NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board

NHS Cambridgeshire & Peterborough Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board

Agenda

Formal Meeting in Common of the Boards of Bedfordshire, Luton and Milton Keynes ICB, Cambridgeshire and Peterborough ICB and Hertfordshire and West Essex ICB

Date: Friday 28 November 2025
Time: 10:00 – 13:00
Venue: MS Teams

The items from each agenda will be added to a ***'Business Transaction Order Agenda'*** which will be used as the overarching agenda for the transaction of business during the meeting and the Chair's notes. It will form part of the final meeting pack and show the time and number for each agenda item and which ICB the item relates to.

Where relevant each organisation will receive a copy of their final agenda showing their items only. All agendas and minutes will be numbered the same irrespective if one ICB does not have a specific item.

No.	Agenda Item	Purpose	Lead	Timings
1.	Welcome, Introductions and Apologies	Note	Chair	10:00
2.	Relevant Persons Disclosure of Interests	Note	Chair	
3. Approval of Minutes				
3.1	Minutes from the previous meeting: • BLMK – held on 26 September 2025 • C&P – held on 19 September 2025 • H&WE – held on 26 September 2025	Approve	Chair	10:05
4. 4.1 4.2 4.3	Review of Action Trackers: • BLMK • C&P • H&WE	Note	Chair	
5. 5.1 5.2 5.3	Questions from the Public: • BLMK • C&P – 1 from C&P • H&WE – 2 in for HWE	-		10:10
6.	Chairs Report	Note	Chair	10:30
7.	CEO Board Report	Note	Chief Executive	10:40
8. Performance and Finance Reports				
8.1	Combined Performance Report for BLMK, C&P and H&WE	Note	Executive Director of Finance, Resources and Contracts	10:50
8.2	Combined Month 6 Finance Report for BLMK, C&P and H&WE	Note	Executive Director of Finance,	11:05

No.	Agenda Item	Purpose	Lead	Timings
			Resources and Contracts	
9.	Neighbourhood Plan	Note	Executive Director for Neighbourhood Health, Place and Partnerships	11:35
10. 10.1 10.2 10.3	Board Assurance Framework Reports: • BLMK • C&P • HWE	Note	Transition Director and Executive Director of Corporate Services and ICB Development	11:45
11.	Research Performance and Future Strategy	Note & Approve	Executive Clinical Director Utilisation Management	12:00
Governance and Assurance				
12.	Governance Update	Approve & Note	Transition Director and Executive Director of Corporate Services and ICB Development	12:10
13.	Any Other Business • BLMK • C&P • H&WE		Chair	12:45

Date of next meeting – Friday 6 February 2025
Deadline for papers will be – 12pm, Tuesday 20 January 2026

Resolution to exclude members of the press and public

The Board of the Integrated Care Board resolves that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest, Section 1(2), Public Bodies (Admission to Meetings) Act 1960.

NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Date: 26 September 2025
Time: 09:00 – 11:35
Venue: Central Bedfordshire Council, Priory House, Monks Way, Chicksands, Shefford SG17 5TQ

Minutes of the Board of the Integrated Care Board (ICB) in PUBLIC

Members:		
Robin Porter	Chair, ICB	RP
Alison Borrett	Senior Non-Executive Member, ICB	ABo
Michael Bracey	Chief Executive, Milton Keynes Council - Partner Member, Local Authorities	MB
David Carter	Chief Executive, Bedfordshire Hospitals NHS Foundation Trust - Partner Member, NHS Trusts and Foundation Trusts	DC
Laura Church	Chief Executive, Bedford Borough Council - Partner Member, Local Authorities	LC
Felicity Cox	Chief Executive Officer (CEO), ICB	FC
Manjeet Gill	Non-Executive Member and Deputy Chair, BLMK ICB	MG
Ross Graves	Chief Strategy & Digital Officer, CNWL - Partner Member, NHS Trusts and Foundation Trusts	RG
Dr Tayo Kufeji	GP - Partner Member, Primary Medical Services	TK
Shirley Pointer	Non-Executive Member, ICB	SP
Dr Andrew Rochford	Chief Medical Officer (CMO), ICB	AR
Sarah Stanley	Chief Nursing Officer (CNO), ICB	SSt
Dr Sahadev Swain	GP - Partner Member, Primary Medical Services	SSw
Dean Westcott	Chief Finance Officer (CFO), ICB	DW
Participants:		
Vicky Head	Director of Public Health, Bedford Borough, Central Bedfordshire and Milton Keynes City Councils	VH
Kelly O'Neill	Director of Public Health, Luton Council	KO'N
Dr Ian Reckless	Chief Medical Officer, Milton Keynes University Hospital – *Deputising for Joe Harrison*	IR
Martha Roberts	Chief People Officer, ICB	MR
Kate Robertson	Interim Corporate Director, Population Wellbeing, Luton Council – *Deputising for Mark Fowler*	KR
Maxine Taffetani	Participant Member for Healthwatch within Bedfordshire, Luton and Milton Keynes	MTa
Cllr Martin Towler	Bedford Borough Council & Co-Chair, BLMK Health & Care Partnership	MTo
Maria Wogan	Chief Strategy & Transformation Officer, ICB	MWo
In attendance:		
Georgie Brown	Acting Director of Operations	GB
Tara Dear	Head of System Transformation Team, ICB	TD
Michelle Evans-Riches	Head of Governance (*support),* ICB	MER
Sarah Frisby	Senior System Engagement Manager	SF
Penny Harris	Strategic Advisor, ICB	PH
Laura MacSweeney	Corporate Governance Officer *(minutes)*, ICB	LMS
Lorraine Sunduza	Chief Executive Officer, East London Foundation Trust (ELFT)	LS
Matthew Winn	Chief Executive Officer, Cambridgeshire Community Services (CCS)	MWi

There were 10 members of the public in attendance (2 in person and 8 remotely)

Apologies:		
Marcel Coiffait	Chief Executive, Central Bedfordshire Council - Partner Member, Local Authorities	MC
Mark Fowler	Chief Executive, Luton Council - Partner Member, Local Authorities	MF
Joe Harrison	Chief Executive, Milton Keynes University Hospital - Partner Member, NHS Trusts and Foundation Trusts	JH
Vineeta Manchanda	Non-Executive Member, ICB	VM
Lorraine Mattis	Associate Non-Executive Member, ICB	LM

No.	Agenda Item	Action
	Opening Items	
1.0	The Chair **welcomed** all present to the meeting of the Board of the Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care Board (ICB) in Public. The Chair advised that the meeting was being recorded for the purpose of the minutes only. **Members were reminded that it is their responsibility to keep their Boards and Councils abreast of developments in the system.** a) Apologies were **noted** as above. The Chair welcomed: • Kelly O'Neill – Director of Public Health, Luton Council. • Ian Reckless – Chief Medical Officer for Milton Keynes University Hospital – Deputising for Joe Harrison. • Kate Robertson – Interim Corporate Director, Population Wellbeing, Luton Council – Deputising for Mark Fowler b) The meeting was confirmed as **quorate**. c) Members of the Board were asked to confirm that the Register of Interests was up to date in respect of their declarations. Members were also asked to declared any gifts or hospitality that had been received. **No declarations were made.** d) The minutes of the meeting held on 27 June were **approved** as an accurate record of the meeting. e) The action tracker was updated with the following updates: • **Action 103 –** Update included in the Primary Care Commissioning and Assurance Committee summary report. The Board **agreed** to close the action. • **Action 104 –** Elizabeth Elliot to circulate finalised Directors of Public Health Annual Report for Luton once finalised: KO'N confirmed that the report is due to be published during October. The Board **agreed** to close the action. • **Action 105 –** Action complete. The Board **agreed** to close the action. • **Action 106 –** Action complete. The Board **agreed** to close the action. • **Action 107 –** Action due to be taken forward as part of the new governance arrangements for Central East ICB and the establishment of the Bedfordshire and Milton Keynes Neighbourhood Health Delivery Committee. The Board **agreed** to close the action.	

	• **Action 108 –** The findings and next steps of the translation and interpretation work are due to be discussed at the Health Equity Board, now rescheduled to November, who is overseeing delivery of the Denny review recommendations. The action is due to be taken forward as part of new governance arrangements for Central East ICB and the establishment of the Bedfordshire and Milton Keynes Neighbourhood Health Delivery Committee. The Board **agreed** to close the action. f) The Board **noted** changes to the decision planner including the proposal of moving several decisions under the Neighbourhood Health Delivery Committee.	
2.0	**Questions from the Public** No questions from the public were received.	

3.0	**Annual Report and Accounts 2024/25**
	Presented by Felicity Cox, Chief Executive Officer, ICB and Dean Westcott, Chief Finance Office, ICB
	
	FC opened the discussion by confirming that the Annual Report and Accounts 2024/25 were approved in June and published on the ICB website. The report contains extensive information required by NHS England (NHSE), but key highlights shared included:
	• The ICB serve over 1.1 million people. Despite historic underfunding, the ICB:
	  ○ Delivered a balanced budget.
	  ○ Met year-end financial targets.
	  ○ Received an unqualified audit report, one of the few ICBs to achieve this nationally.
	• BLMKs population growth is twice the national average, with significant increases in an ageing population and economic development. NHS funding does not keep pace with population growth, and it was recognised that the Office for National Statistics (ONS) figures are likely underestimated.
	• KO'N queried whether the growth in clinical appointments is keeping pace with population growth and service demand. FC acknowledged that while exact figures were not immediately available, it is likely that appointment growth is slightly lagging behind demand due to funding constraints.
	
	The Board noted several achievements across health services:
	• Children being ready for starting school and retention improved through partnership with local authorities.
	• Direct children and young people's mental health service (CAMHS) access for young people.
	• Smoking cessation services delivered with public health teams.
	• Tackling undiagnosed high blood pressure.
	• New services for musculoskeletal (MSK) and end-of-life care.
	• Highest dementia diagnosis rate in the East of England.
	• Warm homes initiative which is linked to reduced emergency admissions.
	• Career development supported through career passport and apprenticeship schemes.
	• Improved translation and interpretation services for diverse populations.
	
	Primary Care and Mental Health Expansion
	• Primary care delivered 1,669,754 appointments between September and November 2024, which is a 10.38% increase on the same period in 2023/24.
	• Initiatives included:
	  ○ Unscheduled care coordination hub.
	  ○ Pharmacy First.
	  ○ Expansion of mental health teams in schools.
	  ○ Increased self-referral for MSK disorders.	

Performance and Challenges

While progress has been made, challenges remain:

- 52-week waits reduced by half.
- Breast cancer screening uptake increased by 15%.
- Expanded postnatal mental health services.
- Increased health checks for people with learning disabilities and autism.

However:

- Referral-to-treatment times remain longer than national averages.
- Cancer and diagnostic waits are still a concern.
- Mitigation actions include:
    - Waiting list reviews.
    - Patient-initiated follow-ups.
    - Opening of Community Diagnostic Centres (CDC) in Bedford week commencing 29 September and Luton CDC in development.
- KO'N queried if there was understanding as to what is driving the diagnostic rates in Bedford. FC noted that capacity challenges are not solely about infrastructure but also staffing. DC elaborated that increased diagnostic usage, particularly by junior doctors, is contributing to pressure on services. AR added that the role of the diagnostic collaborative and hospitals opportunity assessment, is to streamline pathways so patients receive the right tests at the right time, helping to manage demand more effectively.

Place-Based Priorities

Bedford Borough

- Focus on warm homes and free school meals, led by public health.

Central Bedfordshire

- Emphasis on service integration and new clinical space in Leighton Buzzard.

Luton

- Support for NHS careers, care homes, and NHS App uptake.
- Focus on employment as a health determinant.

Milton Keynes

- The Milton Keynes Deal underpins strategy.
- Highlights included:
    - Academy training for care workers.
    - Bletchley Pathfinder community initiative.
    - Fruit stalls in schools to promote healthy eating.

Financial Overview

DW reinforced the financial achievements with an infographic detailing how the £2 billion budget was allocated. Key points included:

- A small surplus was achieved at the end of 2024/25.
- The ICB remained within its running cost allocation, despite a circa 30% reduction.
- The Mental Health Investment Standard was met.
- External auditors found no significant weaknesses in value-for-money arrangements.
- The wider ICS also met NHSE's financial targets, delivering a surplus for 2024/25.

The Board recorded thanks to Gaynor Flynn and contributors for compiling the annual report.

There were no questions from the public.

	The Board **noted** the annual report and accounts for 2024/25.	
4.0	**Chair's Report (*verbal)*** *Presented by Robin Porter, Chair, ICB* The Chair reflected on a period of significant activity and transition. In addition to continuing the induction process for BLMK, the Chair has commenced induction for Hertfordshire and Cambridgeshire & Peterborough systems. Key highlights included: • Attendance at a community-led afternoon tea event in Luton, supporting the local charity Friends of Bright Eyes, alongside KO'N. • Participation in the Bletchley Pathfinder visit, observing collaborative efforts to integrate services and improve outcomes for residents. • A celebration event for BLMK staff, recognised achievements over the past year and highlighted the contributions of FC to the system. • Site visits to Milton Keynes University Hospital (MKUH) and Bedford Hospitals Foundation Trust (BHFT). • Engagement in multiple regional and national meetings related to the ICB reconfiguration. • Attendance at the Cambridgeshire & Peterborough Board meeting on 19 September. • Facilitation of an initial staff engagement session involving over 1,000 staff members. • Upcoming participation in a fundraising abseil from the new Bedford Hospital block in support of the maternity unit. • Planned attendance at the Bedfordshire Hospitals Board next week. The Chair's Report was **noted.**	
5.0	**Chief Executive Officer's Report** *Presented by Felicity Cox, Chief Executive Officer, ICB* FC provided an update on key developments relating to the reconfiguration of the ICB including: • A ministerial statement on 9 September confirmed that the name "Central East ICB" has been accepted and the new ICB will be established on 1 April 2026. • The Chief Executive designate appointment is expected to be announced on Monday 29 September, and executive roles were shared with staff earlier in the week. • Staff support remains a priority, with extensive measures in place to help manage the uncertainty that has persisted since the ministerial announcement in March. AB acknowledged the positive feedback received from staff regarding the range of support mechanisms in place during period and commended the People team's work in making that support possible. **Strategic Planning and Commissioning** • Commissioning intentions for the new ICB are complete and being aligned with C&P and HWE systems. • Contracting rounds will begin on 1 October. • Planning guidance, though delayed, is expected next month and will inform the population health improvement plan due by Christmas. **Neighbourhood and Regional Developments** • While the ICB was unsuccessful in securing a neighbourhood pilot, North Cambridge and Peterborough was selected and will share learning across the region. • The annual assessment review by NHSE was positive.	

	• Progress continues in specialised commissioning, particularly in head and neck cancer pathways with Oxford and Milton Keynes. However, the transfer of the specialised commissioning team has been delayed, now expected in April 2027. • Mount Vernon Cancer Centre work is progressing, with consultation now likely in the new year. • FC expressed gratitude to colleagues and Board members for their support over the past five years. The Board **noted** the Chief Executive's Report.	
	System Strategy	
6.0	**Transformation Priorities Update** *Introduced by Maria Wogan, Chief Strategy & Transformation Officer, ICB* **Transforming Complex Care – Children's** MBr confirmed that progress continues, though the work is more challenging than first anticipated. The programme is surfacing issues and areas for improvement, and partners are working collaboratively to address them. The overall outlook remains positive. **Transforming Complex Care – Adult's** SS advised that the current emphasis was on securing joint funding agreements across BLMK, particularly for All-Age Continuing Healthcare and related services. At this stage, the four local authorities do not have an additional, single system-wide adult transformation they wish to take forward collectively. It was suggested that, under the new neighbourhood governance, the approach and learning from children's services could be considered for adults' services. LC confirmed that owing to CQC assessment activity, adults' complex care work is postponed, not cancelled. **Transforming End of Life (EoL) Care** MTa updated the Board on current progress: • Governance is fully established with bi-monthly Programme Board meetings; monthly education, clinical and finance groups are supporting pace and coordination. • Bedfordshire hub: Phase 1 to launch in December as a single coordination hub and access point for patients/referrers. This will introduce a unified phone system and merged digital infrastructure. SS advised that the Bedfordshire hub will operate 24/7, jointly run by two hospices on SystmOne, with NHS 111 option 4 routing directly to palliative care support. • Patients may opt into a register with proactive three-monthly reviews and rapid step-up access (e.g. virtual ward or Same Day Emergency Care (SDEC)). • Partners will deliver within existing resources this year; planning for potential resource movements is likely for 2026. • As the Bedfordshire go-live approaches, the programme will ensure clear system governance and sign-offs, particularly where resource shifts across acute, community, voluntary, community and social enterprise (VCSE) and primary care. • Milton Keynes is working on a similar hub, with a business case by the end of October. Of an estimated £150m annual system spend on the palliative and end of life cohort, around 25% related to emergency admissions, a key target for reduction. • System finance leads have commenced modelling of last-year-of-life spend to identify efficiencies, resource shifts and new pathways. Early bed days data show positive signs and will be tested further with the Programme Board. • A patient forum has launched; learning from the first session will ensure a safe space for patients/families. An engagement plan with Healthwatch is expected in the coming weeks.	

- KO'N queried whether a target had been set for the proportion of deaths occurring in a preferred placed of death, and what the current ICB baseline and ambition are. SS advised that preferred place of death will be captured and is measurable, but immediate aims are to have 1% of the population on an EoL plan with three-monthly proactive reviews, and to achieve a 50% reduction in emergency admissions for this cohort.

Transforming Admission and Discharge Pathways
MWi updated the Board that the programme remains focused on admission avoidance, discharge capacity (Pathway 2), and expansion of the Unscheduled Care Coordination Hub (UCCH) across Bedford, Luton and Central Bedfordshire with acute, community and ambulance partners. Additional financial support from the East of England Ambulance Service is expected to extend capacity over winter. Individual winter plans are nearing sign-off, though whole-system assurance requires careful aggregation. The ICB has agreed to enhance dementia-specific bed access to improve flow and reduce avoidable long-term care placements.

A recent NHSE letter requested greater specificity on A&E crowding and related targets; current winter plans did not factor this in. The urgent and emergency care (UEC) team will return to the Board with updated assurance once implications are worked through. There is no new money expected for health or social care; the system must live within existing resources.

GB advised that operational improvement runs concurrently with multi-year transformation. Governance and a scorecard are in place to monitor thresholds and progress. Admission-avoidance spans UCCH, primary care access, same-day access, 111, integrated urgent care, Pharmacy First, virtual wards and more. On discharge, the focus is Home First, including discharge to the same level of care as on admission, optimising Integrated Discharge Hubs at each trust, and taking a commissioner view of out-of-hospital capacity. A key near-term measure is to reduce medically-fit delays by one day.

DW emphasised the need to quantify financial benefits as programmes mature, to underpin the 2026/27 position of the new ICB. MWo proposed building the learning and benefits into next-year planning via the Neighbourhood Health Delivery Committee, feeding into the wider Central East ICB plan; the Chair agreed and noted broad support.

The Chair thanked all champions and teams.

Actions arising:
1. MWo to oversee incorporating learning from the three programmes into 2026/27 planning, including quantified financial benefits, and report through the newly established Bedfordshire and Milton Keynes Neighbourhood Health Delivery Committee into the Central East ICB plan.
2. Resume and progress adults' complex care work as Local Authority capacity improves post-CQC assessments.
3. MWi and GB to update the Board with updated winter assurance addressing the recent NHSE requirements on A&E crowding and targets.

The Board noted:
1. The progress made in each of the three transformation priorities led by the System Champions.
2. That progress is being reported in the bi-monthly portfolio report and summary report will be provided to each Neighbourhood Health Delivery Committee meeting.
3. System transformation BAF risk is being reviewed to reflect key risk themes identified by the priority programmes.

7.0	**Winter Planning and Board Assurance** *Presented by Georgie Brown, Acting Director of Operations, ICB* GB introduced the item advising that the system plan was presented to the Board in final draft form ahead of the national winter stress test on Monday 29 September, with learning and outcomes due to the regional and national teams by 7 October. It was confirmed that provider boards had considered their plans this week: MKUH, BHFT, CNWL and CCS approved their individual winter plans and assurance statements; with LS confirming that ELFT had also approved their plan and assurance statement. The BLMK system plan has been co-created across partners over the year, drawing on last winter's debriefs, and will be continuously reviewed and monitored over the winter period. **Approach and scope:** • Focus on maximising existing capacity and resources through agreed initiatives. • Strengthened processes and tools including escalation, broadcasting, Operational Pressures Escalation Levels (OPEL) action cards and a structured early-warning approach to anticipate rising pressure rather than responding in crisis. • Alignment to national UEC requirements and incorporation of system learning from winter 2024/25. • Inclusion of the vaccination and immunisation strategy and an overview of governance and assurance. • Clear steps to maintain system resilience, patient safety and full utilisation of available resources to support residents. GB noted that, while not without risk, the plan sets out key risks and mitigations and leverages the strength of partnership working built over the last year. GB also confirmed that all system partners, including local authorities, are represented at strategic and operational level. All processes including the early-warning arrangements will be exercised during the stress test on 29 September. LC sought assurance on arrangements through the cluster ICB transition. GB assured the Board that there will be a single Accountable Emergency Officer (AEOs) at executive level in the new ICB with responsibility for winter planning; existing winter leads/AEOs in each current ICB will be retained, and a coordination group is being established to ensure consistency and resilience. FC noted that BLMK has been identified by the Region as an "exemplar" winter plan, thanking GB and the team. **The Board:** 1. **Approved** the BLMK Winter Plan 2025/26. 2. **Approved** the ICB Board Assurance Statement. 3. **Noted** the planned next steps, including the testing of plans and arrangements at the Winter Stress Test Exercise on Monday 29 September. 4. **Noted** the commitment to embed further learning following the stress test throughout winter.	
8.0	**Community and Mental Health Transformation Programme Case for Change** *Presented by Maria Wogan, Chief Strategy & Transformation Officer, ICB and Tara Dear, Head of System Transformation Team, ICB*	

MWo thanked Board members, provider partners and local authority colleagues for their extensive collaboration, which had strengthened the analysis and conclusions of the Case for Change. Following feedback, the team undertook additional work on data, analysis and conclusions, resulting in a clearer summary of current service position, improvement opportunities, and system strengths. It was emphasised that the programme was one of the ICB's most important strategic transformation programmes and was being approached explicitly from a strategic commissioning perspective, including a review of how services are commissioned.

Engagement summary

MWo highlighted a significant system-wide engagement exercise, which continued up to the date of the meeting:

- 550+ comments received on the Case for Change document since first publication.
- System Insight Network event (May): 200+ participants.
- Provider engagement session: ~200 staff involved.
- Resident and workforce groups held across BLMK.
- Targeted outreach with the VCSE, Autism Bedfordshire, and Access Bedford, focusing on under-represented groups in line with learning from the Denny Review.

Due to engagement still being live when papers were circulated, MWo provided new insights to be incorporated into the final Case for Change subject to Board approval:

- Palliative and End-of-Life care: Strengthen recognition of its importance and current funding challenges. MTa welcomed the strengthened palliative care and accessibility elements and asked how residents, service users and carers will shape next-stage specifications. PH confirmed that engagement will deepen at specification level alongside development of a long-term outcomes framework to evidence delivery of the transformation priorities.
- Emphasise the need for staff training on neurodivergence across the system to support neurodivergent residents.
- Crisis/out-of-hours support: Reiterate its importance and ensure adequate emphasis.
- Strengthen references to accessible formats for the Deaf community and the use of British Sign Language (BSL) to ensure equitable access.
- Reinforce the role of carers' voices and carers' support in care planning, and the critical role of the VCSE in future service transformation.

It was confirmed that the additions do not alter the four key themes or six transformation priorities already identified in the Case for Change; it enhanced and clarified the narrative and emphasis.

TD explained that the Case for Change sets the foundation for future service design, articulating both why change is needed and what is working well. It was emphasised that community and mental health services are essential in helping people to live well, preventing or supporting through crisis and that BLMK already had positive assets to build on, notably effective neighbourhood examples, strong VCSE partnerships, and digital innovation. However, legacy commissioning had produced variation in access and models of care, affecting outcomes. Demand is rising, driven by significant population growth, for example, a forecast increase in dementia prevalence, one in five children living with a probable mental health disorder and local suicide rates rising against a challenging national backdrop. This complexity is compounded by workforce pressures and limited infrastructure investment. Without reform, costs will rise significantly, and the current service model is not sustainable.

Key findings:

- Variation in service models, access and outcomes differ by geography and provider.
- Prevention & population health: A limited focus to date; services are largely reactive, with clear opportunity to "upstream" preventative support.
- Residents and staff report duplication, repeated storytelling and difficult transitions between services.
- Delivery will require greater provider accountability and a culture shift. As the ICB moves into a strategic commissioner role, providers must take more collaborative responsibility for population outcomes.

Transformation priorities

The programme identified six transformation priorities through extensive market and resident engagement. The presentation drew out the following areas where change will have the greatest impact:

- Develop neighbourhood working, anchoring care in local communities.
- Embed Population Health Management (PHM), using data to target risk and address inequalities.
- Expand innovative models of care focussing on new approaches to manage complexity more effectively.
- Deliver personalised and coordinated care to reduce duplication and improve experience.
- Shift care closer to home by delivering more in community settings to support "left shift" and align with the Hospitals Opportunity Assessment interdependencies.
- Strengthen community urgent care.

Board Discussion

- TK welcomed the direction of travel and sought assurance that interdependencies with primary care would be fully reflected, given neighbourhood working, PHM, and care closer to home all depend on GP workforce and PCN engagement. It was confirmed that the programme is collaborative, and primary care is critical to neighbourhood care. MWo proposed channelling the work through the Neighbourhood Health Delivery Committee to align with neighbourhood development and the Hospitals Opportunity Assessment.
- LC queried what "looking across the rest of Central East" meant for next steps. MWo explained that Cambridgeshire & Peterborough ICB are reviewing community and mental health services with a report due mid-November, and changes are underway in Hertfordshire. With new governance from October and a new executive management team, there is an opportunity to consider strategic options across the wider footprint while maintaining BLMK momentum.
- RG endorsed the collaborative document as a balanced, objective basis for planning and stressed the commissioning landscape must evolve alongside provider models, with careful interface to the Hospitals Opportunity Assessment and the resource implications of left shift. MWi also supported the case and emphasised enabling staff to work differently and jointly, standardising community/mental health data to evidence impact and value and designing cross-boundary specifications that reflect the acute, primary and community interface.
- IR noted that integration was not reflected strongly in the priorities. MWo and PH agreed to make integration more explicit, noting this will be a commissioning principle and a practical focus in provider engagement. DC highlighted the opportunities of the larger ICB footprint to strengthen cross-border integration and neighbourhood working and recommended establishing a clear baseline of current provision including workforce, spend and team structures to unlock potential benefits. MBr confirmed local authorities are ready to play an active role in integration but stressed the need to keep the programme grounded in

	financial reality given high demand. MWo noted the case's stark financial analysis and the necessity of a preventative, targeted model within existing resources. **Actions arising:** • Programme team: Incorporate integration more explicitly in priorities/commissioning principles and strengthen the baseline of current provision. • Neighbourhood Health Delivery Committee: Align community and mental health planning with neighbourhood development and the Hospitals Opportunity Assessment, ensuring primary care dependencies are embedded. **The Board:** 1. **Approved** the Case for Change including the key findings and proposed transformation priorities. 2. **Noted** the progression to the strategic transformation planning phase to develop the related outcomes framework and service specifications noting that the business case itself will be subject to further alignment with the BLMK Hospitals Opportunity Assessment and similar community and mental health programmes in Cambridge & Peterborough ICB and Hertfordshire.	
	System Assurance	
9.0	**Audit & Risk Assurance Committee** **Committee Chair's Report** The report was taken as read. MWo sought assurance from DW regarding ISFE2, the new ledger system for ICBs. DW reported that the system was due to go live on 1 October. While concerns were raised at the Audit and Risk Assurance Committee due to the lack of sandbox testing, DW assured the Board that the ICB was well-prepared for the transition. Regular updates have been provided to VM and AB to maintain oversight. **The Board :** 1. **Noted** the risks regarding ISFE2 and took assurance from the finance team's readiness. 2. **Noted** the report from the meeting held on 11 July 2025. 3. **Approved** updates to the terms of reference, aligned with Healthcare Financial Management Association (HMFA) guidance. **System Risks Register (SRR) and Board Assurance Framework (BAF)** – *Maria Wogan, Chief Strategy & Transformation Officer, ICB* MWo advised that SRR and BAF had been updated to reflect: • Transition risks linked to future governance structures. • Data security breach risks. • Plans to consolidate strategic risks across the Central East ICB and reallocate some system risks to partner organisations. **The Board:** 1. **Noted** the SRR/BAF update 2. **Agreed** any changes to the SRR/BAF including additional actions of mitigations as required.	
10.0	**Finance & Investment** **Committee Chair's Update –** *Manjeet Gill*	

	MG asked the Board to approve the Section 75 (S75) agreements for the four local authorities as recommended by the Committee: a) Bedford Borough Council Section 75 Agreement 2025/26 (Better Care Fund) to a value of £21,840,169. b) Central Bedfordshire Council 2025/26 Section 75 Agreement (Better Care Fund) to a value of £38,820,410. c) Central Bedfordshire Council Section 75 Agreement Personal Health Budgets. d) Luton Borough Council Section 75 Agreement 2025/26 (Better Care Fund) to a value of £31,988,372. e) Milton Keynes City Council Section 75 Agreement 2025/26 (Better Care Fund) to a value of £23,346,761. **The Board:** 1. **Noted** the report from the meeting held on 16 May 2025. 2. **Approved** the S75 agreements as detailed above.	
10.1	**ICS Finance Report** *presented by Dean Westcott, Chief Finance Officer, ICB* DW updated on the Month 4 finance position, noting that: • The system reported a £7.9 million deficit, £4.8 million adverse to plan. • Efficiency delivery was £2.2 million behind target against a £119 million target. • Capital underspends were noted but expected to recover due to timing delays, particularly at Bedford Hospital. • The ICB remained compliant with the agency cap and was forecast to remain so. • Productivity metrics compared favourably with other East of England systems, though data was based on Month 11–12 of the previous year. • Month 5 data showed further deterioration, with the system £6.7 million off plan, £6.2 million of which related to Bedford Hospital. Milton Keynes University Hospital position had stabilised. • All organisations continued to forecast break-even by year-end. Bedfordshire Hospitals had developed a financial recovery plan, currently under discussion with the ICB and NHSE. **Better Care Fund and Planning** MWi raised concerns about the Better Care Fund being signed off in September, despite the financial year starting in April, urging earlier alignment with planning timelines in future. MWo clarified that preparatory work for the Better Care Fund had been completed earlier in the year and that current reviews were underway in readiness for the next cycle. Updates would be brought through the Bedfordshire and Milton Keynes Neighbourhood Health Delivery Committee. **The Board noted** the ICS finance report.	
11.0	**Health & Care Partnership (HCP) Update** **Committee Chair's Report –** *Cllr Martin Towler* Cllr Towler provided an update on the HCP's work over the past year, highlighting strengthened partnership working and contributions to key initiatives, including the Green Plan, Infrastructure Strategy and the Community and Mental Health Transformation Programme. The HCP recently reviewed progress on the following programmes: • The 10-Year Plan for Health and ICB reconfiguration. • The Hospitals Opportunity Assessment. • The rollout of the NHS Modern General Practice model in BLMK. • Members were also briefed on the government's proposal to dissolve Integrated Care Partnerships (ICP) following expected legislative changes in April 2027. In	

	response, governance arrangements are being developed to ensure ICP functions are retained, with a strong emphasis on maintaining accountability to residents. • Concerns were raised about the proposed abolition of Healthwatch, with members stressing the importance of preserving resident engagement. The ICB was encouraged to work with partners to establish alternative arrangements. • The HCP welcomed the progress of the Community and Mental Health Transformation Programme, particularly its engagement with service users and the VCSE sector and expressed support for future co-designed services. • Partners look forward to continued collaboration with the new Central East ICB. **The Board noted** the report from meeting held on 23 September 2025.	
12.0	**Mental Health Learning Disabilities and Autism (MHLDA) Collaboration Committee Chair's Update** **Committee Chair's Update** The report was taken as read and no further questions were raised. **The Board noted** the report from the meeting held on 29 August 2025.	
13.0	**Primary Care Commissioning & Assurance Committee (PCCA) Chair's Update** **Committee Chair's Update** – *Alison Borrett* The report was taken as read and no further questions were raised. **The Board noted** the report from meeting held on 01 August 2025.	
14.0 14.1	**Quality & Performance** **Committee Chair's Update** – *Shirley Pointer* The report was taken as read and no further questions were raised. **The Board noted** the report of the meeting held on 12 September 2025. **Performance Report**, *presented by Sarah Stanley, Chief Nursing Director, ICB and Maria Wogan, Chief Strategy & Transformation Officer, ICB* The report was taken as read. MWi queried the absence of neurodevelopmental data for children and young people (CYP) from the performance report, noting that long waiters remain across the system and that this data had previously been included. The importance of maintaining transparency was emphasised, particularly given the link to high-cost tariff work. It was confirmed the data had likely been omitted in error and it was agreed that it would be reinstated it in future reports. **The Board noted** the Performance Report.	
	ICB Organisational Decisions, Governance and Assurance	
15.0	**Remuneration Committee –** *Shirley Pointer* The report was taken as read with SP highlighting that the Committee had recently met to review race and disability equality data, including associated pay gaps. All indicators showed positive movement, reflecting the executive team's commitment to progressing this agenda. SP also commended the support provided to staff during the ongoing restructuring process, describing it as exemplary.	

	The Board noted the report from the meeting held on 10 July 2025, 21 July 2025, 29 August 2025 and 25 September 2025.	
16.0	**Corporate Governance Update** *Presented by Maria Wogan, Chief Strategy & Transformation Officer, ICB* MWo presented the paper outlining proposed transitional governance arrangements to support working in partnership between Bedfordshire, Luton and Milton Keynes (BLMK) ICB, Cambridgeshire and Peterborough (C&P) ICB, and the Hertfordshire footprint of Hertfordshire and West Essex (HWE) ICB. These arrangements will take effect from 1 October 2025 in preparation for the establishment of the new Central East ICB on 1 April 2026. The purpose of the transitional arrangements was to ensure alignment across the three ICBs, maintain momentum and provide clarity for staff and programmes during the transition. Key elements included: • A streamlined Board structure, reduced to statutory minimum membership, to enable effective joint working across the three ICBs. • It was noted that one Director of Public Health and one Healthwatch representative will be appointed to represent the Central East patch. MTa welcomed the inclusion of Healthwatch representation and confirmed she would work with colleagues across the region to agree on the appropriate representative. • Use of meetings in common and Joint Committees to support efficient governance and to prepare for the future Central East ICB Board. • Amendments to the Constitution, outlined in Appendix B, for Board approval. • A Memorandum of Understanding and a Data Sharing Agreement between the three ICBs to formalise joint working and data handling during the transition. • Delegation of authority to the Chair, Chief Executive, Deputy Chair and Audit and Risk Assurance Committee Chair to make minor amendments post-meeting, if required, in response to parallel discussions at HWE ICB. • The governance framework as detailed in Appendix A. Work is ongoing to finalise the terms of reference for the Bedfordshire and Milton Keynes Neighbourhood Delivery Committee, which will be presented at the first Board in Common meeting expected in mid-October. • The Board formally acknowledged and thanked Michelle Evans-Riches for her significant contribution to developing the governance proposals in collaboration with colleagues from partner ICBs. **Financial Equity and Distance from Target Funding** • MBr proposed an additional recommendation to ensure continued focus on addressing long-standing NHS under funding for BLMK. The importance of maintaining transparent budget monitoring arrangements to track progress was emphasised and it was requested that the Chair ensure this issue is given full and timely consideration by the future Central East ICB. • The proposed additional recommendation was: o "The Board resolves that maintaining clear and transparent budget monitoring arrangements for the population of Bedfordshire, Luton and Milton Keynes is essential to effectively track progress in addressing the area's long-standing funding inequality and requests the Chair ensures that this resolution receives full and timely consideration by the Central East ICB." • The Board supported the principle of the recommendation. Practical concerns were raised about tracking allocations if budgets are aggregated at partnership level in the next financial year. DW acknowledged this uncertainty but noted that disaggregation would still be possible using detailed capitation data, should the new Board choose to do so.	

	• Further discussion highlighted the importance of prioritising the issue, given BLMK's status as a significant outlier in terms of funding disadvantage and its rapid population growth. MBr stressed that continued advocacy and investment in financial tracking systems would be necessary to ensure equitable funding. **The Board:** 1. **Agreed** that maintaining clear and transparent budget monitoring arrangements for the population of Bedfordshire, Luton and Milton Keynes is essential to effectively track progress in addressing the area's long-standing funding inequality and requests the Chair ensures that this resolution receives full and timely consideration by the Central East ICB. 2. **Acknowledged** NHSE'S approval of bringing together the ICBs of BLMK, C&P and the Hertfordshire footprint of HWE ICB which will be formally established as Central East ICB on 1 April 2026. 3. **Endorsed** the proposed transitional Governance Framework outlined at Appendix A, acknowledging that this is an iteration at a point of time which will further develop and be brought to the first Board in Common which it is anticipated will take place during October 2025. 4. **Agreed** the proposed changes to the ICB's Constitution set out at Appendix B and recommend the amendments to NHSE for approval. 5. **Endorsed** the Memorandum of Understanding including the Data Sharing Agreement set out at Appendix C. 6. **Note** that changes are still being made as the transitional framework develops. 7. **Recognised** that there may be potential minor amendments required and acknowledging that C&P ICB Board met on 19 September and HWE ICB Board is meeting on 26 September, the BLMK ICB Board **delegated** final approval of any further amendments to the ICB Chair, Chief Executive, Deputy Chair and Audit & Risk Assurance Committee Chair.	
	Closing Items	
17.0	**Communication from the Meeting** Communications from the meeting will be written up and shared with partners through the usual process. Board members and participants are asked to share information within their organisations.	
18.0	**Meeting Evaluation** The Chair invited feedback from Board members and attendees on meeting effectiveness welcoming responses during the meeting, privately, or via email. It was noted that previous challenging discussions had contributed positively to the collaborative tone of the current meeting and the acceptance of key papers.	
19.0	**Any Other Business** The Chair noted that the membership of the BLMK ICB will change from 1 October 2025 and took the opportunity to offer thanks and reflections, expressing appreciation for the executive team, led by FC, recognising their professionalism, leadership and unwavering focus on improving outcomes for residents. He also thanked the non-executive directors, including VM in her absence, for their oversight, challenge, and support. Acknowledgement was given to partner members and participants for their collaborative contributions, which have helped make BLMK a strong and effective system. The Chair noted that the progress reported during the meeting was a direct result of this collective effort and shared commitment to resident-focused care. **Resolution to exclude members of the press and public:**	

	The Board of the Integrated Care Board resolves that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest, Section 1(2), Public Bodies (Admission to Meetings) Act 1960. *The meeting finished at 11:14*	

Approval of Draft Minutes by Chair only:		
Name	**Role**	**Date**
Robin Porter	Chair	09 October 2025

Minutes

Details	Part 1
Meeting:	ICB Board Meeting in Public
Date of Meeting:	19 September 2025
Time:	10.00 am
Venue:	Seacole Room, Gemini House, Ely

Present:

(Voting Members)

John O'Brien	ICB Chair
Saqhib Ali	Non-Executive Member
Matt Gladstone	Partner Member Local Authorities
Dorothy Gregson	Non-Executive Member
Sarah Griffiths	Chief Finance Officer
Dr Fiona Head	ICB Medical Director
Sarah Hughes	Non-Executive Member
Eilish Midlane	Partner Member NHS Trusts and Foundation Trusts
Jan Thomas	Chief Executive (ICB)
Patrick Warren-Higgs	Partner Member Local Authorities (for Stephen Moir)

(Regular Participants and Observers)

Sharon Allen	VCSE Representative
Sally Cartwright	Director of Public Health
Stacie Coburn	Executive Director of Performance & Assurance (ICB)
Dr Gary Howsam	Chief Clinical Improvement Officer (ICB)
Dr Diana Hunter	Local Medical Committee
Jonathan Jelley	Healthwatch Representative
Claudia Iton	Chief People Officer (ICB)
Louis Kamfer	Managing Director, Strategic Commissioning
Dr Raj Lakshman	Interim Director of Public Health, Peterborough City Council
John Rooke	North Place Representative *(for Hannah Coffey)*
Kate Vaughton	ICB Chief Officer Partnerships and Integration
Matthew Winn	Accountable Officer, Children's and Maternity Collaborative (CCS)

(In attendance)

Sharon Fox	Director of Governance (ICB)
Gemma Keats	Business Support Officer (ICB) (Minutes)
Martin Whelan	Head of Governance and Data Protection Officer (ICB)
Staff	
Members of the public	

Section One – General

ICB25/71 Welcome

The Chair opened the meeting and welcomed all attendees. A special welcome was extended to Sharon Allen, VCSE Representative attending her first meeting as the VCSE representative, and to Robin Porter, observing Chair of BLMK. It was noted that Mr. Porter would formally assume the role of Cluster Chair for BLMK, Cambridgeshire & Peterborough (C&P), and Hertfordshire & West Essex (HWE) from 1 October 2025. The Chair acknowledged the imminent transition into cluster arrangements, with a full merger anticipated in April 2026, and emphasised that all business would be considered with a forward-looking perspective in light of these developments.

ICB25/72 Apologies for absence

Apologies for absence were received from Carol Anderson, Stephen Moir, Hannah Coffey, Steve Grange, and Nicola Ayton.

ICB25/73 Declarations of Interest

The standing declarations of interest were noted. Attendees were reminded to declare any updates to previously submitted interests or any interests specifically related to items on the agenda.

ICB25/74 Notification of Any Other Business

There was no notification of any other business.

ICB25/75 Minutes and Action List

The minutes of the previous meeting were reviewed and agreed as an accurate record. It was confirmed that there were no outstanding actions.

ICB25/76 Matters Arising

There were no matters arising from the previous meeting.

ICB25/77 Formal presentation of Annual Report and Accounts 2024/25

The Annual Report and Accounts for the period 1 April 2024 to 31 March 2025 were formally presented. These had been adopted in June and were made available via the website link included in the agenda papers. No questions were raised by Board members or members of the public in relation to the report.

ICB25/78 Questions from the Public

There were no questions received from the public.

ICB25/79 Chair's Report

The Chair's Report was taken as read. The Chair highlighted the significant transition activity underway, much of which was covered in other agenda items. The report included the annual assessment received from NHS England, which showed an improvement in the ICB's rating from Level 3 to Level 2. The Chair expressed appreciation to all involved in achieving this progress. The report also addressed the potential local government reorganisation, noting Cambridgeshire County Council as one of three structural options under consideration. The Chair emphasised the importance of aligning any future structures with place partnerships, particularly in the context of the Neighbourhood Pioneer Programme. Board members were invited to share their views before a formal response was submitted.

The Partner Member for Local Authorities noted that formal engagement had taken place at regional level and welcomed feedback from general practice colleagues, particularly regarding alignment with place-level structures. The VCSE Representative expressed support for incorporating the VCSE perspective into the system-wide response. The LMC Representative raised concerns about the Huntingdonshire area, referencing the resizing of the Pioneer bid and the implications for neighbourhood configuration. The North Place representative supported the concept of a North Care Partnership, citing benefits for service integration and planning for vulnerable groups. A Non-Executive Member stressed the importance of balancing enthusiasm for change with the need to maintain safety and clarity, particularly in handover processes. The Accountable Officer, Children's and Maternity Collaborative highlighted the emotional and operational impact of the transition process and suggested strengthening risk assessments related to redundancy and organisational change. The Chair concluded that the Board was broadly content with the proposed approach and noted the importance of secure and well-managed change.

The Board **noted** the Chair's Report.

ICB25/80 Chief Executive's Report

The Chief Executive Officer's Report was presented by Jan Thomas and taken as read. The Chief Executive emphasised the continued focus on financial recovery and the importance of maintaining autonomy. Although earlier forecasts had shown a slight deviation from plan, mitigation strategies were in place, and the organisation was expected to meet its statutory financial duties by year-end. The Chief Executive acknowledged the ongoing operational pressures and noted that the organisation no longer experienced quiet periods. Progress on the Neighbourhood Health Programme was also acknowledged. The Chief Executive confirmed that, alongside day-to-day operations, the team was actively engaged in transition planning and the development

of future elements of a team.

The Board is discussed the Chief Executive's Report and **noted** the content.

ICB25/81 Board Assurance Framework

The Board Assurance Framework (BAF) was presented by the Managing Director of Strategic Commissioning.

The Managing Director of Strategic Commissioning explained that the BAF outlined strategic risks that could impact the organisation's ability to achieve its objectives and would inform the internal audit opinion. It was noted that the risk related to industrial action had been reduced in May 2025 but was now reinstated due to recent developments, including resident doctors' strikes. Ministerial guidance on footprint changes was being monitored and mitigated. The LMC Representative supported the increase in the industrial action risk. A Non-Executive Member raised concerns about hostility and racism affecting homecare staff, and the Chief Executive emphasised the need to explicitly address behaviours that compromise staff safety. The Partner Member for Local Authorities highlighted ongoing protests in Peterborough and their impact on workforce morale. The Chief Medical Officer reiterated that safety must be paramount in all planning. Matt Winn suggested strengthening the risk related to redundancy processes and noted the emotional toll of transition. The risk associated with local government reorganisation was identified as significant, with DG stressing the importance of clear handovers and risk mitigation. VCSE Representative noted the impact of industrial action on the voluntary and community sector's ability to access services. The Managing Director of Strategic Commissioning confirmed that the BAF would be updated to reflect the points raised, including the reintroduction of industrial action risk, the impact on VCSE, and the addition of risks related to racism, immigration, and local government reorganisation.

The Board **reviewed and discussed** the September 2025 version of the Board Assurance Framework and **agreed** to the proposed updates.

Section Two – Strategy

ICB25/82 Draft ICS Winter Preparedness and Resilience Plan

The Board received and discussed the draft Integrated Care System (ICS) Winter Preparedness and Resilience Plan. The plan reflects both the ICB's operational planning and the wider integrated care system position. It was noted that the plan had been assured ahead of the end of September and would culminate in a formal submission to NHS England by 30 September 2025.

The Winter Plan was rooted in the operational plan and focussed on maintaining quality and improving performance in urgent and emergency care. It emphasised the importance of clinical oversight, maximising utilisation of system assets, and delivering

the “big moves” programmes. These included addressing urgent and emergency care demand profiles, implementing the urgent care hub, and advancing the frailty model in the northern area of the system.

The Board was informed that the most significant demand peaks were expected around Christmas and New Year. This year, the system had adopted a data-driven approach to real-time forecasting, moving away from historical capacity-based decision-making. Some winter actions have already commenced, targeting interventions at those most in need.

Section 9 of the draft plan outlined the specific requirements from NHS England. Across all areas, the system was working in a multi-disciplinary team (MDT) approach, which was reflected in changes to governance arrangements this year. Winter remained a significant risk, particularly in the context of productivity challenges and performance expectations. The Board acknowledged the level of residual risk, which was influenced by modelling assumptions. However, it was noted that the gap between demand and capacity is smaller than in previous years, and while not all risks can be mitigated, performance improvements continued to be observed.

A system-wide stress test event was scheduled for 30 September to validate the plan and ensure learning is captured before demand increases in November. The Board was asked to note progress and agree to delegate authority to the Chief Executive Officer to finalise and submit the Board Assurance Template to NHS England.

The Partner Member NHS Trusts and Foundation Trusts acknowledged the importance of recognising the risk of industrial action during winter from a provider perspective and emphasised the need to maintain progress on elective recovery. She welcomed the stress testing event but raised concerns about the timing, as the test and submission were scheduled for the same day. The Chief Operating Officer responded that while the date could not be brought forward, NHS England was aware and would continue to support stress testing throughout September and October. She also confirmed that on-site clinical audits were being conducted with providers to ensure pathway delivery was effective.

The North Place Representative echoed the importance of staff and population vaccination programmes and highlighted improvements at NWAFT. He stressed the need to focus on known pressure points and to test plans collectively. Patrick supported the emphasis on stress testing and highlighted the importance of ensuring staff coverage and voluntary sector support, noting the need for whole-system collaboration.

The Partner Member for Local Authorities welcomed the comments and the focus on stress testing, particularly in relation to slips, falls, and the potential use of AI. He expressed interest in seeing more innovative thinking incorporated into the plan. Accountable Officer, Children’s and Maternity Collaborative referred to the Jim Mackey letter regarding crowding in A&E and the importance of ensuring patients are seen in appropriate settings. The Chief Operating Officer noted that not all provider

plans had been received but confirmed that local colleagues were working through governance processes and that provider boards were expected to review their plans locally.

Accountable Officer, Children's and Maternity Collaborative emphasised the need to bring this work into the new cluster board arrangements, noting that ICBs would be held accountable for delivery. He referenced his role as Chair of the UEC Board in the BLMK patch and the responsibility of providers to act on behalf of the system.

The VCSE Representative thanked Patrick for highlighting the role of the VCSE sector and asked whether the system was confident that it had fully optimised VCSE contributions, particularly in areas such as the vaccination programme. She noted that VCSE organisations employ large numbers of people and have significant reach into communities.

The Chief Executive reflected on the recurring nature of winter planning and asked what would feel different for patients this year. She questioned what improvements had been made and what work remained to be done. A non-Executive Member stressed the importance of the vaccination programme and raised concerns about anti-vaccine sentiment in some communities. She highlighted the need to address issues of diversity and access, particularly in mental health, and noted that prevalence of mental health issues is increasing.

The Medical Director shared a positive example of the urgent care hub, where a patient was successfully supported despite initial confusion. The Chief Operating Officer added that mental health expertise must be embedded in urgent care pathways to ensure holistic care. She acknowledged the critical role of the VCSE sector and the need to bring providers together regularly to support continuous improvement. She also noted that a separate mental health event is scheduled for October, with a focus on learning disability and a more positive, integrated response.

The Chief Operating Officer further reported that increased streaming capacity had been implemented at NWAFT and CUHFT, with plans to roll out similar capacity at Hinchingbrooke in the coming weeks. This initiative is enabling the diversion of 30–60 patients per day from emergency departments to more appropriate care settings.

The Interim Director of Public Health added that NWAFT had engaged with the system to reduce paediatric admissions for respiratory illness by offering community-based sessions focused on acute respiratory conditions. The North Place Representative highlighted improvements in ambulance handovers and the importance of robust frailty support, including the development of a frailty hub in the north and the use of predictive analytics and personalised care plans.

The LMC Representative provided an update from the primary care perspective, noting that the GP committee had agreed to maintain online access for routine appointments. She emphasised that the issue was not access itself but ensuring patients were seen in the right place. Locally, the system was well-positioned, and

efforts are being made to improve patient understanding of care pathways.

The Healthwatch Representative concluded by acknowledging the positive examples shared and the importance of monitoring patient experience throughout the winter period. He reminded the Board of the upcoming Healthwatch annual summit on 8 October 2025.

The Chief Operating Officer confirmed that the plan remained a work in progress and welcomed the opportunity to discuss it in mid-September, ahead of the seasonal increase in demand. She thanked members for their contributions and confirmed that authority would be delegated to the Chief Executive Officer to finalise and submit the Board Assurance Template by the end of September.

In conclusion, the Board noted that the Draft ICS Winter Preparedness and Resilience Plan set out the system's approach to coordination and intervention throughout Q3 and Q4. The plan was aligned with operational commitments for 2025/26, including improving productivity, efficiency, and delivery of strategic programmes. It reflected collaborative work across the system and outlined enhanced governance arrangements to support real-time learning and adaptation during peak demand periods.

The Board **acknowledged** that further development of the plan was required, including receipt of provider board-approved plans. The Board **noted** the progress made to date, recognised the residual risks and proposed mitigations, and **agreed** to delegate authority to the Chief Executive Officer to review and submit the Board Assurance Template to NHS England by 30 September 2025.

ICB25/83 Local Get Britain Working Plan

The Chair welcomed Andrea Wood from the Cambridgeshire and Peterborough Combined Authority to present the draft Local Get Britain Working Plan. The Board expressed its appreciation for the inclusion of this item, noting its relevance to discussions held in other forums such as the Health and Wellbeing Board and the Combined Authority. The importance of connecting health and employment was acknowledged as a critical area for integrated system working.

The ICB Chief Officer Partnerships and Integration introduced the item and welcomed Andrea's contribution, noting the longstanding collaboration on the Work Well programme and its impact on population health. Andrea Wood provided an overview of the current draft plan and accompanying local labour market analysis. She explained that the plan aimed to address economic inactivity through place-based partnerships, with a particular focus on the impact of ill health as a leading cause of inactivity in certain communities.

The plan outlined a strengthened system-wide approach involving collaboration with the Integrated Care Board, primary care, Jobcentre Plus, community and voluntary sector organisations, colleges, and universities. It set out key priorities and actions for

the coming months, including targeted skills development and specific programmes of delivery. A central component was the Work Well programme, which supported adults with health issues who were not yet in receipt of benefits. To reach these individuals, strong links with primary care were essential, and Work Well hubs would play a key role. Jobcentre Plus would also focus on increasing disability employment opportunities.

Andrea Wood invited initial feedback on the draft and indicated that a revised version could be brought back to the Board at a later date. The Director of Public Health expressed support for the plan and suggested strengthening the involvement of mental health providers. The VCSE Representative queried the presentation of data on page 21, specifically the grouping of Pakistani and Bangladeshi females, to which Andrea Wood responded that she would follow up on the detail.

The Managing Director, Strategic Commissioning highlighted musculoskeletal conditions as major drivers of economic inactivity and emphasised the value of combining system intelligence with Department for Work and Pensions (DWP) data to improve targeting. The Partner Member for Local Authorities raised concerns about the lack of emphasis on educational attainment and the absence of references to early years and the importance of a good start in life. He noted the potential role of local authorities in addressing these issues.

The Interim Director of Public Health echoed the importance of schools as safe spaces and the challenges in accessing education. A Non-Executive Member reflected on the broader challenge of whether the system was focussed on health optimisation or engaging with individuals in their lived realities. She emphasised the importance of understanding community aspirations, such as securing employment and housing, and framing interventions accordingly.

Andrea Wood acknowledged the breadth of the agenda across skills and employment and noted that the Combined Authority's remit is primarily focused on adults. She agreed to incorporate more detail on current and planned interventions and highlighted the role of anchor institutions and neighbourhood-level engagement. The ICB Chief Officer Partnerships and Integration reinforced the point that individuals do not separate their health needs from other aspects of life and that clinicians often encounter patients whose needs extend beyond healthcare. She stressed the importance of understanding and acting on these interconnections.

VCSE Representative noted the significant number of employers supported by the VCSE sector and advocated for greater emphasis on preparing employers to welcome individuals with disabilities. Partner Member Local Authorities added that care leavers and people with learning disabilities deserved equal opportunities and questioned whether the paper sufficiently addressed mechanisms to support their return to employment.

The Medical Director welcomed the report and referenced Dame Carol Black's work on the positive health outcomes associated with employment, including voluntary

work. She suggested that this framing could be more explicitly reflected in the plan. Andrea Wood agreed and confirmed that Dame Carol Black had participated in stakeholder sessions. She reiterated the importance of employment for mental health and committed to incorporating the feedback received.

North Place Representative raised the issue of employer support, and a Non-Executive Member declared an interest, noting that Mind was working with the Mayhew Review. She emphasised the importance of leveraging decades of experience in the mental health sector and highlighted the role of third sector organisations in delivering employment pathways. She also raised concerns about poverty, digital exclusion, and the need for a life-course approach, particularly for individuals over 60.

The Chief Clinical Improvement Officer noted the absence of the primary medical services voice and stressed that good work is beneficial to health, while poor or no work has detrimental effects. He encouraged the Board to consider its risk appetite in pursuing the right interventions. The Accountable Officer, Children's and Maternity Collaborative welcomed the discussion and highlighted that 24% of adults in Cambridgeshire and Peterborough are currently out of work. He shared a positive example of care leavers progressing to higher education and noted the potential impact of the apprenticeship levy on health outcomes.

The Chair concluded the discussion by acknowledging the strong interest and engagement from Board members. He noted that the Combined Authority Board would be receiving a further report on this topic in the following week.

The Board was asked to comment on the draft plan and support the next steps in its development and implementation. Members **expressed broad support** for the direction of the plan and welcomed the opportunity for continued collaboration and refinement.

Section Three – Well Led

ICB25/84 ICB Transitional Governance Arrangements – Central East

The Board received a paper outlining the proposed transitional governance arrangements for Cambridgeshire & Peterborough ICB during the transitional period before formal establishment of Central East ICB on 1 April 2026.

The Chief Executive emphasised the importance of ensuring safe governance throughout the transition and outlined that the proposals set out a framework combining ICB Board and statutory Board Committees in Common and Joint Committees, which would operate as Committees of the Board. The proposed Committees were aligned with the NHS ICB Model Blueprint, with a particular focus on utilisation management. Significant collaborative work has been undertaken across the cluster (Cambridgeshire & Peterborough, Herts & West Essex, and Bedfordshire, Luton & Milton Keynes), and thanks was extended to all involved.

The Director of Governance reiterated the importance of maintaining safe governance and acknowledged the complexity of the transition. The paper included proposed amendments to the ICB Constitution, particularly regarding Board membership, which would provide for alignment across the three ICBs. Supporting documentation included a Governance Handbook incorporating Terms of Reference for statutory committees, the Scheme of Reservation and Delegation and Functions and Decisions Map was being prepared and would be brought to a Board meeting in common for approval in October. Practical steps were underway, including the appointment of Joint Non-Executive Members (NEMs) which would include nominating a Deputy Chair, as well as addressing the current vacancy for a Primary Medical Services (PMS) representative. These appointments were expected to be confirmed in the coming weeks.

The Scheme of Reservation and Delegation (SORD) was being reviewed to ensure clarity around accountability, responsibilities, and financial limits. A Non-Executive Member highlighted the importance of a safe transition and commented on the need to work with existing lead directors and committee chairs to develop a legacy document identifying key risks, upcoming decisions, and critical workstreams from each of the main subject areas.

Changes to the Constitution were being presented to each ICB Board. To support the transition, formal guidance was being finalised, which would include a due diligence process overseen by NHSE.

The Accountable Officer for the Children's and Maternity Collaborative noted that from 1 October, a Board in Common would operate across the area using a combination of individual and joint committees. He queried whether these arrangements were interim or expected to continue post-April 2026. The Director of Governance confirmed that while the three ICBs remained sovereign, the joint committees would transition to the new Board structure. This interim period provided an opportunity to test the model. The Board composition was intentionally broad to ensure diverse contributions.

The Chief Executive stressed the importance of maintaining a strong focus on place-based and neighbourhood-level delivery. Neighbourhood Health Delivery Committees would be essential for ensuring patient representation and driving local service transformation. Efforts were underway to ensure inclusivity whilst avoiding duplication, particularly given the larger geographical footprint.

A Non-Executive Member acknowledged the significant progress made in a short time and commended the team for balancing risk management with opportunity. She recognised the challenges faced and praised the commitment shown.

The Healthwatch Representative raised the importance of ensuring that neighbourhood-level voices, including VCSE partners and local authorities, were clearly represented. He noted the need for an independent patient voice within the governance structure. The Chief Executive reiterated that the overarching objective

was to improve population health outcomes while ensuring value for money. Neighbourhood Health Delivery Committees would play a key role in delivering locally tailored outcomes with patients at the centre.

The Chief People Officer emphasised the importance of the transition arrangements continuing to support a focus on people and workforce issues, some of which would be transferring. She highlighted the strong performance in temporary staffing and workforce retention, noting the importance of maintaining this momentum.

The VCSE Representation thanked the team for including VCSE representation in the new structure and asked whether the VCSE sector would continue to have a place on the Workforce Committee, given its significant contributions.

The Director of Public Health for Cambridgeshire raised the role of Directors of Public Health and the potential for unintended duplication. She emphasised the importance of leveraging existing resources and acknowledged the positive conversations taking place outside of formal governance structures.

The Chief Executive confirmed that the new Management Executive Committee would oversee areas such as organisational culture and collaborative provider functions. It was noted that while some responsibilities might not be fully deliverable immediately, the focus remained on maximising NHS resource utilisation and ensuring sustainability through effective partnership working.

The Board **agreed** the following recommendations set out in the paper:

1. Acknowledged NHSE's approval of the merger of Bedfordshire, Luton & Milton Keynes ICB (BLMK), Cambridgeshire & Peterborough ICB (C&P), and the Hertfordshire footprint of Hertfordshire and West Essex ICB (HWE), effective from 1 April 2026.
2. Endorsed the proposed Transitional Governance Framework (Appendix A), recognising it as a work in progress to be further developed and presented at the first Cluster Board in Common in October 2025.
3. Endorsed the proposed amendments to the ICB Constitution (Annex A) and recommended them to NHSE for approval.
4. Endorsed the Memorandum of Understanding and Data Sharing Agreement (Annex B).
5. Acknowledged that the transitional framework remains under development and subject to further refinement.
6. Delegated authority to the ICB Chair, Chief Executive, Deputy Chair, and Audit & Risk Committee Chair to approve any minor amendments following the BLMK and HWE Board meetings on 26 September 2025.

The ICB Chair concluded by extending his thanks to the Director of Governance and the Governance leads across BLMK and HWE ICBs for their work to get to this point.

ICB25/85 ICB Board Sub-Committee Overview Reports

The Board received and considered the overview reports from its sub-committees, each summarising the key items of business discussed, and decisions taken at their respective meetings.

ICB25/85/1 Audit & Risk Committee

Saquib Ali, Audit & Risk Chair and Non-Executive Member presented the report from the Audit and Risk Committee, which convened on 8 August 2025. She highlighted the Committee's upcoming focus on the cyber assurance framework, which would be developed further in the coming months. She also noted the importance of ensuring that the emerging cluster arrangements are adequately reflected in the governance structures for the Central East region, particularly for Cambridgeshire and Peterborough.

The Board **noted** the business discussed and **ratified** the Committee's endorsement of a suite of revised policies, including the ICB Confidentiality Code of Conduct for Employees, the Data Protection Policy, the Data Protection Impact Assessment Policy and Procedure, the Information Governance Policy and Management Framework, and the Records Management and Lifecycle Policy, all covering the period 2024 to 2026.

ICB25/85/2 Commissioning & Investment and Improvement & Reform Committee

Dorothy Gregson, Non-Executive Member provided the update from the Commissioning & Investment and Improvement & Reform Committee, which met on 5 September 2025. She reported that the Committee had reviewed and endorsed the updated Procurement Policy and the Provider Selection Regime Representation Policy. She also referenced additional matters raised under any other business, including urgent issues relating to wheelchair provision.

The Board **noted** the discussions and decisions of the Committee and **ratified** the policies presented as appendices to the report.

ICB25/85/3 Quality, Performance and Finance Committee

Dorothy Gregson, Non-Executive Member also presented the report from the Quality, Performance and Finance Committee, which met on 25 June 2025. She confirmed that the Committee had reviewed the latest version of the Cambridgeshire and Peterborough ICB Integrated Performance and Contract Oversight Report for September 2025. She expressed her appreciation to the team for their responsiveness to queries raised and noted that a further meeting of the Committee was scheduled in the coming week to continue the review of the Integrated Performance Report.

The Board was **noted** the business discussed and the contents of the performance report.

ICB25/85/4 People Board

Sarah Hughes, Non-Executive Member provided the update from the People Board, which met on 5 September 2025. She reflected on the positive work undertaken by the Board, particularly in relation to strategic development, collaboration, and the elevation of workforce-related issues. She expressed her thanks to Sharon Allen, VCSE Representative for her contributions to the group and to the Chief People Officer for her leadership and ability to navigate complex discussions with professionalism and grace. She emphasised the importance of preserving the legacy of this work as the system transitions.

The Board **noted** the key items of business discussed by the People Board.

ICB25/86 Close

The Chair thanked everyone for attending the meeting and brought the meeting to a close at 11:50.

Gemma Keats, Business Support Officer
19 September 2025

Hertfordshire and West Essex Integrated Care System

Draft Minutes for approval at November Board

NHS Hertfordshire and West Essex Integrated Care Board

Meeting:	**NHS Herts and West Essex Integrated Care Board Board meeting held in Public**			
	Meeting in public	☒	*Meeting in private (confidential)*	☐
Date:	**Friday 26 September 2025**			
Time:	**11am - 1pm**			
Venue:	**The Forum, Hemel Hempstead and remotely via MS Teams**			

MINUTES

Name	Title	Organisation
Members present:		
Paul Burstow (PB)	ICB Chair	Herts and West Essex ICB
Ruth Bailey (RB)	Non-executive member	Herts and West Essex ICB
Trevor Fernandes (TF)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Jane Halpin (JH)	Chief Executive Officer	Herts and West Essex ICB
Natalie Hammond (NH)	Director of Nursing	Herts and West Essex ICB
Elliot Howard Jones (EHJ)	Board partner member SRO	ENH HCP
Rachel Joyce (RJ)	Medical Director	Herts and West Essex ICB
Chris Martin (CM)	Commissioning Director	Essex County Council
Nick Moberly (NM)	Non-executive Member	Herts and West Essex ICB
Ian Perry (IP)	Partner Member (Primary Medical Services)	Herts and West Essex ICB
Gurch Randhawa (GR)	Non-Executive Member	Herts and West Essex ICB
Angie Ridgewell (AR)	Chief Executive Officer, HCC	Hertfordshire County Council
Thelma Stober (TS)	Non-Executive Member	Herts and West Essex ICB
Karen Taylor (KT)	MHLDA HCP	Herts and West Essex ICB
Jonathan Wilson (JW)	Chief Finance Officer	Herts and West Essex ICB
Mark Hanna	VCFSE Alliance Board Member	VCFSE
Prag Moodley	Partner Member (Primary Medical Services)	Herts and West Essex ICB
In attendance:		
Beverley Flowers (BF)	Director of Strategy	Herts and West Essex ICB
Tania Marcus (TM)	Chief People Officer	Herts and West Essex ICB
Toni Coles (TC)	Place Director, West Essex	Herts and West Essex ICB
Sharn Elton (SE)	Place Director, East and North Herts	Herts and West Essex ICB
Tracey Norris	Meeting clerk	Herts for Learning Limited
Avni Shah (AS)	Director of Primary Care	Herts and West Essex ICB
Frances Shattock (FS)	Director of Performance	Herts and West Essex ICB
Simone Surgenor (SS)	Deputy chief of staff, Governance	Herts and West Essex ICB
Michael Watson (MW)	Chief of staff	Herts and West Essex ICB
Dr Sam Williamson	For item ICB/46/25	Herts and West Essex ICB
Jo Burlingham	For Item ICB/47/25	Herts and West Essex ICB

ICB/38/25	**Welcome, apologies and housekeeping**
38.1	Paul Burstow welcomed all to the meeting. He confirmed that this was not a public meeting but a meeting being held in public (members of the public were welcome to attend to observe the meeting) there was an opportunity for members of the public to submit questions in advance to agenda item 14.
38.2	Apologies for absence had been received from: ■ Thom Lafferty ■ Adam Sewell Jones
ICB/39/25	**Declarations of interest**
39.1	The Chair invited members to update any declarations relating to matters on the agenda and reminded them of their responsibility to update their declarations, for example when they had ceased an association with an organisation. All members declarations were accurate and up to date with the register available on the website: Declaration of interests – Hertfordshire and West Essex NHS ICB
ICB/40/25	**Minutes of the previous meeting**
40.1	**The minutes of the previous meeting held on Friday 27 June 2025 were approved as an accurate record.**
ICB/41/25	**Action Tracker**
41.1	The Chair noted that: ■ 35.3 update on Children's Service carried forward to November meeting. ■ 30.4 update on mental health assertive outreach – see agenda item xx
41.2	**The Board noted the updates to the action tracker.**
ICB/42/25	**Chair's update report**
42.1	The Chair's referred to his report (see pages 24-29 of the document pack) and highlighted the following: ■ This would be the last meeting of the HWE ICB in its current guise. ■ The new ICB footprints had been established, from 1 April 2026 Hertfordshire would join Bedfordshire, Luton & Milton Keynes and Cambridgeshire & Peterborough in the new Central East ICB, while West Essex would join Mid & South Essex and North East Essex in the new Essex ICB. ■ The current HWE ICB would transition into two separate organisations, requiring careful alignment across both future footprints, to ensure focus remained on key areas and accountability was maintained. ■ He thanked all staff for their dedicated service and professionalism during such an uncertain time. There were no questions arising.
42.2	**The Board noted the Chair's update**
ICB/43/25	**Chief Executive Officer's report**
43.1	Jane Halpin (JH) referred to her report (see pages 30-43 of the document pack) drawing the board's attention to the following: ■ The report was more detailed than usual as she hoped to provide a clear and detailed summary of the achievements that had been made by HWE ICB and the priority areas of focus in the coming months.

	■ The ICB's financial plan was on target; a strong position compared to the same time in previous years. ■ Two bids to join wave one of the National Neighbourhood Health Implementation Programme (NNHIP) had been approved within HWE: ○ West Essex ○ South and West Hertfordshire (Dacorum and Hertsmere) ■ This was a great achievement; not all bids had been successful and was testament to the hard work and innovation of colleagues who had worked on these bids.
43.2	Questions and comments were invited: ■ How would the voluntary sector captured in the NNHIP? Ans: The voluntary sector had been very engaged in the bid application in both places. ■ The involvement of MH teams was also well embedded, colleagues from MH teams were already working at neighbourhood level as well as with the national director for system architecture who would put forward the approach for MHND in Herts for national adoption.
43.3	**The Board noted the CEO's report**
ICB/44/25	**Lampard Inquiry Board Update**
44.1	Beverley Flowers presented this agenda item (see report at pages 44-51 of the document pack) highlighting the following: ■ Transition arrangements would be put in place to ensure future updates were shared with the appropriate ICB. BF was in discussion with the Inquiry Board about this. ■ There were no issues of significant concern and no outstanding Level 9 enquiries. ■ The ICB had not been invited to attend the October meeting of the Inquiry Board. ■ Sample cases from 2015-2023 had been identified and deep dives conducted.
44.2	Questions and comments were invited: ■ What improvements/changes had been put in place since the Inquiry Board had been established and had any learnings been made from the sample cases reviewed? Ans: Areas to improve had been identified and related to contractual arrangements, service specification with greater input from clinicians delivering care, listening and reflecting on learning from commissioners.
44.3	**The Board noted and took assurance from the Lampard Inquiry update**
ICB/45/25	**Mental Health Intensive and Assertive Outreach Review**
45.1	Beverley Flowers presented this agenda item (see report at pages 52-64 of the document pack) highlighting the following: ■ The submission deadline of 3 September had been met and informal feedback from NHSE was that no further information was required at this stage. ■ Hertfordshire and Essex had received different ratings. The provision in Essex was more complex with a greater number of system partners; it had been harder to answer the 9 domains of confidence. ■ Next steps: ○ Conversations with national team re workforce/training. ○ Identify ways to link services whilst remaining person-focused. Karen Taylor provided the following context: ■ 375 people in Hertfordshire need assertive outreach; all have an allocated care coordinator. ■ Full fidelity to national standards had not yet been achieved but there were risk assessments in place. ■ This was not a generic cohort and covered such complex conditions as bi-polar, schizophrenia and depression. There were different levels of risk. ■ This was a highly vulnerable group.

	■ Funding was needed to support provision. ■ 44 mental health providers across the country were sharing best practice and participating in a benchmarking exercise. ■ The mental health and disabilities agenda needed to retain a high profile as the new ICBs were created. ■ Co-ordinated digital access across health and social care was a critical digital enabler.
45.2	Questions and comments were invited: ■ The close collaboration between local authorities and acute/primary care was noted; with effective identification of people in need to prevent individuals falling between services. ■ Mechanisms were in place at an operational and system level to balance the risk of harm to individuals vs risk to others. Relationships of trust between LA, police and providers was essential. ■ Crisis care partnership protocols were in place; key was the need to listen to family members/carers who notice a change in behaviour. ■ ECF mechanism provided better tracking of long-term management and crisis management of patients with mental health needs in primary care. ■ Aim: No wrong door for patients, need for new strategic commissioner to maintain focus on a commissioning framework which used impact evidence with a focus on outcomes ie allocative efficiency. ■ The under representation of MHLD outcomes in national outcome tracking needed to change – this was a live issue with MH teams currently making metric recommendations to NHSE. ■ What areas of critical risk was the ICB facing? Were there any urgent issues which needed to be flagged to the new ICB? Ans: There were no known urgent issues in either Herts or West Essex but neither area was currently meeting fidelity to national framework so at some point a conversation was needed on what funding would be provided to achieve this and this message needed to be shared with the new ICB organisations.
45.3	**The Board noted the mental health intensive and assertive outreach progress update**
ICB/46/25	**Frailty Emergency Admissions and Substitute Effect**
46.1	Sam Williamson introduced this agenda item (see pages 52-64 of the document pack) and highlighted the following: ■ Reduction of 32% of frailty admissions from peak (November 2023) compared to June 2025. ■ This had been a whole system approach. ■ Unexpected outcome: substitution effect – an increase in admissions from non-frailty population (both elderly and young). ■ Bed occupancy rates were still above 90% and handover times remained long. ■ Key recommendations related to: ○ Increasing proactive care ○ Care closer to home/community response – where did people want to be treated. ○ Hospital based processes
46.2	Questions and comments were invited: ■ This was a nationally significant piece of work. Mechanisms needed to be in place to ensure the funding followed the patient as the shift from hospital to home continued. ■ Work was needed to understand the substitute effect; if the consequence of successfully treating frailty at home meant other cohorts were now being admitted then the aim of reducing demand on acute had not been achieved. ■ There was still more work to be done, frailty patients were still being admitted unnecessarily. ■ Review of multi-morbidity model vs single morbidity model was required as was more work with LA/social care colleagues on prevention education agenda.

	■ The motivation for this project was about the right care for patients at the right time, reductions in acute care was a secondary outcome. ■ Acute care was a fixed cost; the idea that money could flow to the community would be difficult to unpick. ■ The ECF provided primary care colleagues with the necessary IT systems to deliver high quality advance care planning. ■ Neighbourhood teams were working together to help people manage long term conditions at home. ■ Admitting fewer people to acute would not result in acute closure but might free up workforce to provide "hot clinics". ■ National guidance had not yet been adapted to recognise the changing cohort; frailty and multi-morbidity; clinicians needed the authority/freedom to not follow NICE guidelines in certain cases. Eg fall patients on anti-coagulants require a CT scan – but if the patient has dementia and is bedridden and would not survive head surgery, why have the CT scan in the first place? ■ New pathways would need to be designed and would be aided by rich data sets.
46.3	**The Board noted the frailty emergency admissions and substitute effect update**
ICB/47/25	**Winter Assurance Plans**
47.1	Jo Burlingham presented this agenda item (see pages 71-152 of the document pack) and highlighted the following: ■ The winter assurance plan had been co-developed, and stress tested at the winter exercise on 4 September, this was a live plan with procedures and actions pathways being developed all the time, new cells had been added covering: ○ Infection control ○ Vaccination ■ The plan would be submitted to NHSE at a national event on 7 October. ■ The plan would go live on 1 November – 31 March 2026 and would remain in place for HWE ICB for that time. ■ Learnings from last winter and data analysis had been used to inform this year's plan. ■ The system oversight impact group would review risks on a monthly basis. ■ Sitting below the winter assurance plan were local plans and provider level plans.
47.2	Questions and comments were invited: ■ Board members thanked JB and the wider team for creating the plan; there was strong engagement and partnership working between system partners. ■ Were there sufficient resources to deliver the plan ie workforce? Ans: Yes, good structures were in place to escalate issues/gaps in workforce. Weekly meetings were being held to address and work through resourcing issues. ■ Category One response duty was critical. ■ Other initiatives were expected to reduce acute attendances eg mental health care centre, frailty project. ■ Board members felt the ICB was approaching the winter pressures from a strong position and noted the need to ensure board level oversight remained in place during the coming transition period.
47.3	**The Board APPROVED the winter assurance plan.**
ICB/48/25	**Governance Report**
48.1	Michael Watson presented this agenda item (see pages 153-160 of the document pack) and highlighted the following: ■ Transition arrangements to the new ICB would be discussed in the private session to follow this meeting.

	■ Transitional arrangements for governance were being developed with new operational arrangements in place for April 2026. ■ Approval for transition arrangements covered: ○ Governance framework ○ Changes to the constitution ○ Changes to MOUs and data sharing agreements.
48.2	Questions and comments were invited: ■ Board members thanked the executive team for their work behind the scenes on this; it was tangled and complex. ■ Uncertainty remained at all levels; both individual and committee. NB patient engagement.
48.3	**The Board noted and approved the transition arrangements recommended in the governance report paper**
ICB/49/25	**Integrated Report for Finance, Performance, Quality and Workforce**
49.1	The integrated report was noted at pages 161-182 of the document pack.
49.2	**Performance update: Frances Shattock** FS highlighted the following: ■ Acute provider metrics had improved. ■ 4-hour standard was sitting in the top 10 nationally. ■ Cancer: 62-day standard was being met. ■ Challenges remained in: ○ Diabetics ○ Audiology ○ Children and young people waiting times ○ CHC
49.3	**Finance update: Jonathan Wilson** JW highlighted the following: ■ M4 was on track (spend vs budget). ■ The £36m gap had been reduced to £15m with actions in place across all providers to prevent overspend.
49.4	**Quality update: Natalie Hammond** NH highlighted the following: ■ A never event had occurred at WHH following day surgery; the incident had been investigated, the patient was well, and learnings had been shared. ■ Good progress was being made in paediatric audiology although this still remained an issue: NB 0-3year complex pathway at ENH. Subject matter specialist has been requested from the national team to support clinicians. The new building at ENH (opening in Spring 2026) would resolve current capacity issues. ■ AGM wheelchair provider: now achieving compliance with SLA. Positive feedback had been received from users.
49.5	Questions and comments invited: ■ Financial risk was high – how would this be managed? Transparent reporting on closing the £15m gap and any future deviation from this plan. Collaborative working between all partner CFOs and executive team. ■ The performance committee were closely tracking progress of children and young people waiting times and had conducted a deep dive at its last meeting – risk identified: waiting times would remain static and not reduce. Additional resources were needed. ■ Medium term plan: metrics for admissions during last 12 months of life were not yet being improved. Better advance care planning was required.

	■ Risk identified that focus on financial balance could be diluted as transition to new ICB takes up executive capacity.
49.6	**The board noted the Integrated Report**
ICB/50/25	**Committee Summary reports**
50.1	See pages 183-206 of the document pack.
50.2	**The Board noted the committee summary reports**
ICB/51/25	**Questions from the Patient Engagement Forum and members of the public**
51.1	One question had been received after the papers for the meeting had been finalised from a member of the public (relating to ADHD). An answer would be provided and shared at the next public board meeting.
ICB/52/25	**Any other business**
52.1	Partner members thanked the ICB executive team for their support and professional approach to the upcoming changes. They all demonstrated both individually and collectively a huge dedication to the NHS; the legacy of the HWE ICB was the establishment of strong partnerships across the system.
ICB/53/25	**What would service users, patients, carers and staff take away from our discussion today?**
53.1	■ Frailty focus: the desire by all system partners to do the right thing for patients with care closer to home. ■ Winter planning assurance. ■ Prevention = message for the future for all citizens.
Date of next meeting: Friday 28 November 2025	

Action Log

Details Part 1

Meeting: ICB Board in Public

Date of Meeting: 19 September 2025

There are no outstanding actions

Archive

A record of closed actions is available from the Governance Team on request.

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Herts and West Essex Integrated Care Board Board Meeting Action Tracker Last updated on 15 September 2025								
Private / Public	**Action Tracker Ref No**	**Date of Meeting**	**Subject**	**Action**	**Responsible Lead**	**Deadline Date**	**Comments and Updates**	**Status**
Public	12.2	31/01/2025	What would service user take away	**Lead a session on Digital and AI**	ASJ and MC			**Open**
Public	30.4	27/06/2025	Mental Health Intensive Assertive Outr	**Further work on prioritisation requested.**	BF	**26/09/2025**	**Agenda item for September Board**	
Public	35.3	27/06/2025	Integrated Report	**Childrens Services Update requested for next Board**	BF	**26/09/2025**	**Agenda item for September Board**	

RAG Rating Key:	
Red	**Open (overdue)**
Amber	**Open (on-going)**
Green	**Completed / Action Closed**

Report to the:	(1) NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) - Board (2) NHS Cambridgeshire & Peterborough ICB (C&P) - Board (3) NHS Hertfordshire & West Essex ICB (HWE) – Board with each sovereign Board meeting in public and in-Common
Date of meeting:	28 November 2025
Item 7:	Chief Executive's Report
Report in relation to:	NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) NHS Cambridgeshire & Peterborough ICB (C&P) NHS Hertfordshire & West Essex ICB (HWE)
Executive Lead:	Jan Thomas, Chief Executive
Report Author:	Sharon Fox, Director of Governance
Reason for the report to the Committee/Board:	For information as part of the cycle of business.
Recommendation/s:	1. The Board is asked to **discuss** the report and **note** the content. 2. The Board is asked to **note** the delegation limits approved by the CEO, in consultation with the ICB Chair and Chair of the Finance and Payer Function Committee and the Scheme of Reservation and Delegation will be updated accordingly.

1. Executive Summary

1.1 This report provides an overview of some of the key issues facing Central East (NHS Bedfordshire, Luton and Milton Keynes ICB, NHS Cambridgeshire and Peterborough ICB, NHS Hertfordshire and West Essex ICB) to bring to the attention of the Integrated Care Board (ICB) board at its meeting on 28 November 2025.

2. Finance & Performance

2.1 Finance

2.1.1 At Month 6, all organisations within the Central East area are currently on plan, noting a number of ongoing risks which are summarised below:

2.1.2 NHS Bedfordshire Luton and Milton Keynes (BLMK) are £6.3m adverse to plan at Month 6 which is an improvement from £6.6m reported last month. The main drivers are financial challenges at Bedfordshire NHS Foundation Trust, where recovery actions are underway. The ICB is also managing NHS Continuing Care cost pressures and ADHD/ASD demand.

2.1.3 NHS Cambridgeshire and Peterborough (C&P) are £0.7m favourable to plan mainly due to the improvement trajectory at North West Anglia NHS Foundation Trust (NWAFT).

2.1.4 NHS Herts and West Essex (HWE) are on plan – however the plan is a £25.3m deficit year to date (slightly less than M5). The position reported is after £6.1m of deficit support funding

provided by NHS England (NHSE). Work is ongoing to address the gap in the plan, with the latest estimate ranging from £12m to £15m.

2.1.5 The Finance & Payer Function Committee is responsible for overseeing the financial position going forward and providing assurance to the Board. In addition, a detailed financial report is provided elsewhere on the agenda.

2.2 Performance

2.2.1 The table below provides a summary of performance across three ICBs against national priority indicators as outlined in 25/26 planning guidance including cancer standards, elective recovery, urgent and emergency care, and mental health. A performance paper is included on the agenda which provides more information, and the three ICB integrated performance reports are discussed at length at the Utilisation Management and Total Quality Management Committee that took place on 14 November 2025.

Off plan vs. local trajectory

On plan vs. local trajectory

Indicators	Latest month	BLMK	C&P	HWE
Cancer 28 day waits (faster diagnosis standard)	Aug'25	77.67%	76.5%	77.7%
Cancer 62-day performance	Aug'25	71.65%	71.7%	74.3%
Proportion of total waiting list over 52 weeks for treatment	Aug'25	2.96%	2.6%	2.8%
RTT Performance % (ICB)	Aug'25	57.99%	57.5%	60.4%
Patients waiting for first attendance who have been waiting less than 18 weeks	Aug'25	60.43%	60.1%	63.6%
A&E four-hour performance	Sept'25	76.49%	71.3%	80.0%
Attendances at Type 1 A&E departments where the patient spent more than 12 hours	Sept'25	4.59%	11.9%	9%
Category 2 ambulance response times (minutes) – average across 2025/26 (EEAST Only)	Sept'25	29.12	27.3	36.5mins
Reliance on mental health inpatient care for adults with a learning disability	Sept'25	14	9	5
Reliance on mental health inpatient care for autistic adults	Sept'25	19	14	21
Average length of stay for adult acute beds	Aug'25	55	61	55
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Aug'25	13,415	58,410 (YTD)	21,525
Proportion of those surveyed whose experience with accessing primary care has improved in last 12 months (ONS Survey)	Sept'25	20.9%	20.9%	21.7%
Deliver a balanced net system financial position for 2025/26 (variance)	Aug'25	-£6.3m	-£8.360m	£0.097m
Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	Aug'25	£1.4m	£6.272m	£1.807m

3. Planning

3.1 As the Board is aware, in October our Commissioning Intentions for the forthcoming year were published and shared with our providers. These intentions set out our broad aims for the next 5 years including how we will work and what we will focus on. These were developed as part of the new ICB footprints with separate versions for Central East - which incorporated Hertfordshire intentions - and Essex - which incorporated the West Essex intentions.

3.2 In line with the national planning guidance issued and more detailed Medium Term Planning Framework, the Central East and Essex Cluster ICBs are working together to develop our Five-Year Strategic Plans covering 2026-31. This includes first draft activity, finance and certain elements of workforce plans due to be submitted to NHS England in December, alongside triangulation and Board assurance statements. The final plans including narrative are to be submitted in the first week of February 2026 and will reflect our medium term local priorities as well as our plans to support the delivery of the NHS 10 year Plan ambitions.

4. ICB Transition

4.1 Overview

4.1.1 The Minister for Health in parliament on Tuesday 9 September 2025 NHSE formally announced the bringing together the ICBs of Bedfordshire Luton & Milton Keynes ICB (BLMK) Cambridgeshire & Peterborough ICB (C&P), and the Hertfordshire footprint of Hertfordshire and West Essex ICB (HWE). As a result, the ICBs are now working through a period of transition to create a unified single entity with the utilisation of shared leadership and functions, whilst uniting the best of our legacy systems.

4.1.2 The Joint Transition Committee, chaired by the ICBs Chair, Robin Porter, oversees the implementation plan and ensuring due diligence is undertaken for the establishment of a new ICB which is expected to the established on 1 April 2026. A small programme team is supporting the 11 workstreams that have developed workstream plans and risk registers. Workstream leads meetings are held on a fortnightly basis and the Senior Responsible Owner for the programme, Executive Director for Corporate Services and ICB Development and a representative from the NHSE Regional team attend the meeting to gain assurance that the programme work is being delivered and understand any areas of concern and risk.

4.1.3 Each ICB was required to submit an Equality and Health Inequalities Impact Assessment to NHSE on 14 November 2025 and this will continue to be monitored and developed as the programme progresses. A copy of the Impact Assessments for each ICB is available from the Governance Team.

4.1.4 In accordance with the delegated authority at the last Board, the CEO has approved the financial delegation limits for Executive Directors and sub-committees of the ICB Board during the transition period, on recommendations from the Executive Director of Finance, Resources and Contracts and in consultation with the ICB Chairs and the Chair of the Finance and Payer Function Committee. The Scheme of Reservation and Delegation will be updated accordingly.

4.2 ICB Reconfiguration

4.2.1 We are progressing with ICB Reconfiguration and on 19 November 2025 we launched an all ICB Staff Consultation on the proposed staff structures and roles to fit within the £19 per head of population cost envelope, as set by NHS England; and the proposed process to fill posts. Separately, on the 19 November we also launched a nationally set voluntary redundancy scheme for ICB staff.

4.2.2 Clearly this is a very challenging time for all ICB staff, and we have initiated a wide range of support which includes fortnightly staff briefings, led by myself. The Consultation process will close at noon on 12 January 2026. The Remuneration & Workforce Committee is providing oversight and assurance, and I will keep the Board informed of progress.

5. Recommendation

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

5.2 The Board is asked to note the delegation limits approved by the CEO, in consultation with the ICB Chair and Chair of the Finance and Payer Function Committee and the Scheme of Reservation and Delegation will be updated accordingly.

Report to the:	(1) NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) - Board (2) NHS Cambridgeshire & Peterborough ICB (C&P) - Board (3) NHS Hertfordshire & West Essex ICB (HWE) – Board with each sovereign Board meeting in public and in-Common
Date of meeting:	28 November 2025
Item 8.1:	Combined Performance Report for BLMK, C&P and H&WE
Report in relation to:	NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) NHS Cambridgeshire & Peterborough ICB (C&P) NHS Hertfordshire & West Essex ICB (HWE)
Executive Lead:	Sarah Griffiths, Executive Director of Finance, Resources and Contracts
Report Author:	Stacie Coburn, Director of Contracting and Procurement
Reason for the report to the Committee/Board:	ICB Board oversight of performance against operational plan commitments for 2025/26.
Recommendation/s:	The Board is asked to **note** the report.

1.0 Executive Summary

1.1 This report is split into two sections: 1) a high level overview of ICB performance against key national performance indicators in 2025/26, identified as must do commitments in the national operational planning guidance and 2) a summary of local risks and areas of escalation that do not form part of the national suite of indicators.

1.2 Extensive performance and quality content is included within individual Integrated Care Board (ICB) integrated reports, which are discussed at length at sub committees. The most recent reports were discussed at Utilisation Management and Quality Improvement Committee on 14th November 25 and headlines summarised in the minutes from this meeting, also shared with ICB Board.

2.0 Key Implications

2.1 Financial implications – There are no implications identified.

2.2 Equality and / or health inequalities implications – Equality and health inequalities impact considered for individual performance indicators, as part of ongoing work to mitigate variation and risk.

2.3 Engagement – ICB Integrated Performance reports have been considered by Utilisation Management and Quality Improvement ICB Board subcommittee in November prior to this summary being provided for Board.

2.4 Green Plan commitments – Not applicable.

2.5 Risk – Risks are already sufficiently captured in ICB Board Assurance Frameworks and no proposed changes are required at this stage.

3.0 Performance overview

National key performance indicators

3.1 The table below outlines performance at ICB level against the key priority national indicators for 2025/26. Performance is shown as on plan or off plan, assessed against the monthly trajectories submitted by each ICB as part of planning.

Off plan vs. local trajectory
On plan vs. local trajectory

Indicators	Latest month	BLMK	C&P	HWE
Cancer 28 day waits (faster diagnosis standard)	Aug'25	77.67%	76.5%	77.7%
Cancer 62-day performance	Aug'25	71.65%	71.7%	74.3%
Proportion of total waiting list over 52 weeks for treatment	Aug'25	2.96%	2.6%	2.8%
RTT Performance % (ICB)	Aug'25	57.99%	57.5%	60.4%
Patients waiting for first attendance who have been waiting less than 18 weeks	Aug'25	60.43%	60.1%	63.6%
A&E four-hour performance	Sept'25	76.49%	71.3%	80.0%
Attendances at Type 1 A&E departments where the patient spent more than 12 hours	Sept'25	4.59%	11.9%	9%
Category 2 ambulance response times (minutes) – average across 2025/26 (EEAST Only)	Sept'25	29.12	27.3	36.5mins
Reliance on mental health inpatient care for adults with a learning disability	Sept'25	14	9	5
Reliance on mental health inpatient care for autistic adults	Sept'25	19	14	21
Average length of stay for adult acute beds	Aug'25	55	61	55
Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Aug'25	13,415	58,410 (YTD)	21,525
Proportion of those surveyed whose experience with accessing primary care has improved in last 12 months (ONS Survey)	Sept'25	20.9%	20.9%	21.7%
Deliver a balanced net system financial position for 2025/26 (variance)	Aug'25	-£6.3m	-£8.360m	£0.097m
Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems	Aug'25	£1.4m	£6.272m	£1.807m

3.2 For Cancer, performance remains below local trajectories in both C&P and HWE in August, with BLMK on plan. The variation to trajectory is driven by Cambridge University Hospitals NHS Foundation Trust (CUH) and Princess Alexandra Hospital NHS Trust (PAH), both of whom remain in NHS England Tiering arrangements.

3.3 All three ICBs are reporting achievement of overall referral to treatment times (RTT) trajectories in August, with first outpatient performance only marginally below plan (0.2%). The most significant performance variation is seen in the proportion of patients waiting over 52 weeks, which is above plan in all three ICBs. The national expectation is that all provides get to a maximum of 1% by March, the current forecast outturn is that this will be achieved

across Central East, with recovery plans in place at provider level, tracked either through tiering or contract oversight routes.

3.4 Urgent and emergency care performance is variable across the cluster and is a risk as we head into winter months. Overall A&E four hour performance is strong in both BLMK and HWE, though BLMK are reporting performance below their planned trajectory at 76.5%. C&P has the most variation to plan, with 71.3% performance in September, against a plan of 75.8%, CUH reported performance 3.2% below plan and North West Anglia NHS FT (NWAFT) 6.8% below plan. Long waits in A&E remain a concern for NWAFT and PAH sites and both organisations are in NHS England UEC tiering. C2 ambulance response performance is better than plan in both BLMK and C&P, but above the 30 minute target in HWE. Additional winter governance and reporting is in place, commencing from 1 November 2025. Weekly performance tracking against key indicators, additional surge capacity plans and forecasting for seasonal illness is being reported weekly to ICB Management Executive.

3.5 Performance against Mental Health and Learning Disability indicators is behind plan in BLMK and C&P, with only HWE achieving plan for 3 of 4 KPIs. Discussions are ongoing with providers through contract routes to understand drivers for variation and ensure appropriate recovery plans are in place to return performance to expected levels as quickly as possible.

3.6 September data demonstrates a continued improvement in peoples experiencing of accessing primary care compared to 12 months ago. All three ICBs are reporting positive experience improvement compared to the March 25 baseline, though this aggregate position hides significant practice level variation, which is being picked up through individual practice level conversations and through other oversight forums including Primary care commissioning committees.

3.7 Delivery against financial commitments, including reduction in agency and bank usage are covered in the ICB Board finance report.

Local risks and areas of escalation

3.8 Paediatric audiology remains a concern across all three ICBs in Central East cluster, with contractual and regional escalation in place for several hospital sites. Services are fragile due to national shortages of suitably qualified workforce and several providers are now conducting reviews of historical activity following national identification of quality concerns in paediatric hearing services. The final Kingdon review of children's hearing services, published on 10th November sets out several recommendations for consideration. The ICB is rapidly progressing an assessment of services to establish if current commissioning arrangements are sufficient to meet demand, while also assessing opportunities for bringing together oversight and recovery arrangements across the three ICBs. A further update will be provided to the Utilisation Management and Quality Improvement Committee in December 25.

3.9 Community waiting times in HWE ICS are extensive, with 38.9% of all paediatrics now waiting more than 52 weeks. This includes waits for neurodevelopmental services, which are of concern across all three ICBs. Following discussions between the ICB and Providers in October 25, the Central East Cluster has commenced a review of current HWE contracts and specifications for commissioned community paediatric services, a waiting list review to understand potential and actual harm and consolidation of options for a sustainable new model of care or service reconfiguration. This work is being undertaken collaboratively with providers, with an expected output for discussion in January 26.

3.10 Mental Health out of area placements in BLMK are 600% above plan in the most recent month, with 20 patients placed against the target of 4. The ICB has taken additional actions

ahead of peak winter demand to support core flow improvements, including focus on supporting discharge, crisis provision and addressing step down capacity. Alongside these operational actions, strategic mitigations are also underway, including mobilisation of a short stay admission pilot and creation of 9 additional mental health inpatient beds.

3.11 Diagnostic performance across all three ICBs is challenged. While not a national priority indicator in 25/26, expectations are that this will be reintroduced in 26/27, with an expectation that no more than 5% of patients wait more than 6 weeks for their diagnostic test. Performance in this area is also intrinsically linked to overall RTT delivery. 6 week breach performance in August 25 was 33.4% in BLMK, 31.2% for C&P and 38.7% for HWE. A significant driver for the deterioration seen in 25/26 to date is the removal of additional insourcing and outsourcing providers were able to fund in the previous year. The ICB is assessing demand to identify areas of variation to plan and discussions are ongoing with providers through appropriate contract routes and performance tiering to ascertain recovery plans.

4.0 Next Steps

4.1 As outlined above, Central East ICB has commenced focused work to assess and mitigate risks in both Paediatric Audiology and Community waits, with outputs expected by January 26, considered through Utilisation Management and Quality Improvement Committee governance.

4.2 Routinely, provider performance variation is being addressed through contractual routes, with recovery plans requested as appropriate and through NHS England oversight mechanisms such as tiering. Delivery against provider recovery plans will continue to be reported through ICB integrated performance reports.

4.3 Work is underway to identify the appropriate indicators for ICB performance reporting in 26/27, reflecting likely national oversight framework KPIs for ICBs, effective commissioning indicators, such as demand management, and local priorities and outcomes, as determined through planning. This will mark a significant shift from reporting aggregated provider data against constitutional standards as is largely the case in current ICB reporting. A draft proposal will be considered by the Utilisation Management and Quality Improvement committee in January 26, with the intention of implementation from April 26.

Report to the:	**ICB Board**
Date of meeting:	28 November 2025
Item 8.2:	**Combined Month 6 Finance Report for BLMK, C&P and H&WE**
Report in relation to:	BLMK / C&P / H&WE ICB
Executive Lead:	Sarah Griffiths, Executive Director of Finance, Resources and Contracts
Report Author:	Sarah Griffiths, Executive Director of Finance, Resources and Contracts
Reason for the report to the Committee/Board:	This paper provides the Board with an update on the Month 6 (M6) 2025/26 financial position for the three ICBs and the three systems, highlighting the in-year financial position, emerging risks, and the control mechanisms in place. The Board is also asked to note the strategic financial risks linked to overall financial sustainability, demand growth and elective recovery targets. This report provides early sight of medium-term sustainability challenges that will materially influence planning for 2026/27 and beyond.
Recommendation/s:	The Board is asked to • **Note** the Month 6 position for each ICB and system. • **Note** the scale of full-year risk and the mitigations in progress. • **Acknowledge** the statutory accountability for delivery of three ICB control totals and three system-level control totals. • **Support** continued work on medium-term financial sustainability.

1.0 Executive Summary

1.1 Each ICB has a statutory duty to deliver a breakeven financial position and each system remains collectively accountable for delivering the agreed system financial plan for 2025/26. At the beginning of this financial year, each system agreed a breakeven financial plan which included £12.2m of NHS England Deficit Support Funding (DSF) for H&WE.

1.2 At M6, the financial position across all three ICBs remains under pressure. Growth in CHC expenditure, high levels of independent sector elective activity and rising demand for ADHD and ASD assessments continue to present the most significant risks.

1.3 At a system level, the ability to deliver ambitious efficiency plans presents a further risk, particularly for the H&WE system. This is additional to the financial pressure in responding to ongoing Industrial action, winter UEC demand and the cost of delivering elective activity to meet agreed recovery targets.

1.4 All three systems continue to report a full year forecast in line with the breakeven plans set at the beginning of the financial year with recovery actions and initiatives underway involving all system partners, particularly in H&WE. Enhanced financial control measures remain in place.

1.5 The reported M6 position is:

a) **Bedfordshire, Luton and Milton Keynes (BLMK)**:

- ICB deficit of £0.3m, adverse variance to plan of £0.3m
- Provider deficit of £8.9m, adverse variance to plan of £6.0m
- Overall system deficit of £9.2m, adverse variance to plan of £6.3m

b) **Cambridgeshire & Peterborough (C&P)**:

- ICB breakeven, variance to plan of £0.0m
- Provider deficit of £6.6m, favourable variance to plan of £0.7m
- Overall system deficit of £6.6m, favourable variance to plan of £0.7m

c) **Hertfordshire & West Essex (H&WE)**:

- ICB variance to plan of £0.0m
- System variance to plan of £0.0m

1.6 The transition to ISFE2 remains a significant governance and operational risk, with potential implications for reporting accuracy and financial controls during the cutover period. This risk has been escalated to the Audit and Risk Committee, and enhanced assurance processes have been established.

1.7 Work continues to address financial sustainability ahead of the medium-term planning work for 2026/27 onwards

2.0 Key Implications

2.1 Financial implications
All covered within this report.

2.2 Equality and / or health inequalities implications
No specific implications identified.

2.3 Engagement
The financial position and risks have been reviewed and discussed with provider CFOs, NHS England and the Finance, Planning and Payer Function Committee. The risk associated with the transition to ISFE2 has been discussed with NHS England, NHS Shared Business Services and at the Audit and Risk Committee.

2.4 Green Plan commitments
No specific implications identified.

2.5 Risk
The ongoing financial challenges present a number of risks to our overall financial sustainability, ability to deliver agreed financial plans as well as to operational and performance standards. These are covered in more detail within the report.

3.0 Report

3.1 This paper sets out the M6 financial position for BLMK, C&P and H&WE covering both the ICB financial performance and that of the three system control totals. The paper also covers the risks to the delivery of the full year financial plans, key recovery and mitigation factors and work on medium term financial sustainability.

3.2 Each ICB has a statutory duty to deliver a breakeven financial position and each system remains collectively accountable for delivering the agreed system financial plan for

2025/26. At the beginning of this financial year, each system agreed a breakeven financial plan which included £12.2m of NHS England Deficit Support Funding (DSF) for H&WE

3.2 The table below shows the reported M6 financial position for each organisation, noting that the figures for organisations within H&WE are net of £6.1m of DSF for M6 Year to Date (YTD) and £12.2m for the full year:

System YTD Surplus/ Deficit

BLMK ICS	YTD - M06			FOT		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Bedford Hospital NHS FT	(0.0)	(6.0)	(6.0)	0.0	0.0	0.0
Milton Keynes University Hospital NHS FT	(2.8)	(2.9)	(0.0)	0.0	0.0	0.0
Total Provider - BLMK	**(2.8)**	**(8.9)**	**(6.0)**	**0.0**	**0.0**	**0.0**
ICB	0.0	(0.3)	(0.3)	0.0	0.0	0.0
Total System - BLMK	**(2.8)**	**(9.2)**	**(6.3)**	**0.0**	**0.0**	**0.0**

Cambridge & Peterborough ICS	YTD - M06			FOT		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Cambridge University Hospital NHS FT	(4.2)	(0.5)	3.7	0.0	0.0	0.0
Cambridge and Peterborough NHS FT	(1.2)	(1.1)	0.0	0.0	0.0	0.0
Cambridge Community Services NHS Trust	0.0	0.0	0.0	0.0	0.0	0.0
North West Anglia NHS FT	(1.9)	(4.9)	(3.0)	0.0	0.0	0.0
Royal Papworth NHS FT	(0.1)	(0.1)	0.0	0.0	0.0	0.0
Total Provider - C&P	**(7.3)**	**(6.6)**	**0.7**	**0.0**	**0.0**	**0.0**
ICB	0.0	0.0	0.0	0.0	0.0	0.0
Total System - C&P	**(7.3)**	**(6.6)**	**0.7**	**0.0**	**0.0**	**0.0**

HWE ICS	YTD - M06			FOT		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
East and North Hertfordshire NHS Trust	(9.5)	(9.4)	0.1	0.0	0.0	0.0
Hertfordshire Community Trust	0.0	0.0	0.0	0.0	0.0	0.0
Hertfordshire Partnership Foundation Trust	(3.2)	(3.2)	0.0	0.0	0.0	0.0
Princess Alexandra NHS FT	(2.3)	(2.3)	(0.0)	0.0	0.0	0.0
West Hertfordshire Hospitals NHS Trust	(4.4)	(4.4)	0.0	0.0	0.0	0.0
Total Provider HWE	**(19.4)**	**(19.3)**	**0.1**	**0.0**	**0.0**	**0.0**
ICB	(6.0)	(6.0)	0.0	0.0	0.0	0.0
Total System - HWE	**(25.4)**	**(25.3)**	**0.1**	**0.0**	**0.0**	**0.0**

Non-Recurrent Deficit Support Fund (NR DSF)	(6.1)	(6.1)	0.0	(12.2)	(12.2)	0.0
Total Provider position excluding NR DSF	**(25.5)**	**(25.4)**	**0.1**	**(12.2)**	**(12.2)**	**0.0**
Total System excl NR DSF - HWE	**(31.5)**	**(31.4)**	**0.1**	**(12.2)**	**(12.2)**	**0.0**

ICB financial position

3.3 The main risks to the delivery of the ICB financial positions are set out below. In total, there is a net risk of £23.7m across the three ICBs. The risks below are emerging across all three ICBs with non-recurrent mitigations offsetting the YTD position:

- Independent sector providers are continuing to overperform on elective activity compared to Indicative Activity Plans and agreed financial envelopes. Discussions are in progress with all providers to manage activity levels and make appropriate clinical prioritisations within overall contract values. *(C&P and H&WE)*
- Continuing Healthcare (CHC) and complex MHLDA placements. Cost pressures are due to rising demand, historic appeals and cost escalation. This is combined with an under-delivery of planned efficiencies. *(BLMK)*
- ADHD and ASD Assessments: Demand and activity levels continue to rise under the Right to Choose framework. *(BLMK, C&P and H&WE)*
- Prescribing continues to be an area of financial focus given the scale of the spend with higher drug costs driving increased cost and ongoing delivery of efficiencies key to delivery of the full year financial plan. *(BLMK, C&P and H&WE)*

3.4 All ICBs continue to forecast delivery of a breakeven financial position. This will rely on a number of non-recurrent mitigations alongside further enhanced financial and budgetary control mechanisms. Financial recovery oversight is provided via ICB led Improvement Groups.

3.5 There is a further financial risk associated with redundancy costs to reach the required £19/head for ICBs from the start of 2026/27. It is expected that NHS England national funding will be released without materially impacting on the financial positions of the ICBs.

3.6 The transition to the new finance ledger (ISFE2) presents an operational risk to ICBs. While the finance teams have prepared extensively, there remains an ongoing risk in operating some processes and we continue to work through temporary measures and manual adjustments with NHS England support. These challenges are not isolated to our ICBs.

System financial position

3.7 The system financial position also presents some delivery risks with several organisations stepping up financial recovery actions to address YTD deficits and variances to plan.

3.8 The main risks relate to operational pressures from urgent and emergency care pathways over the winter period, the cost of delivering agreed elective performance targets and the ongoing risk and cost of Industrial Action. All NHS trusts have been asked to reduce their reliance on temporary staffing during 2025/26 with good progress made in reduced agency usage and an overall reduction in bank spend with further work to do in order to meet the national ask. In total there is a net risk of £26.7m across all system provider organisations.

3.9 Efficiency delivery for M6 YTD is £244.0.m across the three systems, which is £10.3m (4.2%) below plan. For the full year, the three systems are expecting to deliver efficiencies of £557.2m with a greater focus on recurrent efficiencies.

3.10 For H&WE in particular there remains a significant further risk due to a systemwide efficiency ambition which was set at the beginning of the financial year. Progress in delivery has been slower than expected and therefore attention has rapidly turned to alternative opportunities to deliver the required savings and efficiencies. This assessment is in progress however solutions are likely to be non-recurrent in nature and therefore will present a financial sustainability concern going forwards.

Medium term financial sustainability

3.11 The NHS continues to operate within a challenging financial environment. Our approach to financial sustainability needs to balance our responsibility for commissioning the right level

of safe healthcare services for our resident population alongside a move towards greater strategic commissioning and transformation in line with the aims of the 10 Year Heath Plan.

3.12 NHS England has asked ICBs and NHS Trusts to develop multi-year plans with aligned assumptions on activity, demand, capacity and productivity opportunities. Over time, ICBs will be looking to fully align funding flows with population health demand, using appropriate contractual mechanisms to ensure that quality, activity and financial outcomes are monitored and managed appropriately.

3.13 We need continue to focus on the recurrent cost base, efficiency and productivity opportunities, recognising that all organisations are required to deliver financial balance without relying on exceptional and non-recurrent financial support.

4.0 Next Steps

4.1 Continued strong oversight and risk management of the financial position, recognising the challenges faced and with an emphasis on recurrent mitigation strategies to support financial sustainability. Strong collaborative working with H&WE system partners to remain on track to deliver a breakeven plan as a system.

4.2 Progress financial recovery workstreams with a particular focus on CHC and Independent Sector contract management, ensuring service need and performance targets can be met from within agreed financial budgets.

4.3 Continue to work with other ICBs and NHS England in relation to challenges arising from ISFE2. Further updates to be provided via the Audit and Risk Committee.

4.4 Progress detailed work on financial stability and medium-term plans with a further update due ahead of the first submission to NHS England.

Report to the:	(1) NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) - Board (2) NHS Cambridgeshire & Peterborough ICB (C&P) - Board (3) NHS Hertfordshire & West Essex ICB (HWE) – Board with each sovereign Board meeting in public and in-Common
Date of meeting:	28 November 2025
Item 9.0:	Neighbourhood Plan
Report in relation to:	NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) NHS Cambridgeshire & Peterborough ICB (C&P) NHS Hertfordshire & West Essex ICB (HWE)
Executive Lead:	Kate Vaughton, Executive Director – Neighbourhoods, Place and Partnerships
Report Author:	Nicky Ward, Director of Partnerships and Integration
Reason for the report to the Committee/Board:	The paper outlines the upcoming neighbourhood planning asks that will be made through DHSC guidance expected before Christmas. Neighbourhood planning is expected to be led locally by Health and Wellbeing Boards
Recommendation/s:	The Board is asked to: • **Note** this report/the following: • Nationally we are seeing an acceleration and drive towards true multi agency neighbourhood planning for delivery. In order to achieve this genuine partnership approach Health and Wellbeing Boards are being asked to lead on the strategic and operational planning elements of neighbourhoods with key deadlines in April 2026 and Q2 2026/27. The ICB will need to ensure that we lean into this process effectively as a key strategic partner and provide consistency where appropriate across our larger footprint.

1.0 Executive Summary

1.1 Neighbourhood health and the delivery of successful multi-agency neighbourhood teams that reduce health utilisation and address inequalities through a person-centred approach is a central government agenda being driven across multi-government departments. Nationally there is a gear change to shift partnerships towards collaborating much more closely to deliver person-centred care through multi-agency teams in communities, drawing on funding opportunities such as the Better Care Fund and pooled budgets as needed.

1.2 Whilst national guidance from DHSC that will contain the specific asks for the strategic and operational plans have not yet been published at time of writing, enough draft information has been shared to begin to work with Health and Wellbeing Boards (HWBs). In anticipation and to align our colleagues and partners around this ask the HWB in Cambridgeshire and Peterborough held a development session on 12th November. We used this session to collectively discuss the ask and agree our approach to tackling the development of these plans in order that they were collaboratively owned. This is particularly important as early material shared on this to date has felt to partners as very

'NHS driven' which is at odds with the multi government department and Local Government Association approach nationally to develop the planning guidance, that very much recognises the need for co-ownership in planning and delivery.

1.3 It is proposed that a consistent methodology is applied, tailored to the geography and infrastructure, to ensure that our plans have key elements of consistency and are collaboratively owned.

1.4 In the draft information available to date, two key deadlines were suggested. April 2026 for completion of the HWB owned strategic plan and Q2 of 2026/27 for the operational plans. The suggestion for the latter is that partnership boards develop the operational plans on the basis that key multi agency partners are also represented at these meetings and are closer to the delivery detail. However, HWB oversight is key to ensure consistency where appropriate and that system wide issues are appropriately addressed. In Cambridgeshire and Peterborough there is a single HWB. Where geographies of multi HWB exist, it was suggested in the draft guidance that individual HWBs work together strategically to deliver a joint plan for the wider system around the appropriate geographical footprint and population.

2.0 Key Implications

2.1 Financial implications – the development of the strategic plan requires systems to consider a review of the Better Care Fund (BCF). BCF will transform into a new *Integrated Care Funding Framework*, beginning in 2026/27. Neighbourhood health plans should set out how HWBs are planning to use this to help achieve their goals for neighbourhood health, with a specific focus on intermediate care and other services that involve integrated packages of health and social care to help people maintain or recover their independence. There is an additional expectation that HWBs explore opportunities to pool funds and the operational plans will need to then reflect this and the implications for new models of delivery.

2.2 Equality and / or health inequalities implications – addressing inequalities is a golden thread that binds system partners in the development of their plans. Their will be an expectation that the plans seek to address and focus on our areas of biggest inequalities and how we could deliver services in a more integrated person-centred way. It will also bring a stronger data focus of the HWBs, in terms of monitoring of impact of agreed schemes of work.

2.3 Engagement – this neighbourhood planning requirement aims to be landed as a joint responsibility not an NHS ask. This is extremely important in the positioning of this guidance and as a key strategic partner it is essential that we position this as a partnership endeavour. It is also likely that the planning ask will be robust, requesting a potential audit of all partner services being provided at neighbourhood level. It also underlines the need for community engagement in order that the plans are reflective of what our communities need and again this is a substantial engagement ask in a short period of time. The existing relationships and engagement at a neighbourhood level will be a key enabler.

2.4 Green Plan commitments – effective neighbourhood delivery within the community has a clear related green deliverable by delivering care closer to home, reducing health utilisation and providing a more efficient person-centred model, supported by digital enablers. This naturally has a benefit on reducing carbon emissions through travel and duplication of services.

2.5 Risk – its is proposed that once the respective footprints have engaged with their HWBs on this planning ask that risks are assessed across the cluster and recorded accordingly, particularly where there are thematic risks. There are some emerging risks around how areas will develop these plans with more than one HWB and how an effective plan can be

developed in the timescales, during a consultation period from an ICB perspective and to some extent the changing local government landscape.

3.0 Report

As described above, the DHSC final guidance is yet to be published but as outlined in the medium term plan guidance:

Neighbourhood Health Plans will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund. The plan should set out how the NHS, local authority and other organisations, including social care providers and VCSE, will work together to design and deliver neighbourhood health services. DHSC will publish separate guidance to support their development.

The plans are asked to be:

- Outcomes focussed
    - Accountable and transparent
    - Evidence-based
    - Multi-disciplinary
    - Credible and deliverable

It is expected from the early information available that the strategic plan will need to be developed by HWBs by April 2026 and reflective operational plans developed by place by Q2 2026/27.

The attached slides demonstrate the approach taken in Cambridgeshire and Peterborough and the board are asked to note this and consider what this means for the cluster wide approach to neighbourhood planning.

It is of note that separate guidance is also expected to be shared in a similar timeline that reflects the model neighbourhood and is an annex to the NHS medium term plan and will contain specific NHS asks on planning for neighbourhoods that reflect areas such as; bridging the gap and primary/secondary care interface, GP access, outpatient pathway transformation and putting INTs on a contractual footing. This is alongside expected publication of single and multi-neighbourhood model contracts and Integrated Health Organisation (IHO) model contracts (also referred to as model system archetypes). Finally further information is also expected to be provided on model neighbourhood hub archetypes. All of this, although driven through an NHS route, has relevance to the planning ask made through the DHSC guidance and it will be crucial to effectively align and integrate the asks in order that places and systems have a single plan that prioritises the needs of their communities.

4.0 Next Steps

Although final guidance publication is a next critical step to confirm the detail provided in draft form only at this stage, the Board is asked to note that a similar approach will be taken across each HWB area within the cluster, and consider how the Board can support this process and significant planning ask over the next few months.

In Cambridgeshire and Peterborough next steps include an action focussed workshop following guidance publication (likely in the New Year) that is independently facilitated to avoid the appearance of one particular partner leading the process. This will aim to drive the framework and to some extent the content of our strategic plan.

List of appendices
Appendix A – Health and Wellbeing Board slides attached

Background reading
Annex A – Related published NHS guidance, DHSC guidance and further NHS model neighbourhood guidance still awaited.

NHS England » Medium Term Planning Framework – delivering change together 2026/27 to 2028/29

NHS England » Strategic commissioning framework

Report to the:	(1) NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) - Board (2) NHS Cambridgeshire & Peterborough ICB (C&P) - Board (3) NHS Hertfordshire & West Essex ICB (HWE) – Board with each sovereign Board meeting in public and in-Common
Date of meeting:	28 November 2025
Item 10.0:	**Board Assurance Framework (BAF) – Cover Report**
Report in relation to:	NHS Bedfordshire, Luton and Milton Keynes (BLMK) ICB NHS Cambridgeshire and Peterborough (C&P) ICB NHS Hertfordshire & West Essex (HWE) ICB
Executive Lead:	Karen Barker, Executive Director of Corporate Services and Delivery
Report Author:	Sharon Fox, C&P Director of Governance
Reason for the report to the Committee/Board:	Assurance – standing item on cycle of business
Recommendation/s:	The Board is asked to **note** and **discuss** the contents of the report.

1.0 Executive Summary

1.1 A Board Assurance Framework (BAF) records the principal risks that could impact on the organisation achieving its strategic objectives and provides a framework for reporting key information to the Boards meeting in Common. The BAF forms a key part of the Risk Management Framework for BLMK, C&P and HWE ICBs

1.2 ICB BAFs and Risk Management Framework are subject to annual internal audit review, the outcomes of which will contribute to the Head of Internal Audit Opinion (HoIAO) at year end for each ICB. It is understood this requirement remains pertinent for the 2025/26 annual accounts process.

1.3 The purpose of this paper is to give assurance on the position of the individual BAFs while the ICBS remain sovereign organisations. It also provides a brief overview of the work in progress to develop a single BAF and risk reporting mechanisms leading up to the planned inception of Central East ICB from 1 April 2026.

2.0 Key Implications

2.1 Financial implications – Not applicable as an overview report. Financial risks are reflected in the separate BAFs included as appendices to this report.

2.2 Equality and / or health inequalities implications - *Not applicable as an overview report. Financial risks are reflected in the separate BAFs included as appendices to this report.*

2.3 Engagement – The BAFs were reported and discussed at the Audit & Risk Committees held in common on 7 November 2025.

2.4 Green Plan commitments – Not applicable to this paper.

2.5 Risk – Report concerns the respective BLMK, C&P and HWE C&P Board Assurance Frameworks (BAF) – all risks

3.0 Report

3.1 As the three ICBs will remain legal entities up to 31 March 2026 there will be a need to retain separate Board Assurance Frameworks that reference the strategic risks of the organisation. This will be done in parallel with work to develop a single BAF for the new Central East ICB from 1 April 2026.

3.2 In regard to development work the Risk and Governance teams across the three ICBs have commenced collaborative work to align the BAFs in preparation for the integrated operating model.. This work includes:

- Considering the thematic overlap of risks and harmonisation of existing BAF structures, scoring matrices, and assurance categories:
- Acknowledging and accepting that different format and styes have been adopted in the way that individual ICBs present and report their strategic risks – and to utilise and adopt examples of best practice from each ICB going forward;
- Testing standardised BAF templates and reporting formats to support consistent Boad-level assurance;
- Exploring digital interoperability between the different 'risk systems' that are currently used by the three ICBs, namely DatixWeb, 4Risk, and InPhase systems; and
- Initial focus is to be given to identifying overarching strategic risks that are then aligned through a single BAF underpinned by consistent risk assessments and agreed risk appetite.

3.3 This work will be overseen by the Audit & Risk Committee. The Board will be kept informed of progress as this work progresses.

3.4 The latest versions of the respective BAFs for each ICB, which were reviewed and updated in advance of their presentation to Audit and Risk Committee earlier this month, are included as Appendices to this report for the Boards review and comment.

4.0 Next Steps

4.1 Collaborative work to align the strategic risks include in the respective BAFs will be progressed in advance of future discussion and reporting at Executive, Committee and Board level.

List of appendices

Appendix A BLMK Board Assurance Framework
Appendix B C&P Board assurance Framework
Appendix C HWE Board Assurance Framework

Background reading

Nil

Report to the:	(1) NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) - Board (2) NHS Cambridgeshire & Peterborough ICB (C&P) - Board (3) NHS Hertfordshire & West Essex ICB (HWE) – Board with each sovereign Board meeting in public and in-Common
Date of meeting:	28 November 2025
Item 11:	**Research Performance and Future Strategy**
Report in relation to:	NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) NHS Cambridgeshire & Peterborough ICB (C&P) NHS Hertfordshire & West Essex ICB (HWE)
Executive Lead:	Dr Fiona Head, Executive Clinical Director Utilisation Management
Report Author:	Dr Philippa Brice, Associate Director for Research & Impact, C&P ICB
Reason for the report to the Committee/Board:	For information (Appendix A, research annual report 2024-25) and discussion / approval (Strategic Research Office proposals)
Recommendation/s:	The Board is asked to: - **Note** the following: • Research annual report 2024-25 (BLMK, C&P and HWE ICBs) - **Discuss** and **approve** the outline plan for a • Hosted National Institute for Health and Care Research (NIHR) funded Strategic Research Office

1.0 Executive Summary

1.1 The 2024-25 system research performance and individual ICB activity in fulfilment of statutory responsibilities in relation to research are outlined in Appendix A. Such reports to the Board are expected to become a biannual requirement from 2026-27.

1.2 There is an ongoing need for ICB research generation expertise and activity. The current financial plans for Central East ICB do not include provision for research activity from core budgets, but statutory requirements in relation to research remain; the latest Model Region blueprint suggests that regional NHS will 'help' ICBs to fulfil these responsibilities (rather than take them on as originally suggested in the Model ICB blueprint 1.0) and 'oversee' research recruitment performance,

1.3 This report proposes plans for a hosted Strategic Research Office for Central East, built on the existing hosted NIHR funded C&P ICB Research Office, providing a low-risk, zero-cost opportunity to retain critical research functions. This will enable growth of activity and income in support of patient-centred research outside hospitals, including commercial research performance and growth (in line with the 10 Year Plan and the Life Sciences Sector Plan); and support strategic system research collaborations to grow future investment and boost population benefits, in line with Central East priorities.

1.4 These plans also align with the latest Strategic Commissioning Framework guidance, which notes the importance for ICBs to ensure that clinical decisions 'are based on best evidence and support the system to maximise value for money' as part of clinical and care professional

leadership. Whilst facilitating high-quality research creates evidence for future rather than current practice and decision-making, the proposals also enhance a research-positive culture that can help inform evidence-based medicine and commissioning.

1.5 The Board is asked to note the Research Annual Report 2024-25 (Appendix A) and discuss and approve the plans to establish a hosted Strategic Research Office from the inception of Central East ICB (April 2026), based on the existing C&P ICB hosted Research Office but operating across the whole geography for the benefit of system partners and populations.

2.0 Key Implications

2.1 Financial implications – research generation activity is supported by external National Institute for Health and Care Research (NIHR) funds ringfenced for specific research capacity building activities, or income from additional sources directly linked to research activities. Income generation and management requires significant dedicated time from expert Research Office staff. Hosting fees may be paid to the ICB, as per arrangements with C&P ICB, or potentially to directly support a portion of an ICB finance role. There is scope for modest expansion of the team to provide continuity with existing BLMK and HWE research staff.

2.2 Equality and / or health inequalities implications – maintaining research activity, including active efforts to support engagement and inclusion of underserved groups in health and care research, plays an important role in ongoing work to understand and address health inequalities. Community-based research opportunities are recognised as offering improved access and engagement for inclusion health groups, helping to provide representative population data and evidence for research.

2.3 Engagement – this report has been produced by the C&P ICB Research Office, with thanks to the BLMK and HWE research teams for the provision of ICB specific information.

2.4 Green Plan commitments – research hosting and funding opportunities require adherence to NIHR guidance on sustainable research and some research applications directly address the sustainability of research and healthcare systems.

2.5 Risk – no BAF risks identified.

3.0 Report

3.1 Supporting high-quality research offers many benefits for health and care systems. Research-active NHS organisations have better clinical outcomes and experiences for patients and improved levels of staff satisfaction and retention; the 10 Year Plan makes clear commitments to embedding research across everyday health and care service delivery in all settings, and the forthcoming workforce plan is expected to reinforce this intent. The evidence generated by research helps to inform future clinical and commissioning decision-making. Research can also attract vital new public and private sector funding to system partners and initiatives.

3.2 Facilitating research is very different from supporting innovation, evaluation, audit and improvement activity; whilst it generates evidence, insights and ideas that can feed into and improve future care and commissioning, the much longer time-scales for delivery, analysis and dissemination mean it is an investment in the future. However, this makes it even more important that the research being developed now should address the most important questions and priorities for our populations. It must also be designed with and for our patients and professionals to make it easy and efficient to deliver and accessible across diverse

groups and communities, generating the best data to help us understand and address health needs and inequalities.

3.3 The funding and governance mechanisms for NHS research also differ markedly from those for health and care delivery, and are changing rapidly in line with new technologies, modes and settings for research delivery and policy drivers. Strict adherence to these requirements is essential, both to maintain the capacity for systems to deliver current research at scale and at pace in line with national directives, and to support robust ethical, legal and financial protections for patients and other research participants, and for the health and care professionals and organisations who support research. Ring-fenced NIHR research funding has highly restricted permitted uses and cannot be diverted to evaluation or improvement activity, important as these are.

3.4 The Research annual report for 2024-25 (Appendix A) outlines the research delivery performance across the three integrated care systems, including from different settings and providers. Whilst research activity levels were generally lower in 2024-25 compared with the previous year, potentially reflecting the impact of changes to the NIHR Research Delivery Network and a reduced national portfolio of studies, performance relative to the rest of the East of England remained relatively strong.

3.5 Improving research performance (especially the speed and volume of commercial research activity) is a key policy priority for the NHS, as is moving more research to neighbourhood settings. There is intent from DHSC that ICB Boards will be expected to consider provider research performance metrics twice yearly from 2026-27; and NIHR research funding incentives and penalties will actively support enhanced commercial research and neighbourhood-based research delivery.

3.4 The Central East geography is well positioned to take a leading role in growing and leveraging research for system health and care benefits. As Appendix A shows, the three ICBs already benefit from an unusually advanced research support infrastructure for primary care and wider settings; higher levels of research income from NIHR; multiple centres of NHS, academic and other research excellence; and well-established collaborations and networks. There is also active and ongoing investment in community engagement around research to promote access and inclusion for underserved groups, which is critical to help address inequalities. Our work has already created a nationally recognised profile, but there is potential to go further and faster in growing partnerships, income and future population benefits through strategic collaborations and capacity building.

3.5 A hosted NIHR funded Strategic Research Office for the new ICB would help deliver these benefits, using existing expertise to maintain and grow current research income streams and local capacity building, with a particular focus on neighbourhood settings and facilitating cross-settings collaboration. It could also identify and exploit opportunities for system partners to work together to attract new research investment to the area and undertake research aligned with current and anticipated future population needs. This would create a ‘virtuous circle’ of growing health and care research activity, income and impact, benefiting local people, professional and providers.

3.6 This approach is exemplified by the recent success of two Cambridgeshire and Peterborough primary care practices in securing NIHR Primary Care Commercial Research Delivery Centre (PC-CRDC) status. Wansford Practice near Peterborough and Mereside Medical based in Soham, Fenland are two of just 14 primary care practices recognised nationally for their commercial research activity and expertise, receiving new investment of around £1 million each for plans to grow primary care commercial research through hub and spoke models. Their outstanding applications were enhanced by C&P ICB and the hosted Research Office, who were able to offer evidence of strongly supportive infrastructure and expertise, ongoing investment and established relationships that will help the new PC-CRDCs realise their vision.

3.7 The PC-CRDCs and associated networks will be prioritised for nationally significant commercial research studies in primary care, enabling access to cutting-edge new tests and treatments close to home for local people. They will help to increase wider primary care research capacity, creating new opportunities for Trust collaboration on research delivery, which will in turn offer direct financial rewards as well patient benefits, and for academic and commercial partnering for further income generation.

3.8 Going further, combined with the selection of Fenland, Peterborough and East, Peterborough as one of the pioneer National Neighbourhood Health Implementation Programme (NNHIP) sites, there is exciting potential to trial an innovative approach to embedding research within neighbourhood health services with support from the Research Office, especially as the PC-CRDCs and local provider and VCSE organisations are already collaborating effectively on cross-settings research engagement and activity. NHS England has already expressed keen interest in this; transferring learning and enablers across other local neighbourhoods could have a truly transformational impact.

3.9 Academic collaborations supported by a Strategic Research Office can also bring substantive opportunities to the region. All ICBs have established partnerships of different kinds with local universities in relation to health and care research: the HWE Research and Innovation Hub; the BLMK & University of Bedfordshire Research and Innovation Hub; and the C&P funding and support schemes for the University of Cambridge Primary Care Unit and Anglia Ruskin University Centre for Primary Care. Support from the ICBs for a recent successful academic application for major research funding in a public health priority condition (currently still embargoed) is also expected to generate strong future benefits.

3.10 The C&P ICB hosted Research Office is fully self-funding through NIHR and associated research contracts and income streams, imposing no costs on the ICB and generating significant research income for system partners. It already delivers a specialist R&D function to support the setup and governance of research conducted within primary, community, and

wider health and care settings across Cambridgeshire, Peterborough, Bedfordshire and Hertfordshire, funded by the NIHR East of England RDN. This offers essential research assurance for provider organisations across the ICS and enables the safe expansion of research opportunities into wider community settings, including non-NHS sites such as schools, care homes and prisons. It also provides an expert research hosting and management service for a portfolio of NIHR research in out-of-hospital settings, generating an income stream of Research Capability Funding of up to £1m p/a, far greater than the maximum £50,000 p/a otherwise available to ICBs for primary care research.

3.11 Establishing a new hosted Strategic Research Office for the Central East ICB would enable continuation of a comprehensive research support offer aligned with the NIHR funded R&D functions across the system geography. This will provide a central team of established experts and services without cost to ICB budgets and offering added value, thanks to efficiencies of scale. Over time, it would be possible to further expand service provision to support neighbourhood-based research, as well as leading and supporting cross-cluster collaboration to attract and exploit new commercial, public and third sector research funding and opportunities.

3.12 The risks posed to the new ICB by hosting a Strategic Research Office would be minimal, and the potential advantages to get ahead of the curve in realising the benefits of the unusually rich local research strengths and assets for our populations whilst simultaneously meeting wider ambitions around the 10 Year Plan shifts and other policy directives would be significant.

STRENGTHS	**WEAKNESSESS**
• Cross-sector and cross-setting healthcare and life sciences research excellence • Diverse populations and partners • Strong reputation, expertise and relationships	• Reliance on NIHR funding streams – diversification via partnerships and services advisable • Current capacity limited by team size – but agile and scalable
OPPORTUNITIES	**THREATS**
• Uniquely well positioned to lead transformative change in line with 10 Year Plan ambitions • Right mix of skills to support collaboration, including with commercial sector, local government, VCSE etc. • Oxford-Cambridge Arc	• Limitations of research funding (permitted uses only) • Fiscally constrained environment • Disruptive effects of system changes • Siloes and competitive research culture across organisations

4.0 Next Steps

4.1 With Board approval for the intention to transform the C&P ICB hosted NIHR funded Research Office function to a hosted NIHR funded Strategic Research Office for Central East, detailed proposals for the best approaches to effect this change will be swiftly advanced in consultation with the Executive Clinical Director for Utilisation Management and other key internal stakeholders as appropriate, for review and approval by the Management Executive. The key staff, research contracts and supporting infrastructure for a hosted Strategic Research Office are already in place, and a rapid transfer to the new Central East ICB from 1st April 2026 can be achieved alongside the current consultation procedures.

4.2 Outline process to operationalise new Strategic Research Office:

- **Nov 25: Board approval** to novate research contracts / agreements and hosted Research Office to new ICB from April 2026.
- **Dec 25: Outline plan** for transformation of existing C&P ICB NIHR funded research structures into new Central East hosted NIHR funded Strategic Research Office, for review by ICB Management Executive Committee; to include structural proposals for staffing (aiming to retain essential research expertise from all ICBs where possible) and practical steps to enable ongoing research governance, financial and operational management in line with NIHR requirements and emerging ICB processes.
- **Feb 26: Agreement of final plan** by Management Executive and operational steps to achieve this.
- **March 26: Draft plan for 2026-27**, for discussion by Boards of C&P, BLMK and HWE ICBs as required.
- **April 26: Final strategic and operational planning for 2026-27 in place**, to include regular reporting to Finance Planning and Payer Function Committee on research finances.
- **By July 26: Research annual report 2025-26** to Central East Board.
- **By Jan 27: Research interim / progress report** to Central East Board, including medium-term income generation plan for next two years.

List of appendices

Appendix A - Research Annual Report 2024-25

Report to the:	(1) NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) - Board (2) NHS Cambridgeshire & Peterborough ICB (C&P) - Board (3) NHS Hertfordshire & West Essex ICB (HWE) – Board with each sovereign Board meeting in public and in-Common
Date of meeting:	28 November 2025
Item 12:	Governance Report
Report in relation to:	NHS Bedfordshire, Luton and Milton Keynes ICB (BLMK) NHS Cambridgeshire & Peterborough ICB (C&P) NHS Hertfordshire & West Essex ICB (HWE)
Executive Lead:	Karen Barker - Transition Director and Executive Director of Corporate Services & ICB Development
Report Author:	- Simone Surgenor – Deputy Chief of Staff – Governance and Policies – HWE ICB - Michelle Evans- Riches - Head of Corporate Governance – BLMK - Sharon Fox – Director of Governance (C&P)
Reason for the report to the Committee/Board:	This report forms part of a regular agenda item to each sovereign board and is presented in support of good governance within each organisation.
Recommendation/s:	Sovereign Boards are asked to **note** the following: • ICB Chair update • Due Diligence update • Committee updates Sovereign Boards are asked to **approve**: • Governance Handbook amendments referenced at paragraph 3.2 below. • Delegated functions as cited at paragraph 3.3.4 (iii) below. • Points for ratification and highlighted in the committee summaries found at paragraph 3.4 (b) below.

1.0 Executive Summary

1.1 As the Boards are aware, NHSE has approved the bringing together the ICBs of Bedfordshire Luton & Milton Keynes ICB (BLMK) Cambridgeshire & Peterborough ICB (C&P), and the Hertfordshire footprint of Hertfordshire and West Essex ICB (HWE). This was formally announced by the Minister for Health in parliament on Tuesday 9 September 2025. As a result, the ICBSs are now working through a period of transition to create a unified single entity with the utilisation of shared leadership and functions, whilst uniting the best of our legacy systems.

1.2 This report will address the following:

- Appointment of ICB Chair
- Governance Handbook update

- Due Diligence update
- Committee Summaries

2.0 Key Implications

2.1 **Financial implications** – none.
2.2 **Equality and / or health inequalities implications** - none
2.3 **Engagement** - none
2.4 **Green Plan commitments** - none
2.5 **Risk** – collaboration between BLMK, Cambridgeshire & Peterborough and Hertfordshire and West Essex ICBs provides continuity during the transitional period to oversee the arrangements of the establishment of Central East ICB.

3.0 Report

3.1 Appointment of ICB Chair

3.1.1 During the transition and whilst the current ICBs retain their sovereign status, BLMK and C&P ICBs from 1st October began working together in collaboration with a joint Chair. The Chair – Robin Porter will also be the Chair Designate for Central East ICB, which is anticipated will be established on 1 April 2026. From 4th November 2025 Robin was also formally appointed with immediate effect, to serve as ICB Chair for HWE ICB.

3.1.2 Joint appointments of Executives across all three ICBs and joint Non-Executive Member for BLMK and C&P have now been made and are subject to ratification by the Board.

3.2 Governance Handbook updates

3.2.1 In compliance with sovereign ICB Constitutions, ratification is sought for the following updates to individual Governance Handbooks:

3.2.1.1 NHS Bedfordshire, Luton and Milton Keynes – amended Audit and Risk Committee Terms for Reference found at **appendix A**. Summary of the amendments:

- Paragraph 4.2 – increase of NEM membership to the committee to three.
- Paragraph 6.10 – updated wording from *Public Sector Internal Audit Standards* to *Global Internal Audit Standards (public sector)*
- Paragraph 6.15 – inclusion of wording - These will include, but will not be limited to:

  Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, CQC; and

  Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies)
  Reference to Management of Risk moved from paragraph 6.40 to 6.33.

3.2.1.2 NHS Hertfordshire and West Essex ICB – approval and inclusion of Essex Joint Committee Terms of Reference (appendix A(i)).

3.3 Due diligence

3.3.1 On 23rd September 2025, NHS England published its Implementing Integrated Care Board Mergers and Boundary Changes to take effect in April 2026 and 2027.

3.3.2 As part of this work, a detailed timeline of actions supported by a due diligence checklist has been issued providing the steps that need to be taken at ICB, regional and national level in order to achieve the proposed ICB mergers on 1 April 2026. All three ICBs receiving this paper, form part of that programme.

3.3.3 In support of the ICB Mergers and Boundary Changes Technical Implementation Guidance – the Board will note that the following pending approvals will be sought:

(a) Draft proposed ICB Constitution (including standing orders).
- Draft for be submitted with NHS by 31st December 2025
- To be agreed with NHS England regional team by 31st January 2026.
- Submission of final proposed ICB Constitution (including standing order) for final review by the NHS England regional team prior to Regional Director approval – by 20th February 2026.

(b) The following is to be prepared by 31st January 2026, and ready for approval once the new ICB is established by 27th February 2026:
- Draft Scheme of Reservation and Delegation
- Draft ICB Standing Financial Instructions
- Draft ICB Governance Handbook

3.3.4 The Board will note that:

i. The sovereign ICB Audit and Risk Committees are being used as points of assurance in respect of the transition work.
ii. Further, updates and proposed amendments to the above documents will also be shared with the Joint Transition Committees and Management Executive Committee.
iii. **Delegation is sought from this board** for that assurance work to continue, and for final documents to be shared with the Board when it sits on 6th February 2026 for final approval, prior for formal submission with NHS England.

3.4 Committee Summaries:

Board sub-committee overviews for the following are presented for noting with decisions being ratified:

a) Utilisation Management and Quality Improvement Committee – sitting as a Joint Committee for NHS Bedfordshire, Luton and Milton Keynes ICB and, NHS Cambridgeshire and Peterborough ICB met in-Common with NHS Hertfordshire and West Essex ICBs System Quality and Transformation Committee as part of a development session on 14th November 2025. Summary notes can be found at **appendix B**

b) Finance Planning and Payer Function Committee - sitting as a Joint Committee for NHS Bedfordshire, Luton and Milton Keynes ICB and, NHS Cambridgeshire and Peterborough ICB met in-Common with NHS Hertfordshire and West Essex ICBs strategic Finance and Commissioning Committee on 14th November 2025. These committees sat in a development and decision-making form. The Board will note the update found at **appendix C** and is asked to ratify those areas receiving approval.

c) Audit and Risk Committees held-in Common on 7th November 2025 for NHS Bedfordshire, Luton and Milton Keynes ICB, NHS Cambridgeshire and Peterborough ICB, NHS Hertfordshire and West Essex ICB. Found at **appendix D**.

4. Next Steps

4.1 Sovereign Boards are asked to note the following:

- ICB Chair update
- Due Diligence update
- Committee updates

4.2 Sovereign Boards are asked to approve:

- Governance Handbook amendments referenced at paragraph 3.2 above.
- Delegated functions as cited at paragraph 3.3.4 (iii) above.
- Points for ratification and highlighted in the committee summaries found at paragraph 3.4 (b) above.

List of appendices

- Appendix A NHS Bedfordshire, Luton and Milton Keynes ICB – amended Audit and Risk Committee Terms for Reference
- Appendix A(i) NHS Hertfordshire and West Essex ICB – Essex Joint Committee Terms of Reference.
- Appendix B Committee notes - Utilisation Management and Quality Improvement Committee – sitting as a Joint Committee for NHS Bedfordshire, Luton and Milton Keynes ICB and, NHS Cambridgeshire and Peterborough ICB met in-Common with NHS Hertfordshire and West Essex ICBs System Quality and Transformation Committee
- Appendix C Committee notes - Finance Planning and Payer Function Committee - sitting as a Joint Committee for NHS Bedfordshire, Luton and Milton Keynes ICB and, NHS Cambridgeshire and Peterborough ICB met in-Common with NHS Hertfordshire and West Essex ICBs strategic Finance and Commissioning Committee
- Appendix D - Committee notes – Audit and Risk Committees held-in Common on 7th November 2025 for NHS Bedfordshire, Luton and Milton Keynes ICB, NHS Cambridgeshire and Peterborough ICB, NHS Hertfordshire and West Essex ICB.