



Board Assurance Framework 2025/26

February 2026

Strategic Risk Summary

Within the Integrated Care System (ICS) there are many organisational risks that are managed through appropriate people, organisations, and governance. For our Integrated Care Board (ICB), we need to have a series of strategic risks that will impact on the objectives for all ICBs. It is essential that our approach makes a real impact on the residents of Cambridgeshire & Peterborough by delivering on our ambitions and our ICS strategy, the four key priorities which are:

Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives.

Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.

Priority 3: Reduce poverty through better employment, skills, and better housing.


Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.

The table below outlines the core strategic risks impacting on our ability to operate as an ICB and the actions we need to hold ourselves to account against everything that we do.


When we speak to the public and look at the data there are three things that are clear:


- 1) Access to care and health is the difference between a service working well and not meeting the needs of people.
- 2) We are in the people business. How we operate and communicate impacts on the outcomes for people, both service users and workforce.
- 3) Hard to reach groups don't exist, they are not well enough understood and are often most under served.



The table will be updated bi-monthly to fit into the ICB business cycle, and a summary page for each risk demonstrates progress as set out in Appendix A.


No	Risk Area	There is a risk that	Impact	Board requirements	Current status	Risk Score
1	Health Inequalities and Outcomes SRO: Managing Director of Strategic Commissioning to 30.09.2025 SRO: Executive Director of Strategy, Planning & Evaluation from 1.10.2025	Health inequalities will widen. As a result, population health outcomes will worsen for our 'Core20PLUS' population.	<ul style="list-style-type: none"> • Disproportionate impacts across our population leading to poorer outcomes for our Core20PLUS population. • Life expectancy and healthy life expectancy gaps will widen across our population. • Increased financial impact on the NHS. • Failure to address root causes of health inequalities if focussed only on access to healthcare services and the outcomes such services deliver. • Barriers to healthcare services remain for those most in need. 	<ul style="list-style-type: none"> • Acknowledge the actions required to manage this risk are long-term, have influences at all levels of government, across multi-faceted areas of service beyond healthcare, and will require continued commitment over a significant period to show improvement. • Acknowledge that the Health Inequalities agenda is complex and sits across all ICB directorates and ICS partners. Although the SCU has a responsibility to oversee the healthcare inequalities agenda, the delivery of commitments made in the joint Health and Wellbeing Integrated Care Strategy and Joint Forward Plan with regards to health inequalities sits with respective stakeholders. • Provide ongoing support of the Population Health Improvement Board with strong collaborative system leadership. The PHI board will oversee implementation of the Healthcare Inequalities strategy and operational plans to tackle healthcare inequalities. This 		16

				<p>feeds into the Commissioning and Investment Committee</p> <ul style="list-style-type: none"> • Ringfence the recurrent health inequalities funding allocation as a targeted financial resource to address health inequalities across the system, with allocation of resources to be agreed through a system level assurance process with review of funding proposals/ business cases. • Support and fund placed-based approaches which strengthen community action and innovation to tackle not only the immediate health needs of our population but also support action to address the wider determinants of health. • Ensure all decisions are supported by evidence as to how due consideration has been given to the impacts of proposed actions on population health groups, i.e., through the completion of Equality and Health Inequality Impact Assessments (EHIAs) • Promote integration and partnership-working to improve health and wellbeing through early intervention and prevention. • Support the collection, analysis and publication of data, associated 		
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				<p>analysis and information on healthcare inequalities in line with the ICB's duty to have regard to reducing health inequalities in the exercise of its function including by reference to access, experience, and outcomes, including via the ICS Outcomes Framework.</p> <ul style="list-style-type: none"> • Ensure that there is sufficient clinical expertise to provide clinical challenge to address variation in clinical practice leading to inequalities. 		
2	<p>Listening to residents</p> <p>SRO: Chief Officer for Partnerships and Integration to 30.09.2025</p> <p>SRO: 1.10.2025 Executive Director of Neighbourhood Health, Place & Partnerships 1.10.2025</p>	<p>Future models of care are not built through listening and understanding what people need to maximise their health and wellbeing.</p>	<ul style="list-style-type: none"> • Future models of care are not built through listening and understanding what people need to maximise their health and wellbeing. • Inequity and lack of access to services because they are not designed with the local people. • Historical approach to engage with service users are models designed for feedback only. • We make assumptions about what we think people need and look for evidence to support these assumptions. • We do not invest sufficient time, energy, resource and commitment to truly listen and understand about what will make a difference. • We do not align data and feedback to inform decision-making • Fragmentation of the user voice as highlighted in the Dash review 2025. 	<ul style="list-style-type: none"> • Every service or investment to demonstrate how people have designed it to meet their needs. • For every service, access is addressed so that it is simple for people to navigate. • Board consideration of alternative service models that are co-designed with our residents. • Review of BCF and MHIS services to ensure it is fit for purpose, and has an impact on C&P patients and offers value for money • An agreed, systematic and transparent approach to this work across our system • Use patient feedback but also outcome- driven reviews of 		8



				<p>current services (particularly with system funding and transformation monies such as SDFs)</p> <ul style="list-style-type: none"> • Work through the implications of the Dash review and actions we need to consider in our system • Learn from CQC guidance and best practice from other systems 		
3	<p>Valuing our Workforce</p> <p>SRO: Chief People Officer to 30.09.2025</p> <p>SRO: Executive Director of Corporate Services & ICB Development from 1.10.2025</p>	<p>We don't focus on our culture and the challenges that staff currently face to ensure that they feel valued and activated to respond to the increasing pressure of working in health and care.</p>	<ul style="list-style-type: none"> • Covid has caused staff to re-evaluate what is important to them. • Cost of living means for many groups of staff working in local retail pays more with less pressure than working in care and health. • Historical reliance on 'going above and beyond' to efficiently deliver services. • Transformation done to staff not with staff. • Increasing service users and staff are reporting increasing incidence of disrespect. • Expiration of unfunded system-wide staff support hub still being felt by staff • Staff feel intimidated and harassed by national acts of racist vandalism • 2025 operational planning commitment to reduce admin and clerical staff by ~ 15% has been challenging to staff in these roles 	<ul style="list-style-type: none"> • Conduct system wide training on cultural intelligence that enables inclusive and compassionate leadership • Every service or investment to demonstrate how staff been listened to. • Ensure every service and investment has a workforce delivery strategy that is realistic. • Reinvigorate our antiracism efforts and provide safe spaces for people who feel unsafe to be reassured • Implement CPICS' Strategy for Inclusion which seeks to drive out racism. Data reflects racism as the largest by type of discrimination experienced by our staff. • Trusts are deploying different approaches to achieve the desired cost reduction, with vacancy freezes explored before outplacement processes used 		16


				<ul style="list-style-type: none"> System has developed a transition hub for increasing visibility and access to any available roles, for people who become displaced by the cost reduction moves 		
4	Service Quality SRO: Chief Nursing Office and Chief Medical Officer to 30.09.2025 SRO: Executive Clinical Directors from 1.10.2025	With services under increasing demand, clinical workforce gaps and access delays, service quality can be impacted.	<ul style="list-style-type: none"> Increasing operational pressures have resulted in delay in Emergency Departments and additional Boarding of patients on wards, as well as corridor care in Emergency Departments. Waiting lists for services are longer meaning people are taking longer to be seen. Access to services and communication for people on next steps is variable. Despite overall growth in workforce, actual clinical workforce data identifies some clinical areas remain challenged with shortage of permanent clinical and medical workforce. Identified gap in proactive identification and management of quality risks in Primary Care and the NHS commissioned Independent Sector. Learning Disability research data show the impact of poor care on outcomes. 	<ul style="list-style-type: none"> Ongoing use of the Clinical Quality Review Management Meeting and wider System Assurance Framework process to understand risks and mitigation. Utilise the contract process to support the recovery and improvement of quality. 		16
5	Getting the basics right	That we don't deliver the basic NHS statutory standards that have been put in	<ul style="list-style-type: none"> Population demand for healthcare services is higher than ever, with residual post COVID backlog recovery still impacting on overall available capacity. This demand, in the context of the workforce pressures and need to deliver a 	<ul style="list-style-type: none"> Ensure that the right balance of time and discussion is given to the 'here and now' of our services and the future transformation, with effective oversight through system 		16


	<p>SRO: Chief Operating Officer to 30.09.2025</p> <p>SRO: Executive Director of Finance, Resources & Contracting/Director of Contracts & Performance from 1.10.2025</p>	place to maximise the outcomes for our residents.	<p>balanced financial plan, is contributing to performance below national and local delivery standards.</p> <ul style="list-style-type: none"> • Shifting expectation on performance delivery at political and national level, with increased focus on contractual delivery of NHS constitutional standards. • Historically performance improvement has been achieved through layering in services and as such, has not always been sustainable. • Reputational risk for C&P not meeting NHS constitutional standards for its local population and the impact of not doing so on health inequalities and outcomes for residents. • Risk increases when we do not respond effectively to mitigate emerging risks and issues. 	<p>boards, QPF and C&I.</p> <ul style="list-style-type: none"> • Use data on performance and actively challenge and loop back to previous commitments. • Support the effective delivery of performance and contract management processes, including appropriate escalation and intervention, with individual providers and at a collective system level to ensure that we are delivering value in line with commissioned services. • Ensure local, regional, and national benchmarking is used to monitor performance to ensure understanding of relative performance and performance improvement. 		
6	<p>Respecting the public pound</p> <p>SRO: Chief Finance Officer to 30.09.2025</p> <p>SRO from 1.10.2025</p>	We do not take effective decisions through the lens of best use of the public money and financial sustainability which will impact on the organisation's ability to achieve its	<p>The ICB and ICS has a statutory responsibility to deliver a break-even financial plan. It has a responsibility to ensure most effective use of capital and revenue budgets.</p> <p>To deliver the break-even financial plan and enable the ICB and the organisations within the system to deliver its statutory financial duties we will need to take a number of actions /make assumptions that could emerge as in year risks</p>	<p>Through ICS board governance processes, CFO and regional review meetings ensure regular monitoring of the 25/26 financial plan to include;</p> <ul style="list-style-type: none"> • In year performance • Run rates across pay, non-pay and overall reported position • Performance against workforce plan and temporary staffing • Elective performance – costs and 		12

	Executive Director of Finance, Resources & Contracting	statutory financial duty.	<p>that without mitigation will drive an in-year deficit. There is a clear emphasis on maximising efficiency and productivity opportunities, removing excess costs and limiting growth where this is unaffordable to ensure the ICS and ICB remain financially sustainable:</p> <ul style="list-style-type: none"> • C&P is a complex system with a large net inflow of activity and funding from other commissioners and is therefore highly exposed to decisions made by other commissioners. The C&P allocation is £2.5bn however the total cost base across all hosted organisations is £4.4bn. We are therefore reliant on commissioners following national planning guidance to appropriately uplift contracts (e.g. for pay award). • Specialised commissioning delegation further increases risk to financial resources flowing to the ICS providers in addition to the risk that the funding delegated does not cover the cost of services • The plans for 25/26 are reliant on significant productivity and efficiency savings in excess of those delivered in previous years which will require a strong delivery focus. Some plans are still to be identified and / or are high risk. • Delays to implementing efficiency and productivity schemes will only deliver a part year effect in 25/26 meaning further schemes will be required or use of non-recurrent means to bridge the gap. Schemes need to be 	<p>performance metrics for NHS and IS providers</p> <ul style="list-style-type: none"> • Efficiency and productivity delivery with a focus on recurrent delivery • Risks and mitigations along with associated impact assessments • Maximising available benchmarking opportunities • Rapid identification of recovery actions and robust tracking / monitoring • Monthly monitoring of prescribing costs, drivers, opportunities and risks through to QPF • ICB and ICS Spec Comm providers to work together in 25/26 negotiations to agree appropriate contract values • Ensure all organisations manage costs/ income that are within their control, act quickly to put in place recovery actions. • Robust tracking of provider corporate services returns and net cost savings in 25/26 alongside the full year recurrent exit run rate impact • Transparency over ICB redundancy and transition cost impact alongside clear impact assessment and any opportunities to mitigate 		
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			<p>delivering savings recurrently to ensure financial sustainability through 25/26 and into 26/27</p> <ul style="list-style-type: none"> • Provider organisations have been asked to remove 50% of their corporate services cost growth since 18/19 by Q3 of 25/26 during. Plans to deliver these savings are being worked up with MARS and VR/CR schemes likely to be implemented, the cost of which is expected to be met from within existing funding provided • ICBs have been asked to reduce the costs of running ICBs to live within £19.00 per head of weighted population. This represents approximately 44% reduction across total programme pay and running costs. • Prescribing budgets may not align with the demand driven by national policies and NICE TAs. • The NHS inflation factor does not match levels agreed with local authorities and/ or increases service delivery risk • The funding available for additional elective activity will be capped in 25/26 meaning allocations are fixed for the ICB however providers and the system will still be expected to meet the RTT targets and continue to address long waits. 	<p>the additional unplanned cost. Appropriate modelling and forecasting for the future cost of the ICB to live within £19.00 per weighted head of population.</p> <ul style="list-style-type: none"> • Nationally available benchmarking opportunities to be reviewed and implemented particularly for CHC and prescribing. Further work to identify prescribing efficiencies will be required in order to limit cost growth, accommodate new NICE TAs and provide funding to support new patient delivery outcomes (e.g. for weight management) • ICB carefully scrutinise new funding requests to appropriately prioritise and ensure affordability. • Ensure that commissioners have skills to challenge expenditure associated with unnecessary/inappropriate prescribing and clinical interventions. 		
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7	Building for the future SRO: Chief Clinical Improvement Officer to 30.09.2025 SRO: Executive Director of Strategy, Planning & Evaluation (Interim – from Dec 2025)	We do not get ahead and build services for the future meaning we adapt what we have rather than considering new care models.	<ul style="list-style-type: none"> • We have large amounts of capital coming into the C&P economy for new buildings. • Digital integration and innovation are key enablers of the delivery. • Research and innovation are high in our ICS, and we need to ensure our population gets an advantage in outcomes from this. • When attempting to stabilise current service provision we do not fully explore the ‘art of the possible’ for future models of care. This includes the embedding of AI and new technologies to support the increasing demand for services • A potential lack of ambition/capacity for scale and pace of change means we will need to actively manage the appetite for change across all system providers 	<ul style="list-style-type: none"> • Ensure proposed solutions to issues are explicit in describing long-term future-proof options. • Ensure where digital is the first solution that digital exclusion is considered. • Assure the public when care and health work outside of traditional provider models this has been well considered. • Manage the environment for change to increase the appetite for scale and pace of change 		9
8	Recruitment and retention SRO: Chief People Officer to 30.09.2025 SRO: Executive Director of Corporate Services & ICB Development from 1.10.2025	We are unable to recruit and retain staff across the system	<ul style="list-style-type: none"> • Workforce shortages are being experienced across particular professions within the system • C&P, like all of E of E has become dependent on international nursing recruits to fill vacancies and ensure adequate staffing levels • Socio-political environment places additional pressure on international recruitment practices • Expanding our domestic supply has become significantly more competitive with hospitality, food suppliers and on-line retailers proving preferable destinations for many potential recruits • Retention continues to be challenging into 	<ul style="list-style-type: none"> • Trusts will embed the work done via the Retention Exemplar Programme and will maintain a range of initiatives that improve employee experience and drive up retention • 2025/26 Agenda for Change above inflation pay increase should provide some mitigation to increased cost of living. • All our Trusts have had growth in their staff in post from 2022/3 to 2024/5. Trusts are currently challenged to limit growth in WTE and are reducing non 		12

			<p>some professions or units</p> <ul style="list-style-type: none"> Providers are reducing WTE in clerical and admin functions, lowering numbers by ~ 15% overall 	<p>patient facing WTE (admin and clerical) in many cases</p> <ul style="list-style-type: none"> Strengthening relationship and information sharing with our HEI partners, developing an engagement programme for student nurses to increase level of joining post qualification. Bank and agency reductions in 2024/25 have been significant and vacancies in substantive roles have been limited. 		
9	<p>Industrial Action</p> <p>SRO: ICB Executive Team</p> <p>Reinstated by the ICB Board on the recommendation of the ICB Executive Team 19.09.2025</p>	<p>Sustained industrial action will impact on the ability of the ICB and wider ICS to deliver services to patients, compromising patient experience and potentially leading to the deterioration of patient's health and wellbeing.</p> <p>The ability of the ICB to deliver its Operational Plan for 2025/2026 and its Joint Forward Plan, alongside meeting the statutory duties set</p>	<ul style="list-style-type: none"> Patient experience is compromised due to extended waiting lists, potential poor quality of services, leading to deterioration of a patient's health and wellbeing. The impact of the Industrial Action and the effect this has on our population has yet to be fully realised. Extended periods of Industrial Action risk with people feeling that their extra effort may not be appreciated and that they are not able to deliver their core roles due to IA priorities, leading to poor staff morale. Poor morale may impact on relationships between staff groups and the availability of staff. Industrial action is having a significant financial impact through cost to maintain safe services and a risk to productivity and Elective Recovery Fund (ERF) achievement including any over performance assumed in our 23/24 operational plan. 	<ul style="list-style-type: none"> Acknowledge the actions required to manage this risk are short and long-term. Acknowledge the implementation of Regulation 7 and seek assurance on compliance due to sustained legal action and risk to the workforce. Be clear that any forecast assumptions need to be based on expectations that Industrial action costs will be mitigated through either, additional funding or a change to the business rules. Maintain our Incident Response to sustained Industrial Action. 		12

		<p>out in the ICB's Constitution including quality, patient safety, finance, health inequalities and delivery may also be impacted.</p>	<ul style="list-style-type: none"> Continuing Industrial Action from August onwards removes the system's ability to recover the operational planned activity levels. Clarity is needed on the revised expectations on activity and finance at ICB and regional levels to manage expectations, reputation and provide ongoing assurance. Interpretation of Regulation 7 could lead to potential legal action. [Currently Regulation 7 of the Conduct Regulations prohibits employment businesses from providing agency workers to cover the duties normally performed by an employee of an organisation who is taking part in a strike or other industrial action, or to cover the work of an employee covering the duties of an employee] 			
10	<p>Organisational Change</p> <p>SRO: Chief Executive - supported by Executive Director of Corporate Services & ICB Development</p>	<p>The pace and scale of the proposed national changes to ICB structures and functions, as outlined in the ICB Model Blueprint, will affect the ICB's ability to deliver its statutory duties, operational and financial plans, and wider system objectives.</p> <p>There is also a risk of legal challenge due to workforce issues and inadequate engagement across the Integrated Care</p>	<ol style="list-style-type: none"> The scale and speed of change may disrupt operational, financial, and quality performance. There is a risk of losing key staff and skills, which could affect delivery of the 2025/26 plan. Staff morale may decline, and organisational memory may be lost. Current capacity may be insufficient to manage the transition effectively. There is uncertainty around the timeline for transferring ICB functions to NHSE. Lack of clarity on redundancy processes may delay progress and increase staff concerns. The complexity of the change could result in legal challenges. Local ICB collaboration may be weakened. 	<ul style="list-style-type: none"> Acknowledge the scale and pace of change required. Ensure full engagement across the Integrated Care System. Maintain strong strategic oversight of performance, finance, and quality. Oversee and assure that staff consultation complies with policy and legal obligations. Enable timely decision-making to meet national deadlines 		16

		System due to tight timescales.				
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Board Assurance Framework 2025/26 – Detailed Risk Summary

There is a risk that:	Health inequalities will widen. As a result, population health outcomes will worsen for our Core20PLUS population
BAF Ref:	BAF01
Date of Risk:	1 July 2022
Senior Risk Owner:	Executive Director of Strategy, Planning & Evaluation
Responsible Committee:	<i>Previously Commissioning and Investment/ Improvement and Reform (Utilisation Management & Quality Improvement from Oct 2025)</i>
Last Review Date:	December 2025
Inherent Risk Score:	5 x 4 = 20
Current Risk Score:	4 x 4 = 16
Target Risk Score:	4 x 3 = 12

Integrated Care System Key Priorities	Indicate which priority / priorities this risk links to
Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives.	Yes
Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.	Yes
Priority 3: Reduce poverty through better employment, skills, and better housing.	Yes
Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.	Yes

Progress 2022/23	Oct	Nov	Dec	Jan	Feb	Mar
Progress 2023/24	May	July	September	November	Jan	Mar
Progress 2024/25	May	July	September	November	Jan	Mar
Progress 2025/26	July	September	November			

Disclaimer: The existing controls, mitigations and planned actions do not serve to definitively measure progress due to the complexities of tackling health inequalities at both a system level and locally. The Core20PLUS5 directive is an evolving approach which will take time to embed throughout the system to fully realise its effects and provide definitive measures of progress.

Cause	Effect	Existing Controls / Mitigations
<p><u>Wider determinants</u></p> <ul style="list-style-type: none"> The impact of the Covid pandemic and the disproportionate effect this had on our population has yet to be fully realised, e.g.: Education and lost learning amongst children; Impact on risk factors for ill health (such as alcohol and tobacco) are not fully known; Increased rates of childhood and adult obesity where obesity rates are already higher in more deprived areas; and the wider mental health impact on the population, particularly in children and young people. The wider determinants of health (such as housing, employment, income, education, and the environment) influence our population's health unequally, which negatively impact health outcomes and widen the gap in life expectancy and healthy life expectancy. <p><u>Data and PHM</u></p> <ul style="list-style-type: none"> Increasing cost of living and the disproportionate effect this has on the population. Lack of robust and consistent PHM capabilities across the ICB and wider system. <p><u>Governance and resourcing</u></p> <ul style="list-style-type: none"> Lack of appropriate system co-ordination, direction and leadership of the broader health inequalities agenda across the ICS. Inadequate resources allocated to provide necessary assurance on the 	<ul style="list-style-type: none"> Widening of health inequalities across the population and between groups in society will disproportionately affect our Core20PLUS population. This will lead to poorer health outcomes for those living in our more deprived areas ('Core20') and for those population groups who are already socially disadvantaged or belonging to an inclusion health group ('PLUS'). Increased financial costs to the NHS to address the health needs of our Core20PLUS population Increased demand and financial burden to the wider system Lack of data maturity and data integration limits the ICB and wider system partners to access data required to identify disparities in access and outcomes and tackle healthcare inequalities. The ICB is unable to meet its statutory duties under the Health Care Act 2022, Equality Act 2010 and Public Sector Equality Duty (PSED). The ICB is unable to publish information on health inequalities within its annual report, as mandated by NHS England and in line with NHSE's Statement on Health Inequalities. The ICS is unable to meet its commitment to reduce smoking rates across the system and contributing to the Government's target for the 	<ul style="list-style-type: none"> We work with system partners to create a positive vision of what an equitable health care system should look like and have embedded the five strategic priorities for tackling health inequalities and the 'Core20PLUS' approach, within the ICS Outcomes Framework to help track future progress. Primary Care data entering the DSCRO to support greater PHM capabilities. Establishment of FDP as the PHM tool to identify health inequalities. We have re-focused and established a collaborative systems-led population health Improvement board governance and associated programmes including health inequalities, population health management, prevention and outcomes. We have embedded metrics around monitoring and addressing health inequalities within NHS provider contracts (Schedule 2N) in 2025/26. 6-monthly reporting on progress against these contractual obligations in place. Assurance on delivery against NHSE's strategic priorities for addressing healthcare inequalities and Core20PLUS5 approaches being captured through system-wide quarterly stocktakes.

<p>ICB's statutory obligations to identify and tackle inequalities in access, experience and outcomes.</p> <p><u>Clinical</u></p> <ul style="list-style-type: none"> Inequalities in clinical practice driven by actions of primary care contractors to sustain practice income (for example; non-compliance with local and national prescribing guidance to maximise dispensing income). Inability to ensure all NHS inpatient providers (acute, mental health and maternity) integrate an "opt-out" smoking cessation service as part of the Treating Tobacco Dependency Programme due to gaps in service provision because of funding limitations. Smoking remains the leading modifiable cause of health inequalities. 	<p>UK to become 'smokefree' by 2030. This equates to reducing rates of tobacco smoking in the general population to less than 5%.</p>	<ul style="list-style-type: none"> We have secured additional opportunities to invest into preventative services such as the Treating Tobacco Dependency Programme and will ensure greater alignment with community-based smoking cessation offers to increase the numbers of people successfully setting quit dates. A local Tobacco Control Summit was held in June 2025 to continue to strengthen the alignment of the TTD Programme with wider system stop smoking initiatives, including targeted preventative approaches for Core20PLUS population groups.
First Line Assurance (Departmental Level)	Second Line Assurance (Organisational oversight)	Third Line Assurance (Independent)
<p>Management oversight of following programme delivery</p> <ul style="list-style-type: none"> Health Inequalities Strategic Oversight Group PHM steering group Joint Prescribing Clinical Group 	<p>Population Health Improvement Board System Quality Group ICB Board and committees of the Board</p>	<p>NHS England Care Quality Commission Healthwatch Health and Wellbeing Board, C&P</p>

Gaps Identified	Planned Actions	Progress	Timescale for Completion	RAG Status
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Lack of a system-level overview and data driven plan to address health inequalities.	<ul style="list-style-type: none"> Refresh NHS metrics in accordance with NHSE's revised statement. Work with Place partners to identify and set priorities, informing plans at Place and neighbourhood level to tackle existing inequalities. 	<ul style="list-style-type: none"> NHSE published its revised Statement on Health Inequalities in Nov-25. This will help inform the next iteration of the ICB's health inequalities data pack due for publication by end of March-26 alongside the ICB's annual report. Continued alignment in approach across the ICS to NHSE's strategic priorities and Core20PLUS5 approach. 	<p>Mar-26</p> <p>Mar-26</p>	
<p>Not all decisions / projects / programmes of work are impact assessed from an equality and health inequalities perspective.</p> <p>Requirement for an agreed Central East ICB Impact Assessment process, including adequate resourcing to align with statutory duties under the Quality and Equality domains. This process is likely to divert away from the combined impact assessment process that was previously embedded across C&P ICB.</p>	<ul style="list-style-type: none"> Development of an agreed interim IA approach across Central East ICB Implementation and embedding of Impact Assessment process across the Central East ICB Confirmation as part of staff consultation around where the IA process will sit and what resources will be available. Monitoring of utilisation of the IA process 	<ul style="list-style-type: none"> Working group established to identify current process across BLMK, C&P and HWE. Process mapped across all three existing ICBs Draft proposal shared with working group 	March-26	
Readily available data to support good decision making	<ul style="list-style-type: none"> Establishment of a joint analytical and intelligence function within the ICS. PHM platform development 	<ul style="list-style-type: none"> PHM platform development is ongoing. We are an early adopter of the FDP PHM tool, which was rolled out during autumn 2025. Increase number of GP practices signed up to support data flows into the DSCRO (currently at 54% by practice number) 	<p>Continued development during 2026/27</p> <p>Dec-25</p>	

	<ul style="list-style-type: none"> Development of approaches for the effective use of data and population health management to better identify need and emerging risk and to target resources more effective. 	<ul style="list-style-type: none"> Re-establish the data analytics network across ICB and Cambridgeshire and Peterborough Public Health teams to help assess priority areas of inequality data analytics 	2026/27	
Alignment and oversight of programmes across the ICB and wider system designed to tackle health inequalities.	<ul style="list-style-type: none"> Mapping of healthcare inequalities work programmes across directorates and providers aligned to Core20PLUS5 approach Identify opportunities to maximise available health inequalities funding as a targeted financial resource to address health inequalities across the system, with allocation of resources to be agreed through a system level assurance process with review of funding proposals/ business cases. Greater assurance from NHS partners. Support and fund placed-based approaches which strengthen community action and innovation to tackle not only the 	<ul style="list-style-type: none"> Greater collaboration with local authority to identify areas for accelerated focus to tackle wider determinants of health and inequalities (e.g., completion of Housing and Health JSNA) Total financial allocation available for targeted programmes of work designed to support health inequalities equated to £800k in 2025/26 (e.g., homeless health hub funding; tobacco cessation support; voluntary sector grant scheme). Ongoing monitoring of delivery against provider contracts (Schedule 2N) and wider assurance being obtained and submitted to NHSE through quarterly stocktakes. 	March-26	

	immediate health needs of our population but also support action to address the wider determinants of health.			
Ongoing resource to adequately provide the necessary level of oversight and assurance on how the ICB is discharging its statutory duties to (i) identify and (ii) tackle health inequalities in terms of access, experience and outcomes. Within the proposed structure of the Central East ICB, it is not clear where this responsibility will sit from April 2026	<ul style="list-style-type: none"> Re-alignment of work to support collection and analysis of health inequalities data where possible. 	<ul style="list-style-type: none"> Data collection has commenced ahead of publication of ICB report as set out in NSHE's Statement on Health Inequalities 	March 2026	
Set up a governance across the new cluster to oversee the delivery of the Population Health agenda including delivery of prevention, health inequalities, evaluation, outcomes innovation and research	<ul style="list-style-type: none"> Establishment of a joint Population Health improvement Board within the ICS. 	<ul style="list-style-type: none"> Discussion with DPHs across the cluster is ongoing and work is in progress to identify the right approach to assure Population Health delivery while addressing health inequalities 	March-26	

There is a risk that:	Future models of care are not built through listening and understanding what local people and communities need to maximise their health and wellbeing.
BAF Ref:	BAF02
Date of Risk:	1 July 2022
Senior Risk Owner:	Executive Director of Neighbourhood Health, Place & Partnerships
Responsible Committee:	<i>Commissioning and Investment/Improvement & Reform to Oct 2025</i>
Last Review Date:	September 2025
Inherent Risk Score:	4 x 4 = 16
Current Risk Score:	4 x 2 = 8
Target Risk Score:	4 x 2 = 8

Integrated Care System Key Priorities	Indicate which priority / priorities this risk links to
Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives.	X
Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.	X
Priority 3: Reduce poverty through better employment, skills, and better housing.	X
Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.	X

Progress 2022/23	Oct	Nov	Dec	Jan	Feb	Mar
Progress 2023/24	May	July	September	November	Jan	Mar
Progress 2024/25	May	July	September	November	Jan	Mar
Progress 2025/26	July	September	November	Jan	Mar	

Cause	Effect	Existing Controls / Mitigations
<ul style="list-style-type: none"> Future models of care are not built through listening and understanding what people need to maximise their health and wellbeing. We use historical approaches to engagement designed for feedback only, lacking the breadth and diversity of views. 	<ul style="list-style-type: none"> People do not receive or have access to what would be most helpful in meeting their health and wellbeing needs. Services designed by experts that can feel more efficient but add in more layers for people using the services. Local people lose confidence in the ICB and disengage. 	<ul style="list-style-type: none"> People and Communities Strategy in place that sets out what good looks like for our work. ICS VCSE Strategy in place that sets how we aspire to collaborate with VCSE partners as key conduits to engaging communities and local people. Public and patient engagement internal audit conducted in December 2023 and System Partnership Audit conducted in 2024.

<ul style="list-style-type: none"> • We make assumptions about what we think people need and look for evidence to support these assumptions • We do not invest sufficient time, energy, resources and commitment to truly listen and understand about what will make a difference • We do not align data and feedback to inform decision-making • We do not work collaboratively with communities and ICS partners to engage local people. 	<ul style="list-style-type: none"> • Health and health care inequalities are further exacerbated by not ensuring breadth and depth of engagement. • Communities are over sampled resulting in 'consultation fatigue' due to lack of collaboration with ICS partners. • Application for judicial review if we do not involve and listen to local people and communities appropriately. 	<ul style="list-style-type: none"> • System-wide Participation and Involvement Network established to encourage wider collaboration, sharing of best practice and reduce duplication. • Close working relationship established with Healthwatch and opportunities for engagement via Healthwatch partnership boards and forums identified. • Healthwatch funded to establish an ICB engagement forum that is flexible in nature to allow diversity of voice, providing opportunities for greater listening and feedback from the public embedded within our governance. • A mapping of existing PPG groups and established toolkits and forums completed to support local PPG improvement developed by Healthwatch following ICB investment. • Opportunities for regular development sessions on ICB strategic priorities with Healthwatch Board and separately with PPG Chair forums. • Advice, templates and resources available to ICB teams to support engagement activity within projects and directorates. • Voluntary Sector Network funding to co-ordinate engagement with communities via local organisations and trusted community leaders, and input into ICB strategic projects. Outputs and progress are reported via the CIIR Committee and then up to Board. • Close working relationship with VCSE infrastructure organisations including non-recurrent funding to support ICB VCSE Strategy delivery.
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		<ul style="list-style-type: none"> Established Comms Cell group including communications professionals across ICS partners to increase reach. New Combined Impact Assessment process in place, to ensure adequate engagement as part of projects and initiatives to inform next steps. Aligning Support VCSE Steering Group held to discuss greater future alignment and collaboration, with a revised approach for 25/26
First Line Assurance (Departmental Level)	Second Line Assurance (Organisational oversight)	Third Line Assurance (Independent)
ICB Programme Executive Reporting and monitoring mechanisms via delivery plans Internal audit on public and patient engagement and system partnership Action Learning Reviews	QPF monthly reporting ICB Board and committees of the Board	NHS England Care Quality Commission Healthwatch Community feedback

Gaps Identified	Planned Actions	Progress	Timescale for Completion	RAG Status
<ul style="list-style-type: none"> A plan required to address the findings of the Dash review 2025 and the user voice being fragmented particularly during a period of change. Working through the implications of the Dash review being implemented particularly around Healthwatch impact. An inconsistent approach to involvement and collaboration with our communities and embedding local people's voices throughout ICB decision-making. An agreed, systematic and transparent approach to this work across our system. 	<ul style="list-style-type: none"> A refreshed action plan for the People and Communities strategy and the ICS VCSE Strategy, that sets out clear deliverables to create a communities-led culture of involvement and consideration of Dash review implications. <p>Development of an ICS insight bank to share insights from involvement activity across ICS partners and collaboration workspace to enable greater</p>	<ul style="list-style-type: none"> Work has begun with Healthwatch to review progress against the People and Communities Strategy to date and develop an updated action plan that will be informed through engagement and consultation with local people and patients. This will be developed within the context and constraints of ICB reform. Work with Healthwatch to develop a proactive forward plan of work that links to the ICB strategic objectives to ensure there is capacity to deliver. This includes establishment of an ICB engagement 	<p>August 2025</p> <p>July 2025</p>	

<ul style="list-style-type: none"> • Tangible action plan to support next phase of implementation of the People and Communities Strategy, that is owned throughout the ICS. • Insufficient measures to monitor progress. • The ability to bring all of the insights gathered through each individual project together to maximise the insights shared with all partners. • Longer-term funding rather than annual or non-recurrent funds resulting in short-term decisions and investments made. • The absence of a single engagement platform. • Governance and reporting arrangements surrounding implementation of the People and Communities Engagement Strategy and ICS VCSE Strategy. 	<p>collaboration across engagement activities. Development of a refreshed Compact agreement between statutory bodies and the VCSE sector, including clear accountability model.</p> <ul style="list-style-type: none"> • Work with CQC to learn from involvement best practice as part of the development of the ICS Inequalities Framework • Establish a People and Communities Engagement Committee to ensure effective oversight and monitoring of engagement activity and strategy delivery. 	<p>forum led by Healthwatch. First meeting scheduled for July 2025.</p> <ul style="list-style-type: none"> • ICS VCSE Strategy action plan agreed by Board in January 2025 and funding agreed for 2025/26 to support implementation. Development of a clear workplan with associated monitoring to deliver the action plan supported through a grant agreement. • Wider promotion of the three digital collaboration platforms to support this work programme including the: <ul style="list-style-type: none"> - Online engagement insights library to showcase existing research/feedback and insights from partner engagement activities. - Online workspace for the system-wide Participation and Involvement Network including a live project-tracker, and engagement forum/opportunity database. - Online workspace for the VSN to coordinate the data catalogue project and provide a space for wider collaboration among members. • Compact working group established including proposed accountability model which has been presented at the Aligning Support Steering Group. Funding identified from NHSE to support this work and ensure wide consultation on draft principles that are being developed. • Development of scope and work plans for the three working groups established within the Participation and Involvement Network to further progress ambitions. 	<p>July 2025</p> <p>September 2025</p> <p>September 2025</p>	
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		<ul style="list-style-type: none">• Draft Terms of Reference and governance chart developed for the People and Communities Engagement Committee following recommendation from the Public and People Engagement Audit. This work has been paused due to ICB changes but will be worked through in the new governance considerations. .	September 2025 (paused) October 2025	
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There is a risk that:	We don't focus on our culture and the challenges that staff currently face to ensure that they feel valued and activated to respond to the increasing pressure of working in health and care.
BAF Ref:	BAF03
Date of Risk:	1 July 2022
Senior Risk Owner:	Executive Director of Corporate Services & ICB Development (Supported by Director of People & Culture)
Responsible Committee:	<i>People Board to Oct 2025</i>
Last Review Date:	July 2025
Inherent Risk Score:	4 X 4 = 16
Current Risk Score:	4x 4 = 16
Target Risk Score:	4 X 2 = 8

Integrated Care System Key Priorities	Indicate which priority / priorities this risk links to
Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives.	
Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.	X
Priority 3: Reduce poverty through better employment, skills, and better housing.	
Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.	

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Cause:	Effect:	Existing Controls / Mitigations:
<ul style="list-style-type: none"> Covid has caused staff to re-evaluate what is important to them. Cost of living means for many groups of staff working in local retail pays more with less pressure than working in care and health. 	<ul style="list-style-type: none"> Lack of focus on our culture and the challenges that staff currently face to ensure that they feel valued and activated to respond to the increasing pressure of working in health and care. Increased turnover of staff and challenges in recruiting to roles particularly in certain professions 	<ul style="list-style-type: none"> Consistent application of the Leadership Compact. Positive culture programmes such as a restorative approach are embedded in all we do. Every service or investment to demonstrate how staff been listened to "You Said We Did."

<ul style="list-style-type: none"> • Historical reliance on 'going above and beyond' to efficiently deliver services. • Transformation done to staff not with staff. • Expiration of unfunded staff support hub by end Mar 2024 • Increasing service users and staff are reporting increasing incidence of disrespect. • Staff feel intimidated and harassed by national acts of racist vandalism • Headcount reductions due to cost pressures across the system are unsettling and potentially demotivating 	<ul style="list-style-type: none"> • Disruption to the provision of services. • People consider alternative careers 	<ul style="list-style-type: none"> • Action Planning in response to staff survey results to be implemented by all system partners • Ensure every service and investment has a workforce delivery strategy that is realistic. • Seeking assurance on the progress of the agreed OD Framework for the ICS. • Reinvigorate our antiracism efforts and provide safe spaces for people who feel unsafe to be reassured • Increase acknowledgement and recognition, closer to the incident. Reduce the chance of people being 'taken for granted' • Establish and maximise communication for transition hub, to support displaced staff across the system, as far as possible
First Line Assurance (Departmental Level)	Second Line Assurance (Organisational oversight)	Third Line Assurance (Independent)
ICB Programme Executive	QPF monthly reporting ICB Board and People Board	NHS England Care Quality Commission Trade Unions and Professional Bodies HealthWatch

Gaps Identified	Planned Actions	Progress	Timescale for Completion	RAG Status
<ul style="list-style-type: none"> • Partner organisations at various stages of OD Plans and employee engagement initiatives • Partner organisations at various levels of cultural intelligence with varying maturity of plans • System level Strategy for inclusion implemented to drive improvements in representation, belonging and discrimination 	<ul style="list-style-type: none"> • OD Programme Board reconstituted as Leadership and Culture Enabler Group to engender faster, more effective rollout of OD programme including the Partnerships • System-wide cultural intelligence champions trained to enable further rollout and 	<ul style="list-style-type: none"> • Plans for Leadership agenda continue in development, with focus on strengthening the adoption of the Leadership compact, along with a system-wide approach to developing a compassionate and inclusive culture • System Leadership and OD Lead effectively integrated with System partners' OD Teams • Cohort of cultural intelligence champions to be trained in Autumn 2025 to continue 	<p>Jun 2025</p> <p>Sep 2025</p>	

	embed the cultural intelligence learning begun in 2024/25	<p>establishment common language and deepening of cultural intelligence and how to lead people inclusively and provide consistent support and input to inclusion focused initiatives</p> <ul style="list-style-type: none"> • Ongoing project to establish measurement consistency and system for monitoring improvement in inclusion across the system. Compilation of evidence-based solutions built into an online repository for use by system partners in selecting interventions 	Aug 2025	
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There is a risk that:	With services under increasing demand pressure, workforce shortages and backlogs, service quality and outcomes can be impacted
BAF Ref:	BAF04
Date of Risk:	1 June 2022
Senior Risk Owner:	Executive Clinical Directors
Responsible Committee:	<i>Quality, Performance and Finance Committee to Oct 2025 (Utilisation Management & Quality Improvement Committee)</i>
Last Review Date:	December 2025
Inherent Risk Score:	4 x 4 = 16
Current Risk Score:	4 x 4 = 16
Target Risk Score:	4 x 2 = 8

Integrated Care System Key Priorities	Indicate which priority / priorities this risk links to
Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives.	yes
Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.	yes
Priority 3: Reduce poverty through better employment, skills, and better housing.	
Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.	yes

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Cause:	Effect:	Existing Controls / Mitigations:
<ul style="list-style-type: none"> • Mismatch between demand for health services and capacity • Increased demand and access to primary care • Waiting lists for services, including mental health, elective care and diagnostics, are longer meaning people are taking longer to be seen. 	<ul style="list-style-type: none"> • Risk of poorer experience and sometimes outcome • Worsening of health outcome inequality as those who are more deprived are disproportionately affected by NHS access and quality issues. • Reputation adversely impacted. 	Controls in place <ul style="list-style-type: none"> • CVD Prevention Programme to decrease medium term demand (monitored through Population Health Board Improvement Board) • Monitor provider activity plan and delivery via contractual process

<ul style="list-style-type: none"> • Access to services and communication for people on next steps is variable. • Availability of NHS dental services • Causes of this demand: capacity mismatch include system productivity, sub- optimal patient flow, physical capacity constraints in some parts of our estate and not maximising preventative interventions • Increasing operational pressures in Acute Hospitals have resulted in additional boarding of patients on wards, as well as corridor care in Emergency Departments • Ongoing resident doctor industrial action could lead to decreased elective activity 	<ul style="list-style-type: none"> • Potential harm may not be identified in a timely manner 	<ul style="list-style-type: none"> • Daily risk assessment through System Operations Centre of balance of community and inpatient risk on Urgent Care pathways (monitored through Urgent Care Board) • Primary Care Access Recovery Plan (monitored through Primary Care Commissioning Committee) • Clinical Quality Review Meetings and System Assurance Framework process for major providers. • Established process for managing industrial action to minimise elective cancellations <p>Mitigations in place</p> <ul style="list-style-type: none"> • Providers are embedding a new national safety reporting framework (ongoing) • Additional roles in primary care funded through the Additional Roles Reimbursement Scheme (implemented) • Ongoing programme of work to increase NHS dental availability (monitored through Primary Care Commissioning Committee) Implementation of System Estates Strategy to mitigate physical capacity constraints • Data analysis including Patient Safety Incident Response Framework data , patient and staff feedback to establish the overall quality and safety of services (developing through the Provider System Assurance Process) • National productivity analysis undertaken and changes being operational planning for acute providers (implementing)
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Because of the organisational changes in Health and Local Government there is a risk of disjointed understanding of the roles of the statutory partner.	Fragmented delivery of the safeguarding system	Controls in place Safeguarding partnership Board Mitigations Meeting of delegated safeguarding partners Safeguarding priorities clearly agreed at partnership level
Quality of care and outcomes for people with Learning Disabilities <ul style="list-style-type: none"> Successive Learning Disability (LeDeR) and Public Health Needs Assessment 2023 data show the impact of poor care on outcomes. 	<ul style="list-style-type: none"> Increased count of deaths in those with Learning Disabilities and number classified as possibly preventable 	Controls in place <ul style="list-style-type: none"> LeDeR process ongoing (monitored through Quality Performance and Finance Committee) LD Health Checks (ongoing process) monitored through Primary Care Commissioning Committee Mitigations <ul style="list-style-type: none"> LD redesign work has been commissioned and has recommenced after a pause. This aims to have specification for sustainable service by December 2025. Specific action plan in place following LeDeR report.
Medicine optimisation <ul style="list-style-type: none"> Prescribing issues including antimicrobial stewardship are both a cause and effect of impacts on service quality. 	<ul style="list-style-type: none"> Prescribing issues including antimicrobial stewardship are both a cause and a consequence of these pressures. 	Controls in place <ul style="list-style-type: none"> Integrated Medicines Optimisation Committee established across the system to assure delivery of major medicine safety and financial programmes. Prescribing issues are managed down to the level of individual medicines by the system Joint Prescribing Group and for antimicrobials the System Antimicrobial Stewardship Group Mitigation <ul style="list-style-type: none"> Specialist Pharmacist for antimicrobial stewardship in the ICB delivering programme of work (reports to Quality, Performance and Finance Committee, work ongoing).

<p>Implementation of ICB blueprint will change focus of ICB increasingly towards commissioning processes and delivery.</p> <ul style="list-style-type: none"> Poor relationships across different system organisations can lead to suboptimal overall pathways for patients, lower staff morale and decreased clinical effectiveness and efficiency. 	<ul style="list-style-type: none"> Increased demand on all sectors of the health and care system 	<p>Controls in place</p> <ul style="list-style-type: none"> Use of System Assurance Framework processes and key metrics from contracts Improved proactive identification of quality risks in Primary Care reports to Primary Care Commissioning Committee <p>Mitigations</p> <ul style="list-style-type: none"> Providers working with a new national safety reporting framework
First Line Assurance (Departmental Level)	Second Line Assurance (Organisational oversight)	Third Line Assurance (Independent)
<p>Metric surveillance via contracting process</p> <p>Local Maternity and Neonatal System Board</p> <p>System Joint Prescribing Group</p> <p>Antimicrobial Stewardship Group</p> <p>Joint Clinical and Professional Executive Group P</p>	<p>QPF monthly reporting</p> <p>Integrated Medicines Oversight Committee.</p> <p>Clinical Quality Review Meetings as part of System Assurance Framework process.</p> <p>ICB Board and committees of the Board</p> <p>Chief Nurse and Medical Direct Meetings</p> <p>Safeguarding Partnership Board</p> <p>Primary Care Commissioning Committee</p> <p>System Mortality Committee</p> <p>Professional Standards Group</p>	<p>NHS England</p> <p>Regional Perinatal Quality & Oversight Group</p> <p>Regional Maternity & Neonatal Programme Board</p> <p>Regional quality group.</p> <p>Care Quality Commission</p> <p>Other regulators</p>

Gaps Identified	Planned Actions	Progress	Timescale for Completion	RAG Status
Focus on the ICB processes on the quality commissioning and improvement elements of current contracts and change way of working with providers to enable this to be the main method of quality improvement delivery and monitoring.	Work with teams in Nursing and medical directorate to refocus and reestablish quality contractual monitoring. Alignment of staff to CQRM process and contracts.	Ongoing	Dec 2025	Amber

Understanding in partners of the forthcoming rapid changes to ICB focus	Exec- top Exec conversations	Ongoing	Mar 2026	Amber
Definition of ICB role compared to regional / NHS E role for quality monitoring and improvement	Discussions with NHS E	Ongoing	Mar 2026	Amber

There is a risk that:	That we don't deliver the basic NHS statutory standards that have been put in place to maximise the outcomes for our residents
BAF Ref:	BAF05
Date of Risk:	1 July 2022
Senior Risk Owner:	Executive Director of Finance, Resources & Contracting /supported by Director of Contracts & Performance
Responsible Committee:	<i>Quality, Performance and Finance Committee to oct 2025 (Utilisation Management & Quality Improvement / Finance Planning and Payer Function Committee</i>
Last Review Date:	December 2025
Inherent Risk Score:	5 x 4 = 20
Current Risk Score:	4 x 4 = 16
Target Risk Score:	2 x 4 = 8

Integrated Care System Key Priorities	Indicate which priority / priorities this risk links to
Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives.	y
Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.	y
Priority 3: Reduce poverty through better employment, skills, and better housing.	
Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.	y

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Cause:	Effect:	Existing Controls / Mitigations:
<ul style="list-style-type: none"> Demand is greater than ever with a growing and ageing population, creating pressure on all services. This demand, in the context of the workforce pressures and need to deliver a balanced financial plan, is 	<ul style="list-style-type: none"> The basic NHS statutory standards are not delivered, that have been put in place to maximise the outcomes for our residents 	<ul style="list-style-type: none"> Ensure that the right balance of time and discussion is given to the 'here and now' of our services and the future transformation.

<p>contributing to performance below national and local delivery standards.</p> <ul style="list-style-type: none"> • Patient satisfaction with the NHS has deteriorated and is at its lowest level, with public expectations on what it should receive from the NHS exceeding reality of current service provision. • Significant growth in funding allocations over recent years to support demand however services have not been sufficiently transformed to maximise productivity and efficiency. • Funding allocations and operational performance standards are skewed heavily to acute hospital provision which is adverse to the areas where investment is required to prevent risk deterioration and improve outcomes for our population. • Contract and performance management arrangements have been limited, with some functions sitting with ICBs and some with NHSE regionally over recent years. Use of block contract arrangements and limited activity plans has made it difficult to manage providers effectively to ensure value. • Shifting expectation on performance delivery at political and national level, with increased focus on contractual delivery of NHS constitutional standards. 	<ul style="list-style-type: none"> • Operational delivery and improvement efforts are stretched too thinly, with a raft of priorities all equally important but without the bandwidth to effect sustainable change. • Changes to priorities impacts on workforce engagement and pace of improvement required. • Changes in national context driving short term behaviours and actions without adequate understanding or mitigation of unintended consequences • Risk increases when we do not respond effectively to mitigate emerging risks and issues. consequences. • Reputational risk for C&P not meeting NHS constitutional standards for its local population and the impact of not doing so on health inequalities and outcomes for residents. 	<ul style="list-style-type: none"> • Use the data on performance and actively challenge and loop back to previous commitments. • Support the effective delivery of performance and contract management processes, including appropriate escalation and intervention, with individual providers to ensure that we are delivering maximum value and outcomes within commissioned services. • Strategically plan for future service commissioning, ensuring use of technology to increase productivity, and deliver more with less resources. • Ensure local, regional, and national benchmarking is used to monitor performance to ensure understanding of relative performance and performance improvement.
First Line Assurance (Departmental Level)	Second Line Assurance (Organisational oversight)	Third Line Assurance (Independent)
<p>UEC, Elective, cancer and diagnostic tiering oversight arrangements</p> <p>Unplanned Care Board</p> <p>Planned Care Board</p> <p>System Diagnostics Board</p> <p>Cancer Board</p> <p>Mental Health, Learning disabilities and Autism Delivery and performance group(internal)</p>	<p>ICB wide System Assurance Framework triangulation review meeting</p> <p>Contract assurance meetings with ICB and Providers</p> <p>Quality, Performance and Finance committee</p> <p>Commissioning and Investment and Improvement and Reform committee</p> <p>ICB Board</p>	<p>NHS England</p> <p>Care Quality Commission</p>

ICB Operational Executive Performance, Assurance and contract management teams Joint Clinical and Professional Executive Group		
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Gaps Identified	Planned Actions	Progress	Timescale for Completion	RAG Status
UEC demand and lack of alternatives lead to increasing attendance at acute providers.	<ul style="list-style-type: none"> ICB focus on demand management to bring demand below planned levels, through maximising out of hospital interventions and improving discharge performance. 	<ul style="list-style-type: none"> UEC hub being optimised with c.500 patients now being supported in out of hospital alternatives on a weekly basis. Vs. average of 120 per week on service commencement. Additional UEC hub GP capacity service went live at HH site in December, early utilisation c60% of appointments. Concerns with PCH and CUH sites, where utilisation still remains below 50%. Escalated to acutes. Overall UEC demand just 1.0% up compared to previous year and 6.3% below provider plans for this year. Significant slowing of growth compared to previous years actual. 	March 2026	
Referral to treatment time standards are not met, with primary care referral demand exceeding planned levels	1. Implementation of advice and guidance approach across C&P to maximise opportunities for specialist advice. Payment mechanism and activity levels set for GPs for delivery in 2025/26.	<ul style="list-style-type: none"> Uptake of A&G below expected levels though known data issue in North of country. Diversion rate performance is good, above national average. Release of additional funds in December to increase payment to practices beyond initial activity levels set likely to drive further use of A&G in Q4. 	March 2026	
	2. Development of Referral Management Centre across C&P to manage demand and ensure appropriate onward triage and treatment.	<ul style="list-style-type: none"> RMC work behind plan due to multiple asks on resource, complexity of work programme design and changing external context. RMC work will not be delivered in 25/26 and will need to be reconsidered in the context of new Central East ICB priorities 	December 2025 <i>Proposed remove as superseded with CE</i>	

	3. Review of clinical policies and mechanisms for checking adherence, including reintroducing clinical audits.	<ul style="list-style-type: none"> Action not completed due to resource constraints, will be factored into planning for 26/27. 	August 2025 <i>Proposed remove as superseded with CE</i>	
Current commissioned services do not represent latest best practice pathways nor maximise productivity and efficiency	1. Develop rolling schedule for specification reviews, aligned to high priority areas (clinical risk, demand, performance) and approach to adopting best practice specifications	<ul style="list-style-type: none"> Action commenced but behind plan due to resource constraints, will be a key feature of planning for 26/27 and will be considered in the context of CE ICB. 	September 2025 <i>Proposed remove as superseded with CE</i>	
	2. Commission Community and mental health service review.	<ul style="list-style-type: none"> Work delayed and being reviewed in the context of ICB clustering and creation of CE ICB, as HWE and BLMK ICBs have completed similar exercises so there is a need to ensure learning and assess strategic approach across the new footprint. Will be considered in context of planning for 26/27. 	September 2025 <i>Proposed remove as superseded with CE</i>	
	3. Fully utilise the contract, including indicative activity plans to enable specialty level activity management of delivery and improvement requirements.	<ul style="list-style-type: none"> IAPs in place with ISPs and Activity query notices and Activity Management Plans in place as appropriate. Outstanding agreement with CUH and NWAFT on the contract due to high cost drugs. 	January 2026	

There is a risk that:	We do not take effective decisions through the lens of best use of the public money and financial sustainability which will impact on the organisation's ability to achieve its statutory financial duty.
BAF Ref:	BAF 06
Date of Risk:	01 July 2022
Senior Risk Owner:	Director of Finance, Resources & Contracting
Responsible Committee:	<i>Quality Performance & Finance Committee – to Oct 2025</i> (Finance Planning and Payer Function Committee)
Last Review Date:	December 2025
Inherent Risk Score:	5 x 4 = 20
Current Risk Score:	3 x 4 = 12
Target Risk Score:	3 x 3 = 9

Integrated Care System Key Priorities	Indicate which priority / priorities this risk links to
Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives.	X
Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.	X
Priority 3: Reduce poverty through better employment, skills, and better housing.	X
Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.	X

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Cause:	Effect:	Existing Controls / Mitigations:
The ICB and ICS has a statutory responsibility to deliver a break-even financial plan. It has a responsibility to ensure most effective use of capital and revenue budgets.	<ul style="list-style-type: none"> Credibility of ICB - reputational risk. Loss of local and organisational control of decision making with enforcement of double/triple lock or other escalation and intervention from NHSE. Deterioration in relationship with Regulators. 	<ul style="list-style-type: none"> Regular monthly ICB reporting of financial position, forecast and risk. Fortnightly CFOs meeting to discuss financial position, recovery plans, efficiencies and capital. This meeting also sets out mitigations and

<p>The ICB and all system organisations submitted a break-even plan for 25/26. This required the use of some non-recurrent resources in the form of additional ICB support and / or share of system revenue incentive for 25/26 available on a non-recurrent basis. To deliver the break-even financial plan and enable the ICB and the organisations within the system to deliver its statutory financial duties we will need to take a number of actions /make assumptions that could emerge as in year risks that without mitigation will drive an in-year deficit:</p> <p>SPECIALISED COMMISSIONING</p> <ul style="list-style-type: none"> As specialised commissioning is delegated to ICBs there is a risk to our provider income if ICBs change flows into their own providers or utilise specialist funding to support other cost pressures.. Risk that the funding delegated does not cover the cost of services <p>PRESCRIBING VOLUME AND PRICE</p> <ul style="list-style-type: none"> 24/25 saw large budget pressures as a result of both price and volume increases.. The plan for 25/26 acknowledges a higher level of run rate expenditure but also assumes there are interventions made to manage further cost growth and maximise the medicine optimisation opportunities NICE are implementing a number of recommended prescribing changes to significantly improve patient outcomes. Some NHSE funding has been provided but this will not fully cover the expected cost. Further efficiencies and savings will need to be made from within the overall prescribing budget and ICB to cover the additional costs. 	<ul style="list-style-type: none"> Deterioration in relationship with providers. Increased NHSE oversight, introduction of special measures and a loss of control over the system delivery. Failure to meet strategic objective to ensure funding flows matches patient need. Failing to meet statutory duty. Failure to attract additional capital and revenue incentive funding and other consequences arising from business rules. Patient services impacted if we have to repay deficit in future years Difficult de-commissioning or workforce cuts required to mitigate deficits 	<p>focussing on run rates and actions to deliver the break-even plan.</p> <ul style="list-style-type: none"> Monthly medicines optimisation group to discuss prescribing budget and opportunities Monthly oversight meetings with Regional Team HFMA ICB CFOs group sharing data, best practice and benchmarking. Scrutiny and assurance through the ICB Quality Performance and Finance Committee. Internal audit of financial process and controls Clinical Priorities Forum reviews and agree system approach to treatments of low clinical value. ICS Productivity & Use of resources steering groups established to drive up productivity and drive down costs. Integrated Medicines Optimisation Committee being established across the system to assure delivery of major medicine safety and financial programmes Weekly Prescribing Finance Turnaround meeting is monitoring progress of efficiencies and maximising actions to increase GP engagement in cost-efficiency programmes both for 2024-2025 and 2025-2026. CICB has implemented additional scrutiny to any new spending requests through exceptional spend process. Operational Exec established where ICB financial performance is scrutinised and efficiency plans are monitored
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HEALTH AND SOCIAL CARE PRESSURES

- The NHS has a cost uplift factor at 4.15% which includes the additional liability arising from higher employer National Insurance Contributions. There is a further 2.0% efficiency factor. This may not allow us to increase contracts or meet levels of pay inflation that match other partners/ providers expectations. This may then have an impact on either service delivery or finances.

EFFICIENCY AND PRODUCTIVITY CHALLENGE

- The plans for 25/26 are reliant on significant productivity and efficiency savings in excess of those delivered in previous years. In particular the system plans to deliver £172m of efficiency schemes plus a further £53m of productivity opportunities. This is alongside meeting all key performance metrics.
- There is still a proportion of efficiencies that are still to be identified and / or are high risk.
- Delays to implementing efficiency and productivity schemes will only deliver a part year effect in 25/26 meaning further schemes will be required or use of non-recurrent means to bridge the gap. The focus needs to remain on delivery of recurrent cost saving schemes.

COMPLEXITY OF C&P

- The ICBs running cost is aligned to its allocation not the £4.4bn of system spend that it has to manage and provide assurance on.

<ul style="list-style-type: none"> Incentives reflect allocations not the scale of the C&P system so mitigations are potentially smaller than they should be. 		
First Line Assurance (Departmental Level)	Second Line Assurance (Organisational oversight)	Third Line Assurance (Independent)
CFO group ICB Execs/ SLT Finance Team, Business Intelligence, Contracting and Programme Management Office Teams Joint Clinical and Professional Executive Group	QPF - monthly reporting Provider Finance Committees ICB Board Internal Audit	NHSE monthly review meeting. External Audit - Annual Accounts process

Gaps Identified	Planned Actions	Progress	Timescale for Completion	RAG Status
ICB efficiency shortfall	Efficiency plans to be discussed and agreed at Operational Exec taking into account opportunities from disinvestment, decommissioning, estates and further CHC, prescribing opportunities above those in the plan. New uncommitted investment requests to be held until all efficiencies identified. Operational Exec to monitor delivery. CFO to set out actions required to ensure the plan is delivered at Execs and up through QPF.	Decommissioning and disinvestment policy being drafted for review at Strategic exec Work underway to assess estates / void efficiency opportunities	Ongoing	

	Operational exec to oversee the drivers for any budget variances and run rates to determine assurance on delivery of plan.			
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There is a risk that:	We do not get ahead and build services for the future meaning we adapt what we have rather than considering new care models.
BAF Ref:	BAF07
Date of Risk:	1 July 2022
Senior Risk Owner:	<i>Previously Chief Clinical Improvement Officer</i> – allocated to Executive Director of Strategy, Planning & Evaluation (December 2025)
Responsible Committee:	<i>Commissioning & Investment/ Improvement & Reform Committee to Oct 2025</i> (Finance Planning and Payer Function Committee)
Last Review Date:	September 2025
Inherent Risk Score:	3 x 3 = 9
Current Risk Score:	3 x 3 = 9
Target Risk Score:	2 x 2 = 4

Progress 2022/23	Oct	Nov	Dec	Jan	Feb	Mar
Progress 2023/24	May	July	September	November	Jan	Mar
Progress 2024/25	May	July	September	November	Jan	Mar
Progress 2025/26	May	July	September	November	Jan	Mar

Integrated Care System Key Priorities	Indicate which priority / priorities this risk links to and how this will impact
Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives.	
Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.	Yes, directly impacts
Priority 3: Reduce poverty through better employment, skills, and better housing.	
Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.	Yes, directly impacts

Cause:	Effect:	Existing Controls / Mitigations:
<ul style="list-style-type: none"> Failure to imagine and co-design new service models for the future, resulting in adaptation of existing models (which may not even be meeting current needs and compromising future opportunities) 	<ul style="list-style-type: none"> Existing services are adapted rather than development of new care models, compromising opportunities for quality, cost, outcome, and experience improvement. 	<ul style="list-style-type: none"> Ensuring the solutions to issues are explicit in describing long-term future proof options. Ensuring where digital literacy and access is required to utilise and benefit from new services, part of the new service co-design process is to consider and mitigate the risk of digital exclusion.

<ul style="list-style-type: none"> Digital integration and innovation (including embedding A&I and technology to support the growing demand for health services) are key enablers for design and delivery of new services, risking digital exclusion of some population groups. Risk of misalignment of providers priorities for improvement to system vision, and ineffective system working to achieve the new vision. Failure of the CCIO directorate to create the conditions * for system level improvement of services impacting the ability to deliver large-scale change. (* collective vision and leadership, aligned operating model for improvement, capabilities, connections, and culture change) 	<ul style="list-style-type: none"> Removal of ‘analogue’ service options leaving some groups underserved or completely excluded. Public and clinicians/carers may not support care and health interventions provided outside of traditional provider models, and that utilise emergent AI / technologies, failing to see the overall benefits to managing increasing demands. Siloed improvement schemes operating only at organisational level fail to maximise service enhancement through system wide, end to end pathway redesign- compromising benefits in terms of safety, efficiency, and cost reduction. 	<ul style="list-style-type: none"> Assuring, re-educating, and resetting expectations of the public when care and health services work outside of traditional provider models. Ensuring this has been well considered and integral to change management programmes. System innovation and research adoption processes embedded into governance. ICS Continuous Quality Improvement (CQI) Strategy adopted and applied. Promotion of NHS IMPACT as business-as-usual approach to creating the conditions for effective change
First Line Assurance (Departmental Level)	Second Line Assurance (Organisational oversight)	Third Line Assurance (Independent)
Quality Improvement and Transformation Committee	<ul style="list-style-type: none"> ICB Board Internal Audit (4.23/24 - Transformation Plans) Commissioning and Investment: Reform and Innovation Committee 	NHS England

Gaps Identified	Planned Actions	Progress	Timescale for Completion	RAG Status
There are limited forums/opportunities to get key stakeholders together to co-design and plan implementation of new models of care, across neighbourhoods and primary care sector ‘at scale.’ There will need to be the ability for ICB to create the environment, and ambition for scale and	Regular combined meetings of all primary care sectors to build working relationships and to understand how collaboration can impact positively on all providers whilst achieving the changes envisioned. Encourage the	Finances to support backfill secured. Dates for ‘combined cross sector primary care meetings’ are being set. Refreshed attempt to convene a ‘General Practice Leadership Forum/ Primary care Collaborative’ - bringing together key general practice leaders to have strategic discussions	March 2026	In progress

pace of change, potentially with less resources and capacity within the ICB team	emergent Primary care collaboratives to take on the delivery of change and improvement activities as one of their core functions	guided by the principles and values of the Leadership Compact, to capture views 'reflective of the voice of General Practice,' to shape and direct strategic moves to ensure sustainability of General Practice		
ICB teams, primary care teams and integrated neighbourhood teams have not all embraced a culture of 'continuous improvement' as the BAU approach to enacting change and managing the status quo	We will continue to work through the system 'Quality Improvement and Transformation Group' to adapt and then spread the acute sector designed 'continuous improvement culture and learning' training across these teams using a train the trainers/champions model. This will ensure maximum spread of knowledge and help engender a new culture	Integrated Neighbourhood Leads have started joining the training days and will spread that out through their own teams	March 2026	In progress

There is a risk that:	Our ability to deploy our workforce to deliver services that ensure patient safety and quality of care are compromised through low levels of recruitment and retention or the onset of industrial action
BAF Ref:	BAF08
Date of Risk:	October 2022
Senior Risk Owner:	Executive Director of Corporate Services & ICB Development /Supported by Director of People & Culture
Responsible Committee:	<i>People Board to Oct 2025</i>
Last Review Date:	September 2025
Inherent Risk Score:	4 X 4 = 16
Current Risk Score:	4 X 3 = 12
Target Risk Score:	4 X 2 = 8

Integrated Care System Key Priorities	Indicate which priority / priorities this risk links to
Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives.	
Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.	
Priority 3: Reduce poverty through better employment, skills, and better housing.	
Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.	

Progress 2022/23	Oct	Nov	Dec	Jan	Feb	Mar
Progress 2023/24	May	July	September	November	Jan	Mar
Progress 2024/25	May	July	September	November	Jan	Mar
Progress 2025/26	May	July	September	November	Jan	Mar

Cause:	Effect:	Existing Actions and Mitigations
<ul style="list-style-type: none"> Workforce shortages have become commonplace across the system in several professions 	<ul style="list-style-type: none"> Dilution of skill mix as newly trained staff are not retained long enough to develop deep experience 	<ul style="list-style-type: none"> International Recruitment programme being maintained

<ul style="list-style-type: none"> • C&P, like all of E of E has become dependent on international nursing and care worker recruits to fill vacancies and ensure adequate staffing levels • Socio-political environment places additional pressure on international recruitment practices, with recent announcements restricting international social workers from having accompanying dependents • Domestic intake is highly competitive with retailers, food suppliers and on-line retailers proving preferable destinations for many potential recruits • 2025/26 nursing entry expected to fall below previous years, as graduating students not guaranteed an offer on completion of courses • ICB's Change Management process of transition to new, merged ICB has begun, but timing and process steps are unclear, creating confusion and loss of confidence with staff 	<ul style="list-style-type: none"> • Risk to service delivery, patient safety and care • However, health providers recorded lower turnover rates and vacancy levels in 2024/25 but sickness absence remains high • Providers have recorded lower usage (volume) of agency staffing in many trusts, with actual below plan for most of 2024/25. Providers continue to drive down temporary staffing costs with agency use down by 30% and Bank down by 10% in 2025/26. • Concerned and anxious staff lacking clarity on their jobs and career opportunities, may lose focus with delivery of ICB objectives impacted 	<ul style="list-style-type: none"> • Programme of five High Impact interventions as prescribed by NHSE embedded by providers to improve nurses' retention • Retention Exemplars programmes are embedded within provider processes • National Long Term Workforce Plan with goal of increasing domestic recruitment, uses initiatives that train, retain and reform with increased apprenticeship levels and other education offerings that improve domestic workforce supply • General Practice nursing workforce retention efforts to be redoubled. GP educators initiated at a favourable rate despite loss of some through retirement. • System partners have adopted real living wage framework, with implementation on an individual basis, as affordable • Community level project launched to drive recruitment into community based health and care roles, from non-traditional entry routes. • Frequent, regular, transparent communications maintained within the ICB to minimise chance of confusion or misunderstanding • Provision of support initiatives for staff learning (outplacement as well as general skills) has been rolled out with positive response
First Line Assurance (Departmental Level)	Second Line Assurance (Organisational oversight)	Third Line Assurance (Independent)
ICB Executive Joint Clinical and Professional Executive Group	People Directorate bi-monthly reporting People Board ICB Board QFP for clinical interface work	NHS England Care Quality Commission Trade Unions and Professional Bodies HealthWatch

Gaps Identified	Planned Actions	Progress	Timescale for Completion	RAG Status
<ul style="list-style-type: none"> Local recruitment initiatives limited in scope and approach Rate of conversion of nursing student placements can be increased 	<ul style="list-style-type: none"> Schools' Expo showcased full range of NHS careers to ~2000 Year 10 and 12 secondary school users in March 2025 Attraction programme with support of HEI providers to raise level of conversion from placements to actual hires 	<ul style="list-style-type: none"> Learnings from initial exercise were identified and programme expanded to include voluntary sector and Yr 12 students as well. Greater collaboration with HEIs receiving ongoing attention and opportunities for higher conversion are being explored ICB is implementing a Clinical Placement Management System to raise visibility and better manage placements and deliver higher conversion rates 	<p>Spring 2026</p> <p>Jan 2026</p> <p>Completed</p>	

There is a risk that:	Sustained industrial action will impact on the ability of the ICB and wider ICS to deliver its Operational Plan and its Joint Forward Plan, alongside meeting the statutory duties set out in the ICB's Constitution.
BAF Ref:	BAF09
Date of Risk:	17 August 2023 (Previously referenced in several BAF risks) Reinstated 19.09.2025
Senior Risk Owner:	ICB Executive Team (Led by Director of Contracts & Performance)
Responsible Committee:	<i>Quality Finance & Performance Committee, ICB People Board to Oct 2025 (Utilisation Management & Quality Improvement)</i>
Last Review Date:	September 2025
Inherent Risk Score:	5 x 4 = 20
Current Risk Score:	3 x 4 = 12
Target Risk Score:	2 x 4 = 8

Integrated Care System Key Priorities	Indicate which priority / priorities this risk links to
Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives.	Yes
Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.	Yes
Priority 3: Reduce poverty through better employment, skills, and better housing.	Yes
Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.	Yes

Progress 2023/24	May	July	September	November	Jan	Mar
Progress 2024/25	May	July	September	November	Jan	Mar
Progress 2025/26	n/a	n/a	September	November	Jan	

Cause:	Effect:	Existing Actions and Mitigations
<p>Sustained Industrial Action from August 2023 across multiple NHS professional groups, though as of July 2024 all staff groups have settled on 23/24 pay award with exception of Junior Doctors.</p> <p>Regulation 7 of the Conduct Regulations prohibits employment businesses from providing agency</p>	<p>Ability to deploy our workforce to deliver services that ensure patient safety and quality of care are compromised due to industrial action or collective action, including lack of engagement in critical patient safety systems (i.e. medications).</p>	<p>Incident Command and Control structures at local, regional and national levels. Tactical and Strategic structures in place for collective action as alternative as does not meet ICC guidance.</p> <p>Planning guidance and subsequent instructions from NHS England national Chief Finance Officer (CFO) to</p>

<p>workers to cover the duties normally performed by an employee of an organisation who is taking part in a strike or other industrial action, or to cover the work of an employee covering the duties of an employee.</p> <p>GP collective action supported from 1 August 24 following non-statutory ballot by BMA GP. 10 potential actions outlined to support general practice to maintain patient safety. Choice regarding engagement with actions, how many and extent to which they are applied is down to individual practices and as such, unclear picture on the potential scale or timing of any potential action.</p>	<p>Significant financial impact through decreased delivery of primary care prescribing efficiencies, cost to maintain safe services and a risk to productivity and ERF achievement including any over performance assumed.</p> <p>Significant potential patient experience and access impact for those not able to access general practice due to collective action, with patients self-presenting at other settings.</p> <p>Potential for deterioration in interface relationships between providers through collective action linked to processes and pathways in place for elective activity, advice and guidance and pathway norms around referrals between settings.</p> <p>Applications for 23/24 nursing entry has fallen, research ongoing to establish reasons, with Industrial action effect seen as a significant influence.</p> <p>Extended periods of industrial action can give rise to staff feeling that it is assumed and taken for granted that additional effort is required.</p> <p>Inability to delivery all business-as-usual activities as staff are re-prioritised to deliver IA related activities.</p> <p>Inability to deliver on the national and local workforce plans.</p> <p>Lack of compliance with Clause 7, leading to potential legal action and risk to agreeing derogations</p>	<p>plan on the basis that Industrial Action has no impact. Now it is having impact we are assuming additional funding will materialise or business rules are adapted to reflect change from planning assumptions.</p> <p>Implementation of Harm Reviews and associated learning.</p> <p>After Action Reviews and Debriefs, alongside developing clear learning and implementation of innovation to address impacts.</p> <p>Mutual aid across the system and wider cross boundary working across the Region.</p> <p>Recognition of the impact on business-as-usual activity and reprioritisation of tasks to ensure minimum core service delivery.</p> <p>Regular monitoring of compliance against Regulation 7.</p> <p>System-wide clinical and professional oversight of the impacts and learning outcomes.</p> <p>Regular review of impacts via ICB Executive Team and ICB Committees.</p>
First Line Assurance (Departmental Level)	Second Line Assurance (Organisational oversight)	Third Line Assurance (Independent)

Management and oversight of the incident response to Industrial Action through ICB Command and Control Structures, including those for collective action. ICB Executive Team oversight	ICB Quality, Performance and Finance Committee ICB People Board ICB Audit & Risk Committee ICB Board	NHS England Care Quality Commission Healthwatch Health and Wellbeing Board, C&P Trade Union and Professional Bodies
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Gaps Identified	Planned Actions	Progress	Timescale for Completion	RAG Status
Clarity on the potential scale of impact of GP collective action from 1 August for an undefined period. Assumption of a new business as usual requiring different plans which are sustainable to manage both immediate and longer-term impact.	<p>Initial phase</p> <ol style="list-style-type: none"> 1. Establish incident arrangements to ensure timely tactical and strategic response to collective action. 2. Detailed mapping of potential risks vs. the 10 defined actions for GPs to understand potential areas for risk and mitigation covering patient safety, quality, access and financial impact. 3. Continued engagement and close working with practices and the LMC to understand potential impact of collective action and opportunities for managing relationships. 4. Assessment of opportunities for different pathways to support redirection or management of patient access in alternative ways particularly during surge winter months. <p>Medium term</p> <ol style="list-style-type: none"> 5. Assessment of need for longer term review and management of patient flows reflecting specifically any 	<ul style="list-style-type: none"> • Tactical and strategic structure set up focused specifically on collective action. • Initial risk assessment completed across all areas though further detail required on potential wider system financial impact and changes to patient flow as a result. • Draft KPI dashboards developed to track potential for patient flow changes across C&P. 	<p>Completed</p> <p>Medium term – Mar 25</p>	

	planned reduction in daily patient contacts to maximum of 25 (national average position 37 per day) and potential for non-engagement with other system pathways i.e. advice and guidance for referrals.			
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There is a risk that	<p>There is a risk that the pace and scale of the proposed National changes to ICB structures and functions set out in the ICB Model Blueprint could impact on the ability of the ICB to deliver its core statutory function, delivery of our ICB Operational / Financial Plan, quality and assurance and loss of focus on delivery of the wider system's strategic objectives, alongside risk of legal challenges around workforce.</p> <p>There is a further risk that the tight timescales will impact on true engagement across the Integrated Care System, impacting on limited time to discuss new ways of working</p>
BAF Ref: 10	BAF 10
Date of Risk:	May 2025
Senior Risk Owner:	Chief Executive – Supported by Executive Director of Corporate Services & ICB Development
Responsible Committee:	ICB Board / Remuneration Committee (Workforce), Quality, Performance and Finance Committee to Oct 2025 (ICB Board & Utilisation Management & Quality Improvement Committee
Last Review Date:	14 October 2025
Inherent Risk Score:	4 X 4 = 16
Current Risk Score:	4 X 4 = 16
Target Risk Score:	4 X 2 = 8

Integrated Care System Key Priorities	Indicate which priority / priorities this risk links to
Priority 1: Ensure our children are ready to enter and exit education, prepared for the next phase of their lives.	
Priority 2: Create an environment which gives people the opportunities to be as healthy as they can be.	
Priority 3: Reduce poverty through better employment, skills, and better housing.	
Priority 4: Promote early intervention and prevention measures to improve mental health and wellbeing.	

Progress 2025/2026	May	July	September	November	Jan	Mar
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<ul style="list-style-type: none"> The scale and pace of change required over a short period of time and need to support delivery of organisational change. 	<ul style="list-style-type: none"> Potential impacts on operational and financial delivery, alongside quality and contract monitoring. 	Maintain Executive Focus on delivery via the ICB Strategic Executive Team meetings and system-wide Programme Executive Committee (Committee of the ICB Board)
<ul style="list-style-type: none"> Lack of uncertainty around future organisational change. 	<ul style="list-style-type: none"> A lack of capacity to support delivery due to organisational change management and focus on securing a future role. 	Regular monitoring and assurance through ICB Committee / Governance Framework. Establishment of an Internal Transition Group.
<ul style="list-style-type: none"> Lack of clarity around future ICB functions which will transfer to NHSE in line with the proposals set out in the NHSE ICB Model Blueprint 	<ul style="list-style-type: none"> Unclear about where accountability lies. 	Oversight and assurance of current ICB functions by relevant Board Committees
<ul style="list-style-type: none"> Lack of clarity and funding of potential redundancy schemes 	<ul style="list-style-type: none"> Staff leaving the organisation to secure new roles, leading to gaps in capacity to deliver, and loss of talent 	Regular communication and engagement with staff. Extranet FAQs Drop In Sessions with Staff VR Scheme now implemented.
<ul style="list-style-type: none"> Short timescales hampering engagement with our Integrated Care System partners 	<ul style="list-style-type: none"> True engagement across the Integrated Care System, impacting on limited time to discuss new ways of working 	Regular briefings with key stakeholders.
First Line Assurance (Departmental Level)	Second Line Assurance (Organisational oversight)	Third Line Assurance (Independent)
ICB Executive Transition Task and Finish Group	Internal Transition Group to C&P ICB Board Joint Transition Group (Cluster ICBs)	NHS England Trade Unions and Professional Bodies Healthwatch

Gaps Identified	Planned Actions	Progress	Timescale for Completion	RAG Status
Governance and assurance of the Transition process.	<ul style="list-style-type: none"> Establishment of an Internal Transition Group, led by the ICB Chair Transition Programme Group now established with detailed Work Programme and Governance. Workstream leads identified 	<ul style="list-style-type: none"> Terms of Reference agreed by the ICB Board. First meeting to be held on 26 June 2025. Joint Transition Committee revised Terms of Reference to reflect clustering arrangements and new Board Membership 	30 June 2025 Ongoing	
Governance and assurance of the Transition – Cluster-wide	<ul style="list-style-type: none"> Establishment of a Joint Transition Committee (in line with the ICB Model Blueprint) Agree approach to escalation. 	<ul style="list-style-type: none"> Terms of Reference endorsed by the ICB Board. First meeting held on 9 June 2025 Governance Leads meeting on a weekly basis to identify issues / trouble shoot. Proposed changes to the ICB Constitution to reflect Transitional arrangements being presented to the ICB Board on 19 September 2025 – has now been approved by NHSE Appoint C&P NHS Trust Partner Member via ICB Constitution process Appoint C&P PMS Partner Member. 	30 June 2025 – Completed Changes approved by the ICB Boards in Common 14.10.2025 - Completed NHSE approved changes. Completed In progress. Closing date for nominations 10.11.2025	

Consultation timescales for Organisational Change and consultation are different across the ICBs.	<ul style="list-style-type: none"> • Negotiation with ICB Staff Side • Amendment of Policy to reflect 45 day consultation 	<ul style="list-style-type: none"> • Agreement with Staff side to move to 45 day consultation that aligns with other ICBs • Remuneration Committee to approve the proposed amendments to the Organisational Change Policy • Combined Staff side meetings • Remuneration Committee meeting in common across three ICBs 	<p>20 June 2025 – Completed</p> <p>Completed</p> <p>In progress</p> <p>In progress</p>	
Clarity on the future function and form of the ICB	<ul style="list-style-type: none"> • Cross ICB Organisational Design Groups • ICB Spokespersons identified and local Organisational Design Groups to inform wider group. 	<ul style="list-style-type: none"> • Form and function of the new ICB and six Directorates established. • Executive Director appointments. • Internal Spokesperson's identified • Work to achieve Vision and Values for each Directorate alongside leadership model. 	<p>Ongoing through consultation response</p> <p>Completed</p>	
Review of governance processes to ensure continuity through change	<ul style="list-style-type: none"> • Review of current processes and procedures 	<ul style="list-style-type: none"> • Risk leads meeting to review current processes and procedures. • Agreed approach to management and oversight of Business Cycle. • Due diligence process completed and acknowledged by NHSE 	Ongoing	