewardship and the embedding of financial discipline across the ICB (in conjunction with the Commissioning, Quality and Resource Committee).

6. Regulatory and System Alignment

- Oversee the organisation's preparations for, and responses to, external regulatory reviews and inspections (e.g., NHS England, CQC).
- Ensure that executive decisions and organisational priorities support the delivery of statutory duties and NHS constitutional commitments.

7. Workforce, Digital and Resilience

- Oversee workforce planning and sustainability to ensure the ICB is equipped to meet its strategic ambitions.
- Provide strategic direction for digital transformation.

Document Control:

Version:	1.2
Status:	Draft
Approval:	
Review Date:	March 2027

Essex ICB Part I Board Meeting

15 October 2026

Agenda Item No:	18.2
Report Title:	Revised Policies
Purpose of Report: 'Check' (x) relevant box(es).	Approval ☐ Endorsement ☒ Discussion ☐ Alert ☐ Advise ☐ Assure ☒ Celebrate ☐ Assurance Rating: ● HC
Confidentiality Status:	General – no additional protection
Executive Director Sponsor:	Michael Watson, Executive Director of Corporate Services
Report Author / Presenter:	Helen Chasney, Governance and Risk Manager
Previously considered by:	Audit, Risk and Compliance Committee, 8 September 2026
Subject of Report:	The report advises the Essex ICB Board of recently revised policies approved through the ICB's governance framework, including the Management of Violence and Aggression Policy and the Strategic Commissioning and Decision-Making Framework. The Board is asked to note these policy updates and the assurance that they support the ICB's legal and organisational responsibilities.
Recommendations:	The Board/Committee is asked to: Note the revised policies set out within this report.
Strategic Objectives: 'Check' (x) relevant box(es).	1. Health inequalities narrowing year on year ☐ 2. A decisive shift towards neighbourhood care delivery and prevention ☐ 3. Timely access and excellent outcomes across services ☐ 4. Financially and clinically sustainable services across Essex which are safe and high quality ☐ 5. An organisation that is up to the job, good to work for and good to partner with ☒
Impact Assessments (IA):	QEHIIA ** ☐ DPIA/DTAC *** ☐ Sustainability ☐ Primary care ☐ Not Applicable ☒ Equality Impact Assessments were undertaken on policy revisions and are included as an appendix within each policy.
Financial Implications:	Not Applicable.

Details of patient or public engagement or consultation:	Not Applicable.					
Conflicts of Interest:	None Identified					
Related risks / new risks:	None.					
Internal Engagement****:	Finance	☐	Procurement	☐	Contracting	☐
	Quality	☐	IG Team	☐	Delivery Unit	☐
	Governance	☒	Comms	☐	Clinical	☐
	List any other teams consulted with					

Notes:

* Guidance on completing the assurance rating and what the assurance ratings mean is included at the end of this report.

** QEHIIA: Quality, Equality and Health Inequality Impact Assessment

*** DPIA/ DTAC: Data Protection and Privacy Impact Assessment / Data Technology Assessment Criteria

**** Commissioning decisions must attach the decision-making checklist and be approved by a finance business partner

Revised Policies

1. Context and Purpose

The purpose of this report is to update the Essex ICB Board on policies that have been revised and approved by sub-committees of the Board.

Since the last Part I Essex ICB Board meeting, the following policies were approved by relevant committees, as per the authority set out in their terms of reference.

Committee / date of approval	Policy Ref No and Name
Audit, Risk and Compliance Committee 9 September 2026	The committee approved the following revised policies: • C010 Management of Violence and Aggression Policy
Executive Committee 22 September 2026	The committee approved the following revised policies: • C007 Strategic Commissioning and Decision-Making Framework
Commissioning, Quality and Resource Committee 6 October 2026	The committee noted the following revised policies: • C007 Strategic Commissioning and Decision-Making Framework (subject to comments from Executive Committee)

2. Findings / Conclusion

The above policies ensure that the ICB accords to legal requirements and has a structured method for discharging its responsibilities. The approved policies will be published on the ICB's website or intranet.

3. Recommendations

The Board/Committee is asked to:

- Note the revised policies set out within this report.

4. Appendices

None.

Minutes of the Neighbourhood Health Committee meeting

Held on 18 May 2026 at 10.00 am

Microsoft Teams meeting and in person at Seax House, Chelmsford.

Attendees

Members

- Jo Churchill (JC), Non-Executive Member (Committee Chair), EICB.
- Beverley Flowers (BF), Executive Director of Neighbourhood Health, EICB.
- William Guy (WG), Director of Commissioning (Primary Care), EICB.
- Dr Ian Perry (IP), Primary Care Partner Member, EICB.
- Dr Matt Sweeting (MS), Executive Medical Director, EICB.
- Amy Jackson (AJ), Associate Director of Community and Neighbourhood Development, EICB (nominated deputy for the Director of Commissioning (Community)).

Other attendees

- Tom Abell (TA), Chief Executive Officer, EICB.
- Jennifer Kearton (JK), Executive Director of Finance and Commercial, EICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, EICB.
- Michael Watson (MW), Executive Director of Corporate Services, EICB.
- Dr Anna Davey (AD), Associate Medical Director, Neighbourhood Health, EICB.
- Natalie Hammond, (NH), Director of Nursing, EICB.
- Ashley King (AK), Director of Estates and Capital, EICB.
- Nicola Adams (NAd), Associate Director of Governance, EICB.
- Clare Angell (CA), Associate Director of Children Young People/Learning Disabilities Autism Commissioning, EICB.
- Alfred Bandakpara-Taylor (ABT), Associate Director of Mental Health Commissioning, EICB.
- James Halden (JH), Chief of Staff, EICB.
- Ekelechi MacPepple (EM), Associate Director of Data, Analytics and Population Health Intelligence, EICB.
- Lynn Stimson (LS), Associate Director of Neighbourhood Health (South West Essex), EICB.
- Vicky Cline (VC), Consultant Practitioner Quality, EICB.
- Jane King (JKi), Assistant Governance Manager, EICB (minutes via recording).

Apologies

- Neha Issar-Brown, Non-Executive Member, EICB.
- Jenni Speller, Associate Director of Neighbourhood Health (South East Essex / Mid Essex), EICB.

1. Welcome and Apologies

JC welcomed everyone to the meeting and a round of introductions took place. Apologies were noted as above. The meeting was confirmed as quorate.

2. Declarations of Interest

The Chair asked members to note the Register of Interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

There were no further declarations raised.

3. Minutes of the Previous Meeting

It was the inaugural meeting of the Neighbourhood Health Committee, therefore there were no minutes presented for approval.

4. Matters arising

The Committee confirmed that there were no matters arising that were not on the agenda.

5. Action Log

There were no outstanding actions to note, as this was the inaugural meeting of the Neighbourhood Health Committee.

6. Neighbourhood Health and Primary Care – Strategic Context and Local Position

BF presented the purpose of the neighbourhood health, highlighting key priorities and providing background on primary care to support the Committee's understanding of the current position.

AJ provided an overview of Essex geography, highlighting the integration of three legacy ICBs into a single Essex-wide model that maintained local identity while strengthening alignment. Members considered the proposed configuration of five unitary footprints for place-based planning and commissioning, recognising that this aligned with emerging local government reform proposals and was subject to ongoing development.

Members noted the potential impact of local government reform on neighbourhood arrangements and agreed that developments should be monitored closely through the Committee's future work programme.

The Committee noted the establishment of 38 neighbourhoods across Essex, operating within three tiers: Essex-wide (strategy and resource allocation), place (service transformation), and neighbourhood (care delivery). It was confirmed that the model built on existing arrangements, with a focus on prevention and improving access.

JC queried the maturity of the shared data infrastructure. AJ responded that further work was required to align and integrate data across the system, including the redevelopment of

datasets to reflect neighbourhood footprints, with some data currently being collated manually. Members emphasised the importance of robust data to support decision-making, accountability, and population health management, and agreed this as a priority area for development.

Further discussion noted variation in legacy systems and tools across former ICBs, highlighting the need to develop a consistent approach to population health management and data utilisation over the coming year.

The Committee discussed the operational model, noting services delivered at Essex-wide level, the role of place in service integration and addressing wider determinants of health, and the importance of neighbourhood multi-disciplinary team working, social prescribing, and partnership with local authorities, the voluntary sector and Healthwatch.

Members noted the national Neighbourhood Health Framework and its six core components, which focused on shifting from reactive to proactive care, strengthening community services, reducing hospital reliance, and addressing unwarranted variation.

The Committee emphasised the need for clear measures of success, including outcomes, workforce and financial implications, and the impact of outpatient transformation and the shift of care to community settings. Members also sought clarity on funding responsibilities, accountability for services such as virtual wards and potential cost transfer between providers.

It was agreed that further work was required to define data, outcome measures and the wider financial and operational implications of the neighbourhood health programme.

IP raised concerns regarding the transfer of activity from secondary to primary care without corresponding funding, noting increased workload from Advice and Guidance processes, growing waiting lists in general practice, and the impact of delayed outpatient follow-ups and associated clinical risk.

Members emphasised the importance of maintaining continuity of care and ensuring that neighbourhood health centres complemented rather than fragmented existing general practice relationships.

Pressures on primary care capacity and the need to balance demand, access and risk were discussed. The implications of outpatient transformation and demand management within the neighbourhood health model required further consideration.

Members noted that most primary care funding and activity was determined through national contractual arrangements, with limited scope for local commissioning. Discussion focused on the extent of local financial and commissioning levers, with Members seeking greater clarity on the proportion of funding under local control and the implications for neighbourhood health transformation, commissioning and investment decisions.

The complexity of commissioning arrangements across primary care, including pharmacy, dentistry and optometry was noted, with some contractual and pathway arrangements, particularly in ophthalmology, limiting opportunities to shift care into community settings.

Members noted variation in legacy commissioning arrangements across the three former ICBs and agreed that harmonisation and identification of best practice were required, with a future deep-dive review on performance, variation and data being proposed.

The Committee agreed that further work was required to strengthen data, understand variation, and align financial frameworks to support neighbourhood health priorities.

ACTION: A future meeting or seminar should provide further clarity on primary care funding arrangements, including the proportion of funding under local control or influence and the implications for commissioning and transformation, while supporting improved data, understanding of variation, and alignment of financial frameworks with neighbourhood health priorities.

Outcome: The Committee NOTED the Neighbourhood Health and Primary Care – Strategic Context and Local Position paper.

7. Committee Role and Expectations

NA presented the proposed governance framework, outlining roles, responsibilities, reporting arrangements and the wider committee structure. Members noted the interdependencies with programme governance, including the Neighbourhood Health Programme Board, and the need to avoid duplication while ensuring appropriate assurance and oversight of Population Health Improvement Plan (PHIP) delivery.

The proposed sub-committee structure was outlined, including the Primary Care Commissioning Group, multi-neighbourhood place arrangements, Health Inequalities Group and Better Care Fund arrangements; it was noted that development of the sub-groups would be phased to support the developing arrangements for neighbourhood work. Members acknowledged the complexity of governance and the need for clarity on relationships with community services, local authorities and emerging local government reform.

Members discussed the transition to new commissioning and provider models, emphasising the need to move towards multi-neighbourhood provider arrangements and avoid legacy approaches. The importance of aligning system partners, particularly local authorities and public health, was emphasised, recognising this would take time and there were sensitivities regarding funding responsibilities and the need for clear leadership on health inequalities and prevention.

It was agreed that the Committee should maintain oversight of commissioning transformation, including financial flows and market development, with further work required to reflect this within the work programme.

ACTION: Incorporate oversight of commissioning transformation, including financial flows and market development, into the Committee's work or seminar programme.

NA noted that the Committee was at an early stage of development and that governance and operating arrangements would evolve. Members agreed to adopt a learning approach, supported by seminars and deep-dive reviews.

Members identified key measures of success, including development of a shared dataset, progress in reducing health inequalities, establishment of effective neighbourhood and multi-neighbourhood arrangements, piloting new commissioning models, and improved estate planning.

Progress in reducing health inequalities was identified as a central measure of success, and the need to monitor unintended consequences arising from service redesign was noted.

Members emphasised the importance of transparency across partners and highlighted risks relating to workforce capacity, financial constraints and unintended consequences of service shifts.

The Committee noted the importance of community engagement and co-production and agreed that effective engagement with communities and service users should form a key component of neighbourhood health development and governance arrangements, with further work required to embed this within its approach.

The proposed meeting cadence of quarterly formal meetings, supplemented by seminars in the intervening months, was agreed as supportive of governance and organisational development.

ACTION: Establish a structured programme of Neighbourhood Health seminars and deep-dive reviews, including primary care services, data, estates, primary care performance and variation, metrics and benchmarking with topics agreed by the Chair and Executive Lead.

Outcome: The Committee NOTED the paper outlining the Committee's role, responsibilities, governance arrangements and set expectations for measuring the success of the Committee.

8. Committee Terms of Reference and Establishment of Neighbourhood Health Committee (NHC) Sub-groups

The Committee considered proposed amendments to its Terms of Reference (ToR), including revised membership, and approved these for recommendation to the ICB Board.

The ToR for the Primary Care Commissioning Group (PCCG) were approved, noting its delegated function from NHS England, Essex-wide remit, clinical chairing and role in providing assurance on primary care contracting and decision-making within the remit of delegations from NHS England.

Members noted the proposed sub-group structure, including alliances, the Health Inequalities Group, and Better Care Fund (BCF) governance arrangements, and agreed that further phased development was required to ensure clarity and alignment with neighbourhood delivery.

It was noted that existing alliance arrangements would continue on an interim basis whilst transitioning to multi-neighbourhood models, with progress varying across areas and timelines remaining indicative. Members emphasised the need to support system partners to assume greater ownership as the ICB developed in its strategic commissioning role.

The Committee noted the complexity of multi-neighbourhood reporting and performance oversight, agreeing that further work was required to develop meaningful metrics and reporting arrangements.

Members noted that the Health Inequalities Group remained in development, with further work required to clarify its role, membership and alignment with partners.

An update on BCF governance was received, noting variation across legacy systems and the need for greater consistency and oversight; it was agreed that a detailed report on BCF arrangements, including expenditure, outcomes, and governance, would be presented at a future meeting.

ACTION: Present a detailed Better Care Fund report (spend, outcomes, governance) to a future meeting.

Outcome: The Committee **APPROVED** the Primary Care Commissioning Group Terms of Reference and **NOTED** that governance arrangements for the Health Inequalities Group remained under development.

9. Neighbourhood Health Centres National Submission

The Committee received an update on the development of the Neighbourhood Health Centres national submission, noting the accelerated timescales and requirement for submission by 28 May 2026. AJ highlighted the significant work undertaken to develop a robust evidence base, despite data being held across three legacy systems and some analysis having to be completed manually.

An initial needs assessment had been completed across the emerging multi-neighbourhood areas, supported by engagement with local authorities, Primary Care Networks (PCNs) and system partners. Following a multidisciplinary workshop, 14 potential sites across five multi-neighbourhood areas had been identified for further consideration.

Members noted that the submission was based on high-level planning assumptions, including the transfer of activity from acute to community settings, particularly outpatient, diagnostic and urgent care services, alongside a whole-population approach focused on prevention, planned care and urgent response. It was emphasised that the model remained flexible pending further national guidance.

AK outlined the proposed sites and highlighted a range of estate challenges, noting that the ICB did not own estate assets, which added complexity to future development and delivery.

Members discussed the need to align proposals with population growth, Section 106 funding opportunities, primary care estate needs and wider capital programmes. It was recognised that site selection would require a clear narrative demonstrating that proposals were driven by population need.

IP emphasised that future site selection should be guided by population need, and account for factors such as deprivation, accessibility and transport considerations, recognising that overall population figures alone may not fully reflect local demand for services.

Members noted the need to align neighbourhood health centres with related programmes, including mental health neighbourhood hubs, urgent and emergency care services, primary care estate development and future commissioning arrangements. It was recognised that neighbourhood health centre development should be service-led rather than estate-led.

Discussion also highlighted the importance of maintaining continuity of care with Members noting that neighbourhood health centres should complement existing general practice services and avoid generating unmanaged demand.

Next steps included further stakeholder engagement, refinement of the service model and planning assumptions, and development of a supporting communications narrative.

Outcome: The Committee SUPPORTED the Neighbourhood Health Centres National Submission in principle, noting its early stage of development and the need for ongoing refinement.

10. Primary Care Action Plan

The Committee received an overview of the Primary Care Action Plan, noting the national requirement for all ICBs to develop plans to improve access to primary care services.

WG advised that the plan focused on improving urgent, same-day access in general practice and maximising the contribution of community pharmacy. Following NHS England feedback, the plan had been revised to include greater specificity, including identification of outlier practices and expected improvements against defined metrics.

Members noted that NHS England data would be used alongside local intelligence to understand variation and underlying causes, including data quality issues, rather than relying solely on performance measures.

It was confirmed that delivery would utilise existing functions and resources, including the Connected Pathways team and community pharmacy commissioning arrangements and would not require additional funding.

The Committee noted the need to strengthen contract management where appropriate while maintaining collaborative relationships with providers.

Outcome: The Committee NOTED the Primary Care Action Plan update.

11. Escalations from Primary Care Commissioning Group

The Committee received an update on key issues escalated from the Primary Care Commissioning Group (PCCG) following its inaugural meeting.

WG reported the Committee's endorsement of the intention to re-procure orthodontic services across Mid and South Essex and North East Essex, noting that West Essex arrangements were already covered by a longer-term contract. It was confirmed that detailed proposals would be progressed through the appropriate governance routes.

Partnership Dispute

The Committee noted an ongoing GP practice partnership dispute in North East Essex and the associated service continuity risks. It was confirmed that a detailed report, supported by legal advice, would be presented to Executive Committee and an extraordinary PCCG meeting for decision.

Outcome: The Committee NOTED the escalations from Primary Care Commissioning Group including plans for re-procurement of services as described.

Orthodontic proposal

The Committee considered a recommendation to permit all dental and orthodontic contract holders to deliver up to 110% of contracted activity in order to maximise access. It was noted that this would be subject to Executive Committee and Commissioning, Quality and Resource Committee approval due to the financial value of the contract.

Wider pressures in dental services were noted, including access challenges and variation in provision across Essex. The complexity of commissioning arrangements, including legacy differences across former ICB areas, was also acknowledged.

Outcome: The Committee SUPPORTED the PCCG recommendation to permit dental and orthodontic contract holders to deliver up to 110% of contracted activity, subject to Executive Committee and Commissioning, Quality and Finance Committee approval.

12. Escalations from Alliances & Health Inequalities and Prevention Group

The Committee noted the early stage of development and maturity of alliance groups and the Health Inequalities and Prevention Group and that there were no escalations at this stage.

Outcome: The Committee noted the update on the alliances and Health Inequalities and Prevention Group.

13. Primary Care Commissioning Group Minutes

The Committee noted that PCCG minutes were not yet available, as the Group had only recently held its inaugural meeting, and that the item had been included to establish future reporting arrangements.

Outcome: The Committee noted the update on PCCG minutes.

14. Other NHC Sub-Group minutes

The Committee noted that minutes were not yet available from other Neighbourhood Health Committee sub-groups, as these remained in development. The item was included to establish future reporting arrangements.

Outcome: The Committee noted the update on other NHC Sub-group minutes.

15. Any other Business

There was no other business.

16. Chairs Key Issues / Risks to escalate

The Chair noted that no issues or risks required escalation to the Board or other committees at this stage.

Members acknowledged the breadth and complexity of the discussions and agreed that priority should be given to establishing effective reporting arrangements and progressing the seminar and deep-dive review programme to support Committee development and understanding. An early deep-dive review into primary care performance, variation, benchmarking and commissioning arrangements to support a consistent Essex-wide approach was supported.

ACTION: Develop and implement a programme of seminars and deep-dive reviews, with an early focus on primary care, and establish clear reporting and assurance arrangements between the Committee and the Neighbourhood Health Programme Board.

The importance of clearly defining the respective roles of the Committee and the Neighbourhood Health Programme Board was emphasised to avoid duplication and strengthen assurance. It was anticipated that these relationships would be further refined as governance arrangements matured.

Outcome: The Committee NOTED that no issues or risks required escalation to the Board or other committees at this stage.

17. Effectiveness of Meeting

The Chair invited reflections on the effectiveness of the meeting, acknowledging the breadth of agenda items and extended duration. It was recognised that the inaugural meeting had been comprehensive and provided a valuable foundation for shared understanding.

Future meetings should strike an appropriate balance between strategic and operational matters, supported by streamlined agendas and greater use of pre-reading.

The discussion helped establish a common understanding of neighbourhood health and primary care priorities, with continued focus on both transformational and operational issues considered essential to the Committee's effectiveness.

A structured programme of seminars and deep-dive reviews was welcomed to support ongoing development and more effective formal meetings.

18. Date of Next Meeting

9.30 am, Thursday, 20 August 2026,
Hybrid meeting held via Microsoft Teams and in person at Seax House, Chelmsford.

Essex ICB Part I Board Meeting

15 October 2026

Agenda Item No:	19
Report Title:	Approved committee minutes
Purpose of Report: 'Check' (x) relevant box(es).	Approval ☐ Endorsement ☐ Discussion ☐ Alert ☐ Advise ☐ Assure ☒ Celebrate ☐ Assurance Rating: ● HC ● MC ● LC ● N *
Confidentiality Status:	General – no additional protection
Executive Director Sponsor:	• Beverley Flowers, Executive Director of Neighbourhood Health • Michael Watson, Executive Director of Corporate Services • Jennifer Kearton, Executive Director of Finance and Commercial • Giles Thorpe, Executive Chief Nurse
Report Author / Presenter:	Helen Chasney, Governance and Risk Manager
Previously considered by:	The minutes have been formally approved by the relevant committees.
Subject of Report:	This report presents the approved minutes of meetings of the Neighbourhood Health Committee, Audit, Risk and Compliance Committee, and Commissioning, Quality and Resource Committee. The minutes provide the Board with assurance regarding the work undertaken, matters considered and decisions made by the committees while exercising functions delegated to them by the Board.
Recommendations:	The Board is asked to: • Note the approved minutes of the meetings as set out within this report.
Strategic Objectives: 'Check' (x) relevant box(es).	1. Health inequalities narrowing year on year ☒ 2. A decisive shift towards neighbourhood care delivery and prevention ☒ 3. Timely access and excellent outcomes across services ☒ 4. Financially and clinically sustainable services across Essex which are safe and high quality ☒ 5. An organisation that is up to the job, good to work for and good to partner with ☒
Impact Assessments (IA):	QEHIA ** ☐ DPIA/DTAC *** ☐ Sustainability ☐ Primary care ☐ Not Applicable ☒ Impact Assessments are not required to be undertaken.

Financial Implications:	Not Applicable.																		
Details of patient or public engagement or consultation:	Not Applicable.																		
Conflicts of Interest:	None Identified																		
Related risks / new risks:	None.																		
Internal Engagement****:	<table><tr><td>Finance</td><td>☐</td><td>Procurement</td><td>☐</td><td>Contracting</td><td>☐</td></tr><tr><td>Quality</td><td>☐</td><td>IG Team</td><td>☐</td><td>Delivery Unit</td><td>☐</td></tr><tr><td>Governance</td><td>☒</td><td>Comms</td><td>☐</td><td>Clinical</td><td>☐</td></tr></table> List any other teams consulted with	Finance	☐	Procurement	☐	Contracting	☐	Quality	☐	IG Team	☐	Delivery Unit	☐	Governance	☒	Comms	☐	Clinical	☐
Finance	☐	Procurement	☐	Contracting	☐														
Quality	☐	IG Team	☐	Delivery Unit	☐														
Governance	☒	Comms	☐	Clinical	☐														

Notes:

* Guidance on completing the assurance rating and what the assurance ratings mean is included at the end of this report.

** QEHIIA: Quality, Equality and Health Inequality Impact Assessment

*** DPIA/ DTAC: Data Protection and Privacy Impact Assessment / Data Technology Assessment Criteria

**** Commissioning decisions must attach the decision-making checklist and be approved by a finance business partner

Revised Policies

1. Context and Purpose

The purpose of this report is to provide the Board with a copy of the approved minutes of the following committees:

- Neighbourhood Health Committee (NHC), 18 May 2026
- Audit, Risk and Compliance Committee, 9 June 2026
- Commissioning, Quality and Resource Committee, 7 July 2026

Committees of the Board are established to deliver specific functions on behalf of the Board as set out within their terms of reference. Minutes of meetings held (once approved by the committee) are presented to the Board to provide assurance and feedback on functions and decisions delivered on its behalf.

2. Assessment / Analysis

The following summarises key items discussed, and decisions made by committees as recorded in the minutes approved since the last Board meeting.

Neighbourhood Health Committee (NHC), 18 May 2026

The following items were considered:

- Neighbourhood Health and Primary Care – Strategic Context and Position
- Committee Role and Expectations
- Committee Terms of Reference and Establishment of Neighbourhood Health Committee Sub-groups
- Neighbourhood Health Centres National Submission
- Primary Care Action Plan
- Escalations from Primary Care Commissioning Group
- Escalations from Alliances and Health Inequalities and Prevention Group
- Primary Care Commissioning Group Minutes
- Other NHC Sub-Group Minutes

Audit, Risk and Compliance Committee, 9 June 2026

The following items were considered:

- Final Mid and South Essex ICB Annual Report and Accounts 2025/26
- Mid and South Essex ICB Health Inequalities Annual Report 2025/26
- Risk Framework, including Board Assurance Framework
- Governance Update
- Policy Update
- Company Seal
- Health and safety Update

- Information Governance Update
- Emergency Planning Update
- Losses and Special Payments
- Contract Governance and Procurement Register
- Provider Selection Regime Year End Report 2025/26
- Waiver Report
- Quality Statutory Compliance Report
- Internal Audit Progress Report
- Local Counter Fraud Service

Commissioning, Quality and Resource Committee, 7 July 2026

The following items were considered:

- Service Restriction Policies
- Changes to the Scheme of Reservation and Delegation
- Executive Director Report
- Updates from Sub-Committees
- Establishing sub-committees and approving their terms of reference
- Commissioning, Quality and Resource Committee Workplan 2026/27

3. Findings / Conclusion

The approved minutes provide the Board with assurance that relevant strategic, operational and regulatory matters were considered through the established committee governance arrangements. No matters requiring additional escalation to the Board were identified within this report.

4. Recommendations

The Board is asked to:

- Note the approved minutes of the meetings as set out within this report.

Minutes of the Essex ICB Audit, Risk and Compliance Committee meeting

Held on 9 June 2026 at 2.00pm

Microsoft Teams meeting and in person at Seax House, Chelmsford.

Attendees

Members

- Rex Smith (RSm), Non-Executive Member, Essex Integrated Care Board (EICB) – Audit, Risk and Compliance Committee (ARCC) Chair.
- Mark Bailham (MB), Non-Executive Member, EICB - Deputy ARCC Chair.
- Jo Churchill (JCh), Non-Executive Member, EICB.

Other attendees

- Jennifer Kearton (JK), Executive Director of Finance and Commercial, EICB (up to Item 14).
- Michael Watson (MW), Executive Director of Corporate Services, EICB.
- Dr Giles Thorpe (GT), Executive Chief Nursing Officer, EICB.
- Nicola Adams (NAd), Associate Director of Governance, EICB.
- Natalie Hammond (NH), Director of Nursing, EICB (for item 19).
- Natalie Brodie (NB), Associate Director of Financial Management Accounts and Financial Services, EICB.
- Janette Joshi (JJ), Associate Contracting Director, Strategic Commissioning, EICB.
- Darren Mellis (DM), Head of Financial Services, EICB.
- Iain Gear (IGe), Information Governance Manager, EICB.
- Jim Cook (JCo), Head of Emergency Preparedness, Resilience and Response (EPRR), EICB (for Item 14).
- Hannah Calvert (HC), Assistant EPRR Manager, EICB (for Item 14).
- Amy Jackson (AJ), Associate Director of Community and Neighbourhood Development, EICB (up to Item 18).
- Emma Larcombe (EL), External Audit Partner, KPMG.
- Dakshita Takodra (DT), Senior Audit Manager, TIAA.
- Arti Scott (AS), Anti-Crime Manager, TIAA (for Item 21).
- Rowana Conway (RC), Information Governance Officer, EICB

Apologies

- Hannah Wenlock (HW), Anti-Crime Specialist, Counter Fraud, TIAA.
- Bob Street (BS), Security Management Specialist, TIAA.
- Jane King (JKi), Assistant Governance Manager, EICB.

- Helen Chasney (HC), Governance and Risk Manager, EICB (minutes transcribed from meeting recording).

1. Welcome and Apologies

RSm welcomed everyone to the meeting. Apologies were noted as above and the meeting was confirmed as quorate.

2. Declarations of Interest

The Chair asked members to note the Register of Interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

There were no further declarations raised.

3. Minutes of the Previous Meeting

The minutes of the meeting held on 22 April 2026 were received. The following amendment was raised:

Item 6 (Establishment of ARCC Sub-Committees) – ARRC to be amended to ARCC.

Outcome: The minutes of the meeting held on 22 April 2026 were approved as an accurate record, subject to the amendment being made as noted above.

4. Matters arising

There were no matters arising from the previous meeting.

5. Action Log

The action log was reviewed and noted.

6. Final Mid and South Essex ICB Annual Report and Accounts 2025/26

RSm noted that the annual report had undergone robust governance processes, with minor amendments and additional information included. NAd confirmed that the final draft reflected the feedback from KPMG and NHS England (NHSE), including a new section explaining the 'Service Auditor Reports'.

EL advised that KPMG had reviewed the annual report and noted that the Mental Health Investment Standard (MHIS) had been included within the accounts. Assurance work on the comparator remained ongoing and was expected to result in a disclaimer, subject to any further wording.

NAd confirmed the resignation dates for George Wood and Joe Fielder as 31 March 2026.

In response to a query from RSm, JK explained that sickness absence figures reflected organisational change and some long-term absences, which had largely resolved.

Monitoring arrangements remained in place through quarterly staff surveys. MW noted the figures related to Mid and South Essex (MSE), and that a wider Essex workforce plan would be required.

EL presented the Annual Audit Report and ISA 260 Report. One significant risk relating to management override of controls had been identified; however, all audit work had concluded with no material findings. The MHIS disclosure work, search for unrecorded liabilities and a final accrual query had all been completed. No issues of unlawful or unusual expenditure had been identified, including losses, special payments or redundancy costs, and no amendments were required to the Remuneration Report. The governance arrangements and data transfer testing had been reviewed in relation to the migration to ISFE2. No concerns were identified and any challenges were mitigated locally.

Audit certification would follow completion of the NHSE processes but would not delay the audit opinion. One minor control deficiency relating to journal reviews under ISFE1 system had been noted, and additional testing under ISFE2 was planned. Previously identified recommendations had been implemented.

In response to a query from RSm, EL confirmed that, following the dissolution of MSE ICB, services had continued under Essex ICB and had therefore been assessed as a going concern.

The annual audit report identified no significant weaknesses in financial sustainability, governance or value for money. Governance arrangements during transition were considered appropriate, with future focus placed on embedding these arrangements and maintaining financial control. JKe clarified that regional ICB configurations had been explored but not mandated. JKe thanked KPMG and the finance team for their work throughout the organisational transition and ledger system changes.

DM presented the MSE ICB Annual Accounts and reported achievement of all four statutory targets, including a £117k revenue underspend, delivery of capital and administrative resource limits, and compliance with the Better Payment Practice Code.

Outcome: The Committee APPROVED the final MSE ICB Annual Report 2025/26 and Annual Accounts 2025/26, under delegated authority from the Essex ICB Board.

7. Mid and South Essex ICB Health Inequalities Annual Report 2025/26

AJ presented the final report for the MSE footprint, which covered three years of data and met the ICB's statutory requirement to report on health inequalities. Progress was demonstrated in priority areas, although inequalities remained in maternity outcomes, vaccination uptake and vulnerable groups, including people with serious mental illness and learning disabilities.

MW noted future work would place greater emphasis on population health management, enhanced data use and internal analytics capability, with health inequalities embedded across all commissioning activity.

The report demonstrated a more mature, system-wide approach to identifying and addressing inequalities and would also be presented to the Neighbourhood Health Committee and Board.

Outcome: The Committee endorsed the Mid and South Essex ICB Health Inequalities report.

8. Risk Framework including Board Assurance Framework

NAd updated the committee on development of the Essex ICB risk appetite and risk management framework. The approach, based on the Good Governance Institute model, would support organisational objectives, decision-making and delivery of the Population Health Improvement Plan (PHIP) and statutory duties.

Proposed risk appetite levels included a high but controlled appetite for financial risk, moderate appetite for regulatory risk and a high appetite for quality improvement, workforce and reputational risk, balanced by transparency and engagement.

The development of the risk framework remained on track, including closure of MSE risks and establishment of new Essex risks, with the first iteration of the Board Assurance Framework (BAF) scheduled for July. The Risk Management Policy and Strategy would support maturity assessment, continuous improvement, and clearer organisational risk profiling over time. A revised approach to separate risks and issues, intended to strengthen ownership, oversight and early intervention.

Future work would include Executive Committee approval, cyclical risk review processes, training and aligning Board agendas and reporting with strategic objectives.

MW and DT welcomed the approach.

Outcome: The Committee NOTED the update on the development of the Essex ICB Risk Appetite and Risk Management Framework.

9. Governance Update

NAd outlined governance changes following establishment of Essex ICB, including formalisation of sub-groups and updates had been made to the relevant Terms of Reference (ToR) and the Functions and Decisions Map. Changes included the establishment of the Corporate Oversight, Resilience and Emergency Preparedness (CORE) Group and creation of a Staff Partnership Forum.

The Neighbourhood Health Committee ToR had been amended to include an additional Non Executive member and to reflect provider attendance in line with the ICB's role. Minor updates to the Commissioning, Quality and Resource (CQRC) ToR clarified reporting arrangements between CQRC and ARCC.

Outcome: The Committee:

- **Noted the changes to the Governance Framework (updated Board sub-committee terms of reference, establishment of sub-groups and the updated Functions and Decisions Map).**

- **Approved the revised terms of reference of the Audit, Risk and Compliance Committee.**

10. Policy Update

NA presented the Lone Worker, Management of Violence and Aggression and Security and Lockdown policies, which had been delayed during organisational establishment. Amendments reflected legislative changes, including Martyn's Law.

RSm emphasised the importance of equivalent policies within commissioned organisations.

MB requested consistency in policy formatting and terminology within the Security and Lockdown Policy.

GT identified the need to strengthen references to sexual violence within the Management of Violence and Aggression Policy. NAd confirmed this would be amended and recirculated for approval.

ACTION: HC to add references to sexual violence in the Management of Violence and Aggression Policy.

Outcome: The Committee approved the following policies, subject to the amendments noted above.

- **C008 Lone Worker Policy.**
- **C011 Security and Lockdown Policy.**

The Management of Violence and Aggression Policy was not approved and would be amended and circulated for virtual approval.

11. Company Seal

NA advised that there was one instance of use of the company seal in relation to an amendment to a partnership agreement with a local authority.

Outcome: The Committee NOTED the use of the company for the following:

- **Variation to the Partnership Agreement relating to the Commissioning of Learning Disability Services between Essex County Council, Southend on Sea City Council, Thurrock Council and NHS Essex ICB.**

12. Health and Safety Update

NAd advised that the Committee would receive regular updates from the Health and Safety Group. The report outlined the current framework, noting that further work was required to ensure full compliance with health and safety legislation. Reporting would transition to a dashboard approach with clear performance measures.

Assurance was provided that all sites were landlord-managed and no significant workplace risks had been identified. In response to a query from MB, NA confirmed that future dashboards would include bands and percentages to indicate performance against thresholds.

Outcome: The Committee NOTED the update on health and safety.

13. Information Governance Update

IGe presented the Information Governance Report. Key issues included concerns regarding GP practices withdrawing from data sharing agreements linked to the Federal Data Platform, with potential impacts on direct care, population health management and health inequalities analysis. The matter had been escalated to Executive Committee.

Further updates included developments towards a cradle-to-grave health record, challenges retrieving historic data following SharePoint migration. Actions were underway to improve data storage, retention, and retrieval processes. Over 100 FOI's had been received since April 2026, with one breach and one phishing incident reported. Data Protection Impact Assessments (DPIAs) had increased as commissioning activity resumed.

A new Data Protection and Security Toolkit (DPST) and expected requirements were expected later in the year. Work was underway to identify Information Asset Owners to strengthen awareness of responsibilities, and a targeted training approach had been discussed.

Future plans included replacing spreadsheet-based processes with SharePoint solutions and greater automation.

In response to a query from RSm, IGe confirmed that concerns relating to GP data-sharing arrangements were being considered by the Information Governance team, Primary Care and the Chief Information Officer, with a report being prepared for Executive Committee. MW noted the national nature of the issue and emphasised the need to maintain data access while addressing GP concerns regarding data use and security. JCh highlighted the contractual and potential financial implications of non-compliance.

MB queried how risks and issues linked to the BAF and whether dependencies should be referenced more in the report. NAd advised that reporting would be aligned through ARCC sub-groups, with supporting appendices available on request. Reporting would be refined to focus on key risks and assurance and would move to a dashboard format supported by an alert, advise and assure approach.

Outcome: The Committee NOTED the Information Governance update.

14. Emergency Planning Update

JCo outlined the ICB's statutory emergency preparedness responsibilities which was supported by robust governance arrangements. The establishment of the CORE group was proposed as a formal ARCC sub-group. The group would oversee emergency planning, resilience, climate change and PHIP-related activity, operating as a coordinating and information sharing forum.

NAd confirmed administrative support would be provided from within the EPRR team.

Outcome: The Committee endorsed the creation of the Corporate Oversight of Resilience and Emergency Preparedness (CORE) Group.

15. Losses and Special Payments

There were no losses or special payments to note since the last report.

Outcome: The Committee NOTED there were no losses or special payments reported.

16. Contract Governance and Procurement Register

JJ presented the procurement register and published contract award notices, noting the statutory requirement to publish both on the website following committee ratification.

MB queried the zero-value contract. JJ explained this reflected a cost-and-volume contract arrangement and confirmed that no procurement challenges had been received in relation to the contracts listed.

Outcome: The Committee NOTED the Contract Governance and Procurement Register Report.

17. Provider Selection Regime Year End Report 2025-2026

JJ advised that the annual report was a statutory requirement covering contracts awarded under the Provider Selection Regime (PSR) between 1 April 2025 to 31 March 2026 and should be published within six months of year end, following committee ratification.

In response to a query from MB, JJ agreed to confirm details of the contract rejected by the panel following the meeting.

ACTION: JJ to provide details to MB of the contract rejected by the Provider Selection Regime Panel.

Outcome: The Committee RATIFIED the Provider Selection Regime Year End Report 2025-26.

18. Waiver Report

JJ advised that five waivers had been approved since the last report, with details provided in the paper. Waivers were required where procurement regulations were not followed and subject to compliance with the Scheme of Reservation and Delegation (SoRD). The waiver process only applied to non-healthcare contracts, as healthcare contracts were awarded under the PSR regulations.

Outcome: The Committee NOTED the Waiver Report.

19. Quality Statutory Compliance Reports

NH presented the compliance report covering patient experience, complaints, infection prevention and control and safeguarding.

Challenges were identified in managing legacy complaints and safeguarding cases transferred to Essex ICB, and further work to align functions with the new structure and national guidance was required. Moderate assurance was reported, although dashboard

reporting remained under development due to data limitations.

In response to a query from JCh, NH confirmed that there was strengthened oversight arrangements within the complaints function to improve escalation and case management, noting data quality remained a key risk.

GT presented the Special Educational Needs and Disabilities (SEND) compliance report, highlighting new responsibilities arising from SEND reforms, ongoing local authority inspections and system pressures within neurodevelopmental services. Risks remained around effective health involvement in education, health and care plans.

In response to RSm, GT confirmed Essex would receive funding from the national £1.8 billion allocation to support health workforce capacity and joint commissioning activity. Demand continued to exceed supply, particularly for children awaiting a diagnosis of Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD).

JC sought assurance regarding the red rated duty-to-cooperate indicator. GT reported strengthened partnership working with upper tier local authorities and expressed confidence in improvement by Quarter 3.

In response to a query from RSm, GT confirmed that national benchmarking data was available and a new SEND dashboard was being developed to improve oversight and supported a needs-led approach to service delivery. The dashboard would be presented at a future ARCC meeting.

Outcome: The Committee NOTED the Quality Statutory Compliance Reports.

20. Internal Audit Progress Report and Follow Up of Recommendations

DT reported that delivery of the 2026/27 audit plan was on track and audit engagement remained strong. It was noted that some audits, such as contract management, could be rescheduled and would be discussed with the leads.

Five recommendations remained outstanding; revised dates had been agreed for four, with the remaining update pending the appointment of a new postholder.

Re-audit activity was planned for SEND audit and ASD referral pathways following previous limited assurance opinions. A comprehensive action plan had been developed and a follow-up audit was planned later in the year.

DT highlighted recent King's Fund guidance on housing and health in strategic planning.

Outcome: The Committee NOTED the Internal Audit Progress Reports.

21. Local Counter Fraud Service

AS presented the anti-crime and security reports and advised that no significant counter-fraud issues had been identified. The annual assessment for the ICB had achieved an overall green rating, with the exception of Standard 3 (Fraud Risk Assessment), reflecting the introduction of a new NHS Counter Fraud Authority methodology. HW had commenced work in this area, with risk assessment findings.

The declaration of interest review was being finalised. A fraud check review had been completed in response to new legislation, resulting in nine medium priority recommendations. A National Fraud Initiative (NFI) review had identified payroll matches; however no investigations had been required.

MB asked who would monitor progress against actions arising from Prevent activity. AS explained that actions would be tracked through regular meetings with the Fraud Champion or Executive Director of Financial and Commercial. Any identified gaps would inform the risk assessment and reporting process.

MB queried staff survey results relating to fraud reporting and secondary employment. AS confirmed the results were consistent with other ICBs and noted ongoing work to improve declaration compliance. Clarification on allegation figures were requested, and AS agreed to provide this information.

AS presented the Local Security Management Service report, noting no areas of concern, and sought approval of the 2026/27 workplan.

MB requested clarification regarding the number of security alerts and advisories issued. NAd advised that site visits to Seax House, Brentwood Community Hospital, Rowan House, Colchester and Kao Park, Harlow, were planned. It was noted that the workplan aligned with existing contractual arrangements.

ACTION: AS to provide information on the allegation figures for fraud reporting.

Outcome: The Committee:

- **Noted the MSE ICB Counter Fraud Annual Report 2025/26.**
- **Noted the MSE ICB Annual Security Report 2025/26.**
- **Approved the Security Workplan 2026/27.**

22. Any other Business

There were no items of any other business discussed.

23. Chairs Key Issues

The Committee confirmed that no formal items were identified for escalation to the Board. It was noted that risks, including safety compliance and information governance, had been discussed but were not considered to be a level requiring escalation.

24. Effectiveness of the Meeting

The Committee expressed concern regarding the volume of papers and agreed future reporting should be shorter, clearer and more focused on key risks and assurances.

RSm suggested prioritising approval items earlier on agendas and clearly identifying papers for noting or discussion. NAd advised future committee reporting would increasingly use dashboards format and concise sub-group reporting. MB suggested incorporating the Alert, Advise, Assure approach.

25. Date of Next Meeting

Tuesday, 8 September 2026 at 2.00pm, 6th Floor Boardroom, Seax House, Chelmsford or via Microsoft Teams.

Minutes of the Essex ICB Commissioning Quality and Resource Committee

Held on 7 July 2026 at 2.00pm

Microsoft Teams meeting and in person at Seax House, Chelmsford

Attendees

Members

- Mark Bailham (MB) Non-Executive Member, Chair
- Neha Issar-Brown (NI-B) Non-Executive Member (part)
- Tom Abell (TA) Chief Executive Officer
- Giles Thorpe (GT) Executive Chief Nursing Officer
- Jennifer Kearton (JK) Executive Director of Finance and Commercial
- Sam Goldberg (SG) Executive Director of Commissioning – Acute & Adult Mental Health Services

Other attendees

- Matt Sweeting (MS) Executive Medical Director
- Michael Watson (MW) Executive Director of Corporate Services
- Nicola Adams (NA) Associate Director of Governance
- Natalie Brodie (NB) Associate Director of Financial Management, Accounts & Financial Services
- Keith Ellis (KE) Associate Director Value, Planning and Productivity
- William Guy (WG) Director of Commissioning for Primary Care and Neighbourhoods (for agenda items 5 and 6)
- Ashley King (AK) Director of Capital and Estates
- Paula Wilkinson (PW) Director of Pharmacy, Medicines and Clinical Policies (for agenda item 7)
- Emma Seabrook (ES) Business Manager (Minutes)

1. Welcome and apologies

MB welcomed attendees to the Commissioning, Quality and Resource Committee and confirmed the meeting quorate.

Apologies were received from Sarah Crane - Deputy Medical Director, Beverley Flowers – Executive Director of Neighbourhood Health and Vicky Sawtell - Director of Commercial.

2. Declarations of interest

MB asked members to note the register of interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

There were no declarations of interest raised in relation to the agenda items.

Outcome: The Committee Register of Interests was noted.

3. Minutes of the previous meeting

The minutes of 21 April 2026 were agreed as an accurate record.

Outcome: The minutes of the 21 April 2026 were approved.

4. Action Log / Matters arising

All actions were noted as complete; there were no matters arising.

Outcome: The action log was noted.

5. This item was minuted confidentially.

6. This item was minuted confidentially.

7. Service Restriction Policies

PW presented a report outlining the proposed approach to harmonise legacy Service Restriction Policies (SRPs) across Essex into a single, coherent suite of commissioning policies for Essex ICB.

It was noted that the team had reviewed more than 120 policies, the majority of which were closely aligned. Policies had been categorised using a red, amber and green (RAG) rating to identify the level of change required.

PW reported that 95% of policies had been classified as green, requiring only minor editorial amendments with no material clinical, financial or equality implications. It was recommended that the approval of those policies be delegated to MS.

The Committee was asked to endorse the proposed approach for policies requiring material changes, or those with significant access, financial or equality implications. It was noted that such policies could require Board approval and, where appropriate, statutory public consultation.

MW confirmed that a communications and engagement plan was being developed to support public consultation where material changes were proposed.

Members noted that arrangements were established for patients already on waiting lists for treatment under previous policies.

In response to a question from NI-B on how Essex ICB's approach compared nationally, PW advised that the policies were broadly consistent with National Institute for Health and Care Excellence (NICE) guidance and the Evidence-Based Interventions (EBI) programme.

PW highlighted that the programme aimed to deliver a fully harmonised and ratified suite of Essex ICB Service Restriction Policies by December 2026.

The Committee noted the efforts by PW and team to review the breadth of policies.

Outcome: The Commissioning, Quality and Resource Committee:

- **Approved the proposed approach to harmonisation and approval of Essex ICB Service Restriction Policies (SRPs) (implemented within a minimum of one month's notice, once approved, and published on the ICB website), including categorisation of policies as either:**
 - 'Green' SRPs, where no material change to commissioning intent is identified; and
 - 'Red' SRPs, where a new or materially changed commissioning position is proposed.

- **Delegated authority to the Executive Medical Director to approval the final versions of 'green' SRPs, following Committee consideration, where only minor editorial, administrative or other non-material amendments are required.**
- **Approved the proposed governance route for 'red' SRPs and noted that policies representing new or materially changed commissioning position would be submitted for approval through the appropriate governance process, including statutory engagement or consultation as required and referral to the ICB Board for approval. Consequently, existing policies will remain in effect until formally replaced.**
- **Noted the programme objective to achieve a fully harmonised and ratified Essex ICB SRP suite by December 2026.**

8. Changes to the Scheme of Reservation and Delegation

NA presented the paper seeking the Committee's endorsement to recommend that the Board approve an amendment to the Scheme of Reservation and Delegation (SoRD) to increase the authorisation limits for staff responsible for complex care.

It was noted that increasing these limits would streamline decision-making, improve operational efficiency, and support the timely provision of care for patients. Following discussion GT noted his support for the change.

Outcome: The Commissioning, Quality and Resource Committee recommended the Board approve the change to section 9 of the SoRD.

9. Executive Director Report

JK, GT and SG continued to develop the reporting pack for the Committee and welcomed feedback.

At Month 2, the ICB remained on track to deliver its financial duties in line with plan. Future reporting would place greater focus on the 'run rate' and underlying financial position to provide a clearer indication of the expected year-end position, including the split between the impact of savings that would be recurrent and those limited to the current year only.

JK highlighted the significant work undertaken by the Finance and Contracts teams to finalise and approve budgets. This work had enabled the teams to identify opportunities to release central funding, reduce financial risk, and develop a clearer understanding of the financial and contractual position inherited across Essex.

MB queried the materiality of incomplete data and the associated level of assurance. JK highlighted that the main concern was the absence of activity data for contract management purposes. Providers were expected to submit data within the next two weeks, followed by validation, which would provide the ICB with a clearer understanding of activity flows. Indicative Activity Plans were in place to support discussions with providers on performance against plan.

A structured deep-dive review would commence in Month 4 looking at planned activity, financial impact, and waiting list positions, supporting decisions on funding priorities for the second half of the year.

KE provided an update on efficiencies, reporting that the ICB had delivered £24.676m of efficiencies year-to-date. Executive Resource Review meetings were supporting ongoing discussions with budget holders to identify opportunities and address unidentified efficiencies.

The Committee were informed the procurement plan was on track, all procurements were progressing as expected or without significant delay.

JK confirmed agreement of the 2026/27 NHS Contract baselines for acute providers, including the three main Essex acute contracts.

NI-B left at this point in the meeting.

AK provided an update on Strategic Capital and the Estates Programme, confirming that feasibility options for Shoebury and Laindon, funded through the ICB's Business as Usual (BAU) Capital allocation, had been received and were currently under consideration by the ICB.

GP IT: Two Project Initiation Documents (PIDs), totalling £412k, had been submitted to NHS England for review.

A wider discussion took place on underutilised estate. It was noted that work was underway to rationalise and dispose of surplus estate, with the majority of annual billing schedules still awaited to inform the next steps.

The Committee received an update from the Quality, Contracts and Performance Meetings, noting that the meetings would continue to evolve as activity data became available to support contractual and performance discussions. Key issues remained waiting times and delays in performance reporting.

It was noted that no contract notices or formal correspondence had been issued.

Recognising the investment in the *Time to Care* programme inherited across Essex, the EPUT QCPM requested an end-to-end review of mental health pathways to evaluate outcomes and ensure the investment was delivering the intended benefits.

GT advised there were no significant quality concerns to report for NHS Providers,

The ICB had submitted a response to the NHS England and Department of Health and Social Care consultation on the "Post-Place" Host Commissioner Guidance. GT highlighted concerns regarding the additional capacity requirements being placed on ICBs to deliver the expected level of oversight for out-of-area activity.

The Committee agreed that the report provided partial assurance, acknowledging that while the data continued to evolve, good progress had been made.

Outcome: The Commissioning, Quality and Resource Committee noted the Executive Director Report.

10. Updates from Sub-Committees:

NA presented a draft reporting template to support consistent reporting from subgroups to Committees. The template summarised key discussions and provided a structured escalation report.

Capital & Estates Group

AK provided feedback from the inaugural meeting held on 1 June 2026, which established the Group's remit, operating arrangements and governance, including approval of the Terms of Reference. Key agenda items included the 2026/27 ICB Capital Plan, Return to Constitutional Standards capital allocations across Essex, and responses to Local Planning Authority consultations.

The report was received for information, with no matters requiring escalation.

Essex Medicines Commissioning Group

PW presented the Committee Summary / Escalation Report from the first Essex Medicines Commissioning Group (EMCG) which met on 30 April 2026.

The report provided an update on the establishment and early activities of the EMCG, including governance, financial, and clinical priorities for medicines optimisation across Essex.

Key areas of focus included identifying the £12m of required efficiencies and addressing the high

level of high-dose opioid prescribing in Essex compared with national benchmarks.

PW updated the Committee on the rollout of tirzepatide, noting that GP prescribing commenced at the end of June in line with NICE guidance and interim NHS England commissioning arrangements. PW emphasised that prescribing should remain within the defined eligibility criteria to avoid creating additional cost pressures.

There was a further discussion around improving the prescribing of antibiotics.

The report was received for information, with no matters requiring escalation.

The Committee agreed that the reports provided reasonable assurance, recognising the positive progress made by the groups and acknowledging that their effectiveness would continue to develop over time.

11. Establishing sub-committees and approving their terms of reference

Following discussion at the April meeting, NA presented the updated Terms of Reference for the Commissioning, Quality and Resource Committee, reflecting the agreed transfer of specific responsibilities to the Audit, Risk and Compliance Committee.

NA also presented the draft Terms of Reference for the System Quality Group and Quality Contract Performance Meetings (QCPMs) with Providers: Essex Partnership University NHS Foundation Trust (EPUT), Mid and South Essex NHS Foundation Trust (MSEFT) and Princess Alexandra Hospital NHS Trust (PAHT).

MB highlighted a typographical error in Section 1 – General Contract Management (Point 1). NA agreed to amend this across all QCPM Terms of Reference.

It was also noted that the wording on Page 3 – Quality and Safety Requirements (Point 7) required clarification to ensure the sentence was clear and coherent.

Outcome: The Commissioning, Quality and Resource Committee:

- **Approved its revised terms of reference for approval by the ICB Board.**
- **Established the sub-committees of CQRC and thus approve their terms of reference for the:**
 - **System Quality Group**
 - **Quality, Contracting and Performance Review Meetings.**

ACTION. NA to amend the typographical error in Section 1 – General Contract Management (Point 1) across all QCPM Terms of Reference and clarify the wording in Page 3 – Quality and Safety Requirements (Point 7).

12. For information only

No items this meeting.

13. Commissioning, Quality and Resource Committee Workplan 2026/27

NA presented the draft 2026/27 Commissioning, Quality and Resource Committee Workplan and invited members to suggest any amendments or additional items to support the Committee in discharging its responsibilities.

NA advised that the Workplan would be updated as the procurement pipeline developed. Work was also underway to populate directorate risk registers, with a Risk Report to be introduced at future

meetings covering risks within the Committee's remit.

MB suggested the Committee receive updates on the progress and benefits realisation of approved business cases. JK confirmed that procurement progress and any issues would be reported through the regular Contracting and Procurement update. It was agreed that, where appropriate, the Committee could request follow-up updates on new investments, with the timing agreed at the point of approval.

NA confirmed that the Delivery Team and Programme Board were responsible for monitoring whether business cases delivered their intended benefits.

GT advised that the Quality Improvement Strategy could be removed from the Workplan as it was no longer an ICB requirement.

Outcome: The Commissioning, Quality and Resource Committee noted the Workplan for 2026/27.

ACTION. As the Quality Improvement Strategy was no longer an ICB requirement, this would be removed from the Workplan.

14. Any other Business

There was no any other business.

15. Items for Escalation

There were no items raised for escalation.

16. Review of meeting effectiveness

Despite the meeting concluding ahead of schedule, the Committee agreed that sufficient time had been allocated to discuss each agenda item. It was agreed that the duration of future meetings would remain unchanged, as the Committee anticipated a fuller agenda as the new ICB became established.

17. Date of next meeting

Tuesday 6 October 2026 at 9.30 am – 11.30 am