North East London Health & Care Partnership

NHS North East London

Fit for the Future: 10 Year Health Plan, Changes to ICBs, and implications for LBH

Havering Overview and Scrutiny Committee Paper

September 2025

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Political messages

Fit for the Future: the 10 Year Health Plan for England (published on 3rd July 2025) **aims to reinvent the health service** while maintaining the core principle that services should be free at the point of use.

The Change.nhs consultation was a widespread engagement exercise that received over 250,000 public, staff and expert contributions.

The **key drivers for change** cited in the 10 year health plan are:

1. Public satisfaction with the NHS is now only 21%, down from 70% in 2010.
2. The NHS faces increasing pressure from an ageing population with long term conditions and widening levels of inequality.
3. The NHS consumes 38% of government spending, productivity is down 20% to 25% compared to pre-pandemic, the NHS is not delivering value for taxpayers.
4. Patients wait passively to receive care from an antiquated service reliant on posted letters, telephone queueing systems and convoluted access routes.
5. Centralisation of the running of the NHS, particularly because of the reforms introduced after the 2010 elections, has inhibited innovation.

The main solutions and innovations identified are:

1. A move to **patient-controlled and personalised** system with more people having instant access to healthcare and electronic care plans.
2. The transfer of care from **Hospitals to the Neighbourhood** in a way that will revitalise General Practice and provide more care closer to people's homes.
3. The NHS will undergo a **digital revolution** including more use of AI, the NHS App and centralised patient records, this will include the use of genomics data as a way to actively prevent ill health.
4. The NHS will be decentralised, frontline staff will be empowered to reshape services, and **the role of the Integrated Care Board has been reclarified as the organisation that uses strategic commissioning to improve population health.**

Our approach: 10 Year Plan engagement

The People's Panel

What we did

- The People's Panel is made up of more than 2,400 people living in north east London, who receive a monthly newsletter inviting them to participate in various engagement activities
- We invited People's Panel members to participate in a workshop to discuss the 10 Year Plan and the proposed three shifts:
    - Moving more care from hospitals to communities
    - Making better use of technology
    - Preventing sickness, not just treating it
- Our partner organisations also helped us promote the opportunity through their networks too
- We delivered 7 in person workshops at Place, with around 80 participants overall on cold winter evenings

Key learning / feedback

Hospital to community

- Moving care from hospitals to the community could have a profound positive impact in particular on waiting times and patient experience
- Potential to be more cost effective
- Could aid recovery as people are looked after in more familiar surroundings , making use of community assets and focusing on prevention
- Need to consider impact on unpaid carers who are already under pressure as well as how services would be monitored to ensure high quality

Better use of technology

- Across the groups, people could see the potential benefits for the increased use of technology, however overall, it was felt that there still needs to be options which do not exclude people who are unable to access digital tools, information or services
- Could be beneficial in enabling early diagnosis and supporting prevention of long-term conditions through empowering individuals to manage their health and wellbeing
- Need to consider digital exclusion

Preventing sickness

- People felt that focusing on prevention and early intervention, could reduce hospital admissions, improve self-management, and promote healthier lifestyles. This would not only save money but also enhance the overall well-being of individuals and communities.
- Government’s focus should be on primary prevention, rather than secondary prevention
- People wanted to focus discussions on things that can have a positive influence on people’s health, such as good quality housing, information about nutrition and employment

“I’m sure with a bit more information early on, half my family could have avoided getting diabetes. There was never any information about what they should be doing to stay healthy, only when it was too late”

“Why don’t different teams work together? Surely things would be a lot more efficient if everyone just talked to each other and shared information?”

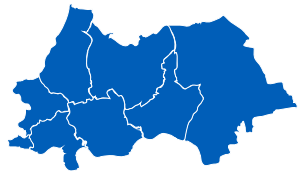
"I know what it's like, I can see where things go wrong when I'm using services, and I want to make it better for other people"

“I once had the most lovely nurse in hospital who made such a difference to my experience, I wish they could copy and paste him. A little bit of kindness makes all the difference”

From Hospital to Community

Key Concepts:

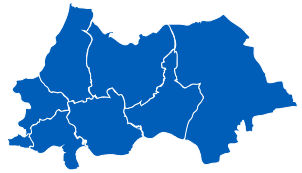
- The **Neighbourhood Health Service** will become an alternative to the Hospital based health service, bringing care into the places where people live and restoring GP access.
- Neighbourhood Health Centres will be created (that are open 12 hours a day, 6 days a week), co-located with other services and offer a one stop shop for NHS patient care, council services and voluntary services.
- More services will be provided on the high street, in patients homes, online, and very importantly more services will be provided outside of the 9 to 5.
- Two-thirds of outpatient appointments (currently costing £14bn) will shift to digital advice, while 95% of complex patients will have universal care plans by 2027.
- Two new neighbourhood provider contracts will be introduced - '**single**' and '**multi**' neighbourhood serving around 50,000 and 250,000+ people respectively – these contracts will 'encourage' GPs to work over larger geographies and lead neighbourhood providers.
- ICBs have freedom to contract with **GP federations or NHS Trusts** to provide Neighbourhood Health Services.
- Well-performing FTs will have the opportunity to become Integrated Health Organisation (IHO) with responsibility for a whole health budget for their population.
- The Neighbourhood Health Service will expand over a 3-4 year timeline which is linked to the timeline for the financial shift from Hospital to out of Hospital services, and the modernisation of Hospitals.
- Increase the number of **Mental Health Emergency Departments** co-located with A&E.



From Analogue to Digital

Key Concepts:

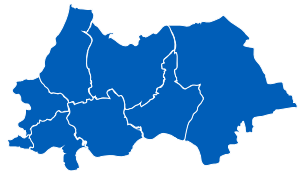
- A nationally procured **Single Patient Record** will facilitate the integrated, personalised and the predictive healthcare model.
- Patients will access the NHS via the **NHS App that will become the "front door"** to the NHS by 2028. The NHS App will support AI-powered rapid advice and diagnostics, self-referral, appointment booking, medicine management, and care planning – together these form the '**doctor in your pocket**'.
- The NHS App will be supplemented by '**HealthStore**': a marketplace for NICE approved digital health apps patients can use.
- New AI tools are being tested on the Federated Data Platform which connects information across healthcare settings, links siloed sources and can increase productivity.
- The shift to digital is citied as the clearest route to financial sustainability because it reduces duplicative efforts, reduce cost of communicating with patients, releases clinicians from pre-assessment, frees frontline staff from paperwork. A national procurement framework for AI tools will be established in 2026/27, which can be accessed by all NHS organisations so they can adopt the new technology safely.
- The key AI clinical tool will be ambient voice technology (the '**AI scribe**') which should reduce paperwork by 51% and release time to care.
- **Genomics data will be integrated into the Single Patient Record** to supplement the personalised and predictive care model approach.



From Sickness to Prevention

Key Concepts:

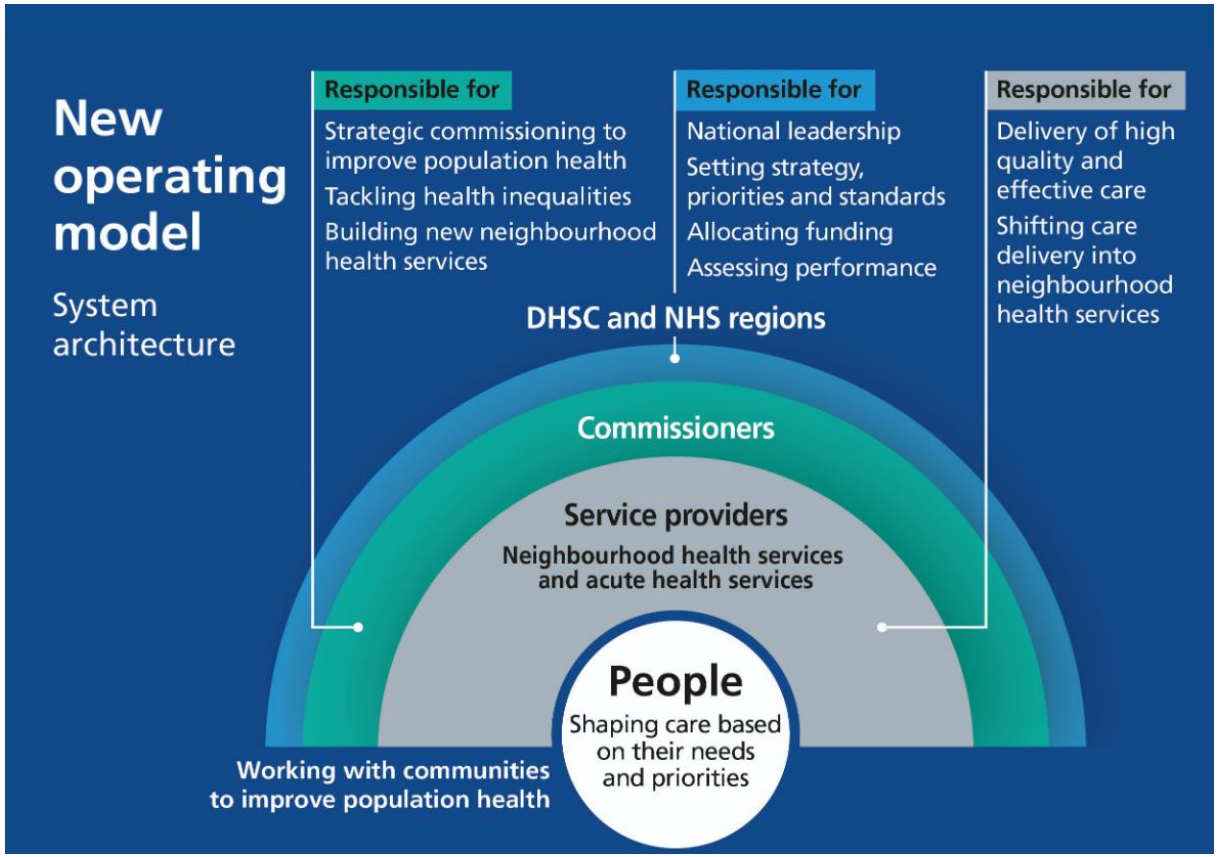
- Prevention will be how we deliver healthier, more prosperous lives for all, particularly for those suffering the consequence of widening heath inequality.
- The report talks about a lot of primary prevention initiatives like the work on smoking cessation, the Tobacco and Vapes Bill, ban on junk food advertising, energy drinks ban, alcohol health warning labels, decarbonising transport, and several other cross government initiative, however it also says…
- The new NHS role will be to use genomics, predictive analysis and AI to usher in a **new era in secondary prevention** giving us the ability to better target prevention initiatives.
- Embracing **technological advance in Vaccines, Screening and Genomics** are seen as critical to turning the NHS into a prevention service / population health service.
- NHS specific secondary prevention initiatives include:
  - Expand the Healthy Start scheme
  - Collaborate with industry to test weight loss models like GLP-1
  - Introduce digital NHS points scheme that reward people for taking healthy actions
  - Achieve national coverage of mental health support teams in schools
  - Increase update of vaccination and screening through the Neighbourhood Health Service
- As part of **the Get Britain Working White Paper** – establish ‘Our Health and Growth Accelerators’ to test models where NHS systems are held accountable for the impact they have on people’s work status.
- **Commitment to clean air** by supporting active travel, decarbonising transport, rolling out clean technologies and tackling poor housing conditions that create damp or mould. (part of *wider government initiatives*)



New operating model

Principal Objective / Rationale

The NHS was founded on principles of universal care, publicly funded and free at the point of delivery; as well as an original ambition of patient empowerment and the distribution of power. The ambition has never been fully realised and this situation is being perpetuated by the on-going centralisation of decision making.



The Vision

- There will be a simple hierarchy of DHSC, Commissioners and Providers - all accountable to government, and with responsibilities clarified.
- The key purpose of the new Department of Health is to set strategy for the NHS and form partnerships at a national or international level with investors, industry and the rest of government.
- The key purpose of ICBs is to become strategic commissioners of local health services and to make evidence based decisions and achieve financial sustainability.
- Earned autonomy will be reintroduced to give the best performing NHS Trusts giving them the opportunity retain surpluses and use that funding to innovate. The poorest performing NHS Trusts can be put into 'administration' and then taken over by another provider.

ICBs will need :

1. Excellent analytical capability, and be guided by population health data
2. A strong strategy function and staff with good problem solving skills
3. Capability in partnership working
4. Intelligent healthcare payer understanding with the ability to develop novel payment mechanisms and strategic resource allocation
5. User involvement functions to ensure services meet the needs of the local community

(summarised from the NHS 10 Year Health Plan page 79)

New transparency on quality of care

Principal Objective / Rationale

A lack of transparency was a major contributing factor behind patient harm events not being reported then fixed.
A lack of transparency on the quality of care makes it difficult for patient to make informed decisions.

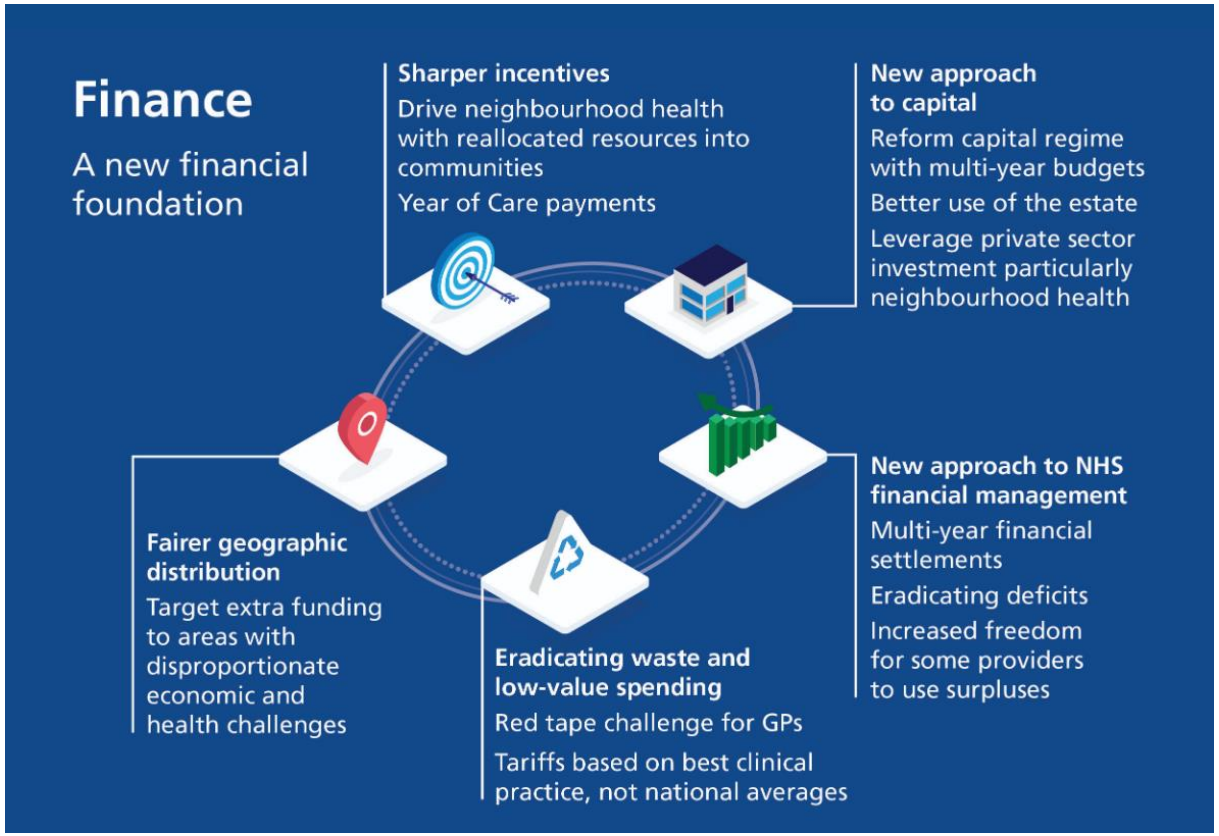
The Vision

- To empower patients to make informed decisions about their care the following needs to happen:
    1. Better data is made freely available to support patients to make choices
    2. Patient feedback is routinely and frequently collected alongside public and staff experiences
    3. Clear incentives to improve patient care will be made available to leaders and to staff to ensure they deliver the best quality care
    4. There is investment in technology to support improvement in patient care
- The National Quality Board will be revitalised and tasked with developing a new quality strategy by March 2026.
- The NQB will become the single authority on quality as recommended in the Penny Dash Report.
- The Health Services Safety Inspection Board (HSSIB) functions will transfer to the CQC and the hosting arrangements for the Patient Safety Commissioner (PSC) will transfer to the Medicines and Healthcare products Regulatory Agency. This will simplify the healthcare inspection regime.

Finance and Productivity

Principal Objective / Rationale

More funding has not always led to better care especially over the last 10 years when funding went up but outcomes and productivity declined.
The objective is to reverse the increase in NHS costs as the country deals with pressure on public finances.



The specific milestones for the delivery of NHS financial sustainability have been defined as:

- Deficit support funding will be phased out from 2026/27
- For the next 3 years there will be an NHS target to deliver a 2% year-on-year productivity gain which will return the NHS to pre-pandemic level of productivity
- Multi-year budgets for service funding will be introduced meaning commissioners can offer multi-year contracts to providers and incentivise innovation
- A minimum 3% of the budget must be set aside for service transformation
- On a trial basis “Patient Power Payments” will be introduced – this is where patients will be asked whether the full payment for the cost of their care should be released to the provider or redirected to a regional improvement fund
- The ‘majority’ of NHS providers are expected to be in surplus by 2030
- The profile of health spending is to shift over the next 3-4 years where expenditure on Hospital care will fall and there will be greater investment in out of Hospital care.
- This will be supported by a move away from national tariffs based on average costs to tariffs based on best clinical practice that maximises productivity and outcomes.
- There will be the development of ‘**year of care**’ payments starting in financial year 2026 to 2027. This will also drive the shift of activity and resource from hospital to community.
- Multi-year capital budgets will be introduced on a rolling 5 years basis, the capital approval process will be streamlined and the government will explore the feasibility of new Public Private Partnership financing options

New NHS Workforce

Principal Objective / Rationale

Many experienced staff have left the NHS because of low levels of satisfaction caused by a culture of top down working, bureaucracy and contradictory guidance. The workforce of the future will need skills to deal with the growth in the ageing population, digital technological advances and work in a flexible way.

The Vision

- Later this year a 10 Year Workforce Plan will be published setting out more details of the new workforce approach. This will create a workforce model with staff genuinely aligned with the future direction of reform.
- It is acknowledged that there will be fewer NHS Staff in the future and they will need a different set of skills and competences to work in the digital healthcare environment focussed on AI and productivity.
- There will be:
  - Support for nursing students to overcome the financial obstacles to training
  - Support for resident doctors by improving postgraduate medical training
  - More research opportunities for nurses, midwives and AHPs
  - Implementation of changes to senior leadership working in line with the General Sir Gordon Messenger's Review
- Trust will be expected to recruit locally, specifically targeting individuals who are unemployed or economically inactive, and to expand apprenticeships and accessible training programs to enable people to "earn while they learn".
- Trusts will also be expected to assist care leavers in finding employment within the NHS.

Fit for the Future will introduce a new set of standards for NHS workers which will be co-produced with staff through the Social Partnership Forum and implemented in April 2026.

The new set of standards will **make the NHS a great place to work**:

1. Nutritious food and drink at work
2. Protection from violence, racism, sexual harassment at work
3. New standards of healthy work
4. Flexible working options

NHS Employer will publish data on these standard every quarter!

Innovation and Research

Principal Objective / Rationale

The UK is a leader is life sciences, research and technology and the NHS is the holder of a powerful data set but the NHS is not effectively leveraging the competitive advantage it possesses. The objective is to position the NHS to be in the driving seat to harness technology to create the new model of care.

The Vision

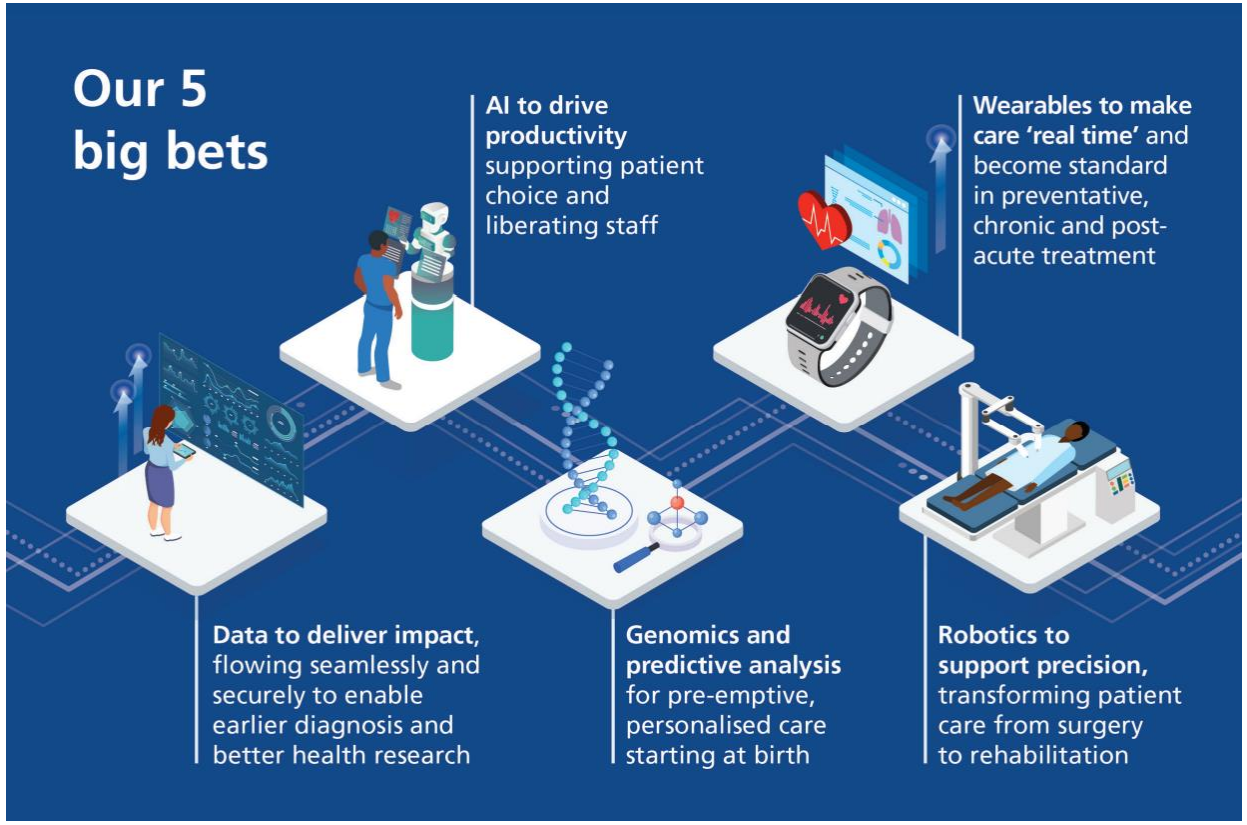
- The key technological drivers of healthcare reform will be the '**FIVE BIG BETS**' to drive healthcare reform:

    1. Interoperability of data
    2. AI empowering patients and driving productivity
    3. Predictive analysis drives prevention and personalisation
    4. Wearable technology provides real time data
    5. Increased use of robotics

- **Regional health innovation zones will bring together ICBs, Providers and Industry to drive local innovation.** The NHS can work alongside innovators to bring technology into the NHS more quickly.

- The plan sets out proposals to **increase research opportunities** for Nurses, Midwives and AHPs, and encourage skill development in research and innovation.

- Research will increasingly be done in the primary care and neighbourhood health service settings.



Summary – Fit for the future

The **New Model of Healthcare** will:

- Create a **Neighbourhood Health Service** that will bring care to the places where people live and restore GP access.
- Digitise every aspect of the NHS and create a **centralised patient record system** that NHS staff can access through a single login, and all patients will access through the NHS App.
- Increase the importance of **Patient choice and patient experience** will drive the expansion of electronic care planning and personal health budgets
- Create a system of **complete transparency on quality and performance** with published league tables.
- Move funding, activity and staff into **Neighbourhood Health Services** that are GP led. ICBs can commission NHS organisations or contractors, like a GP Federations, to run the Neighbourhood Health Service.
- **Expand NHS secondary prevention, which is supported by Genomic testing;** this is part of a cross governmental drive to get the country fit and back into work.

- Redefine the role of the ICB as the strategic commissioners of local health services that will make evidence based decisions to improve population health, tackle health inequalities and deliver financial sustainability.

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Appendix 1: Infographics from Fit for the Future

Hospital to community

Bring the NHS to you In your community, including homes and high streets

Modernise hospitals
Long waits reduced and a renewed focus on world-class, life-saving care

A neighbourhood health centre
In every community, with multi-disciplinary teams working together, under one roof

Create teams that work around you
Different professions, social care and voluntary sector

A new era for general practice
End the 8am scramble and bring back the family doctor

Analogue to digital

for staff

Liberating staff from bureaucracy - Using AI to automate tasks. Building care plans and recording clinical information, which can save clinician time

Embrace AI to support clinicians - Using AI as part of treatment to improve clinical outcomes

for patients

A Single Patient Record - Giving you control over your data, accessible by all healthcare professionals, with your consent

Manage your care digitally - Book and change appointments and discuss your care all through the NHS App

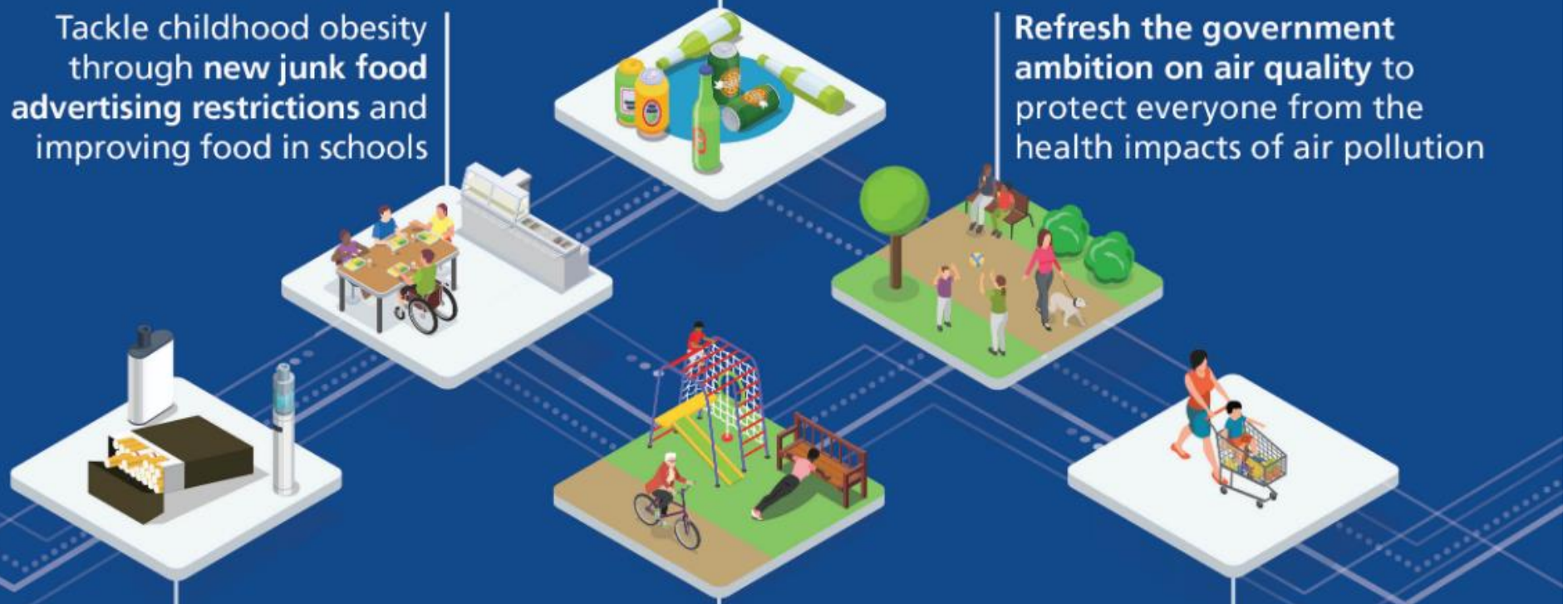
Your NHS companion - By 2035, you'll have a virtual assistant - a doctor in your pocket

Sickness to prevention

Ensure people have the information they need to **make healthier choices** on alcohol

Tackle childhood obesity through **new junk food advertising restrictions** and improving food in schools

Refresh the government ambition on air quality to protect everyone from the health impacts of air pollution



Create the first smoke-free generation and crackdown on vaping amongst children

Millions more people will be encouraged to move and exercise regularly through a new national campaign

Work with businesses to help children and families make the healthy choice

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Havering Neighbourhood Boundaries

August 2025

Background: Boundaries?

National Guidance

"**System leaders** will need to **work with partners** across local communities **to define population boundaries** for neighbourhood health"

"It is essential that care is planned to meet all health and social care needs and that service boundaries do not prevent seamless, joined-up care"

London Guidance (Target Operating Model)

Working within each ICS, **place partnerships will be responsible for agreeing the footprints of neighbourhoods** based on local evidence and data, including existing capacity and demand, and mapping of local assets and needs.

INT boundaries in London will not automatically be defined by existing primary care network (PCN) footprints, **except where these boundaries align with recognisable neighbourhoods**.

It is much easier to begin by enabling people to work together differently, rather than to start with trying to reconfigure organisations.

Background: Boundaries?

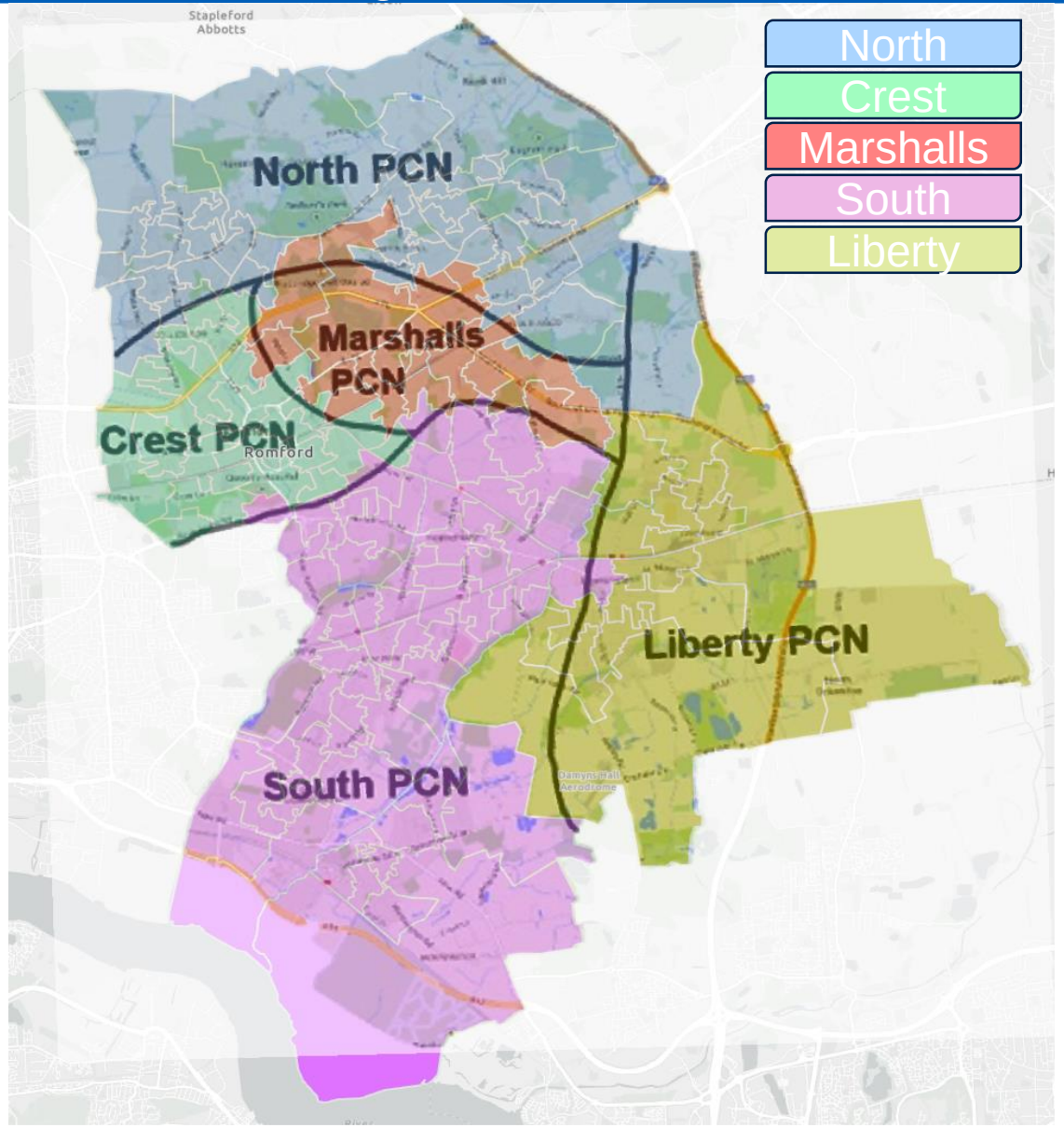
MH

North East London Guidance

Vision - Everyone in north east London lives in a neighbourhood which supports and actively contributes to their physical and mental health and wellbeing

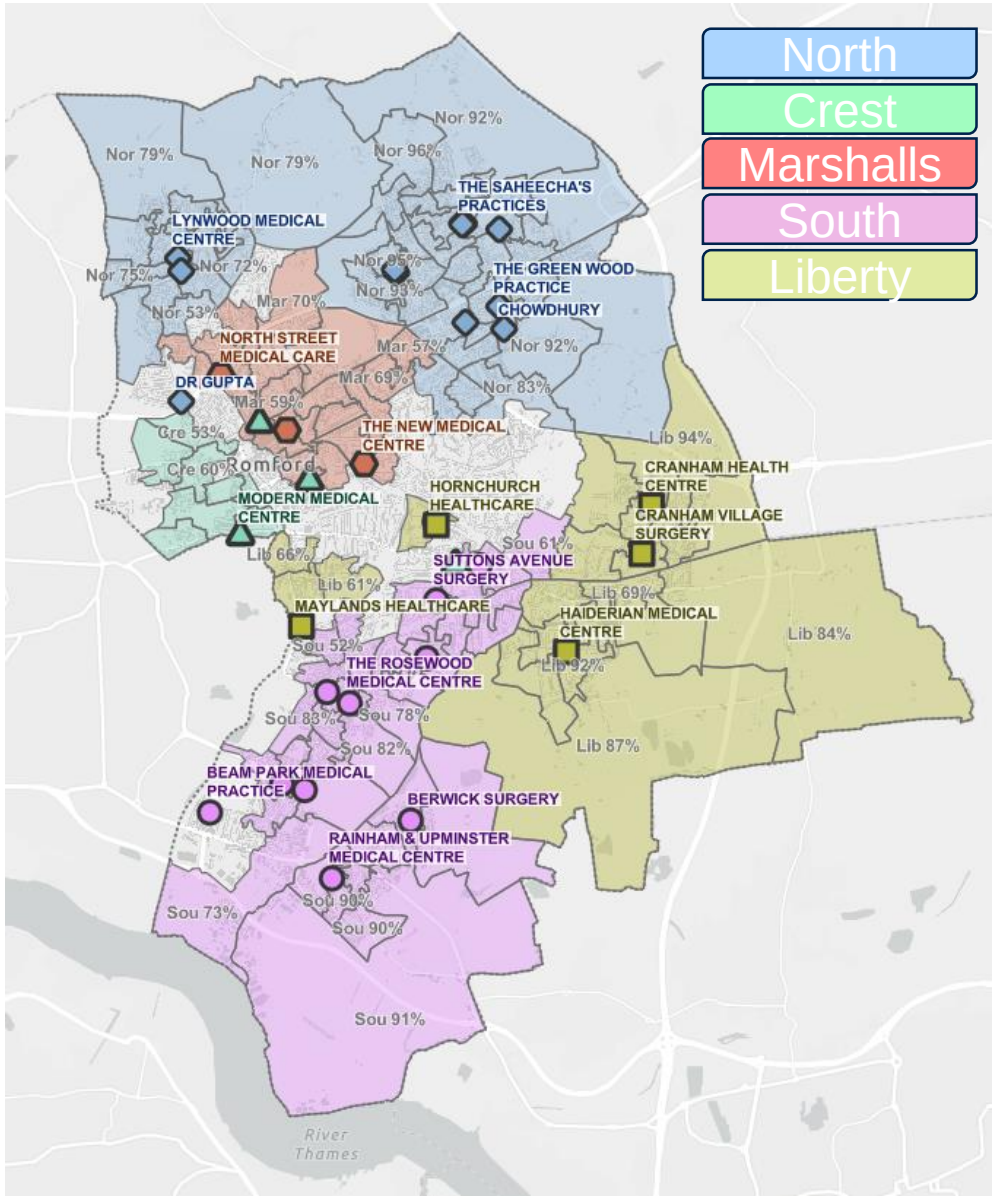
The size of the **neighbourhoods** will vary according to a number of factors, but broadly they should be small enough to resonate and reflect local communities but also large enough to be able to practically and efficiently deliver services. In our emerging north-east London landscape the **smallest neighbourhoods are around 30,000 in population, increasing to up to c. 100,000** which is very much in line with national benchmarks.

Recommendation: Initial Mapping
3 Localities & 5 Neighbourhoods



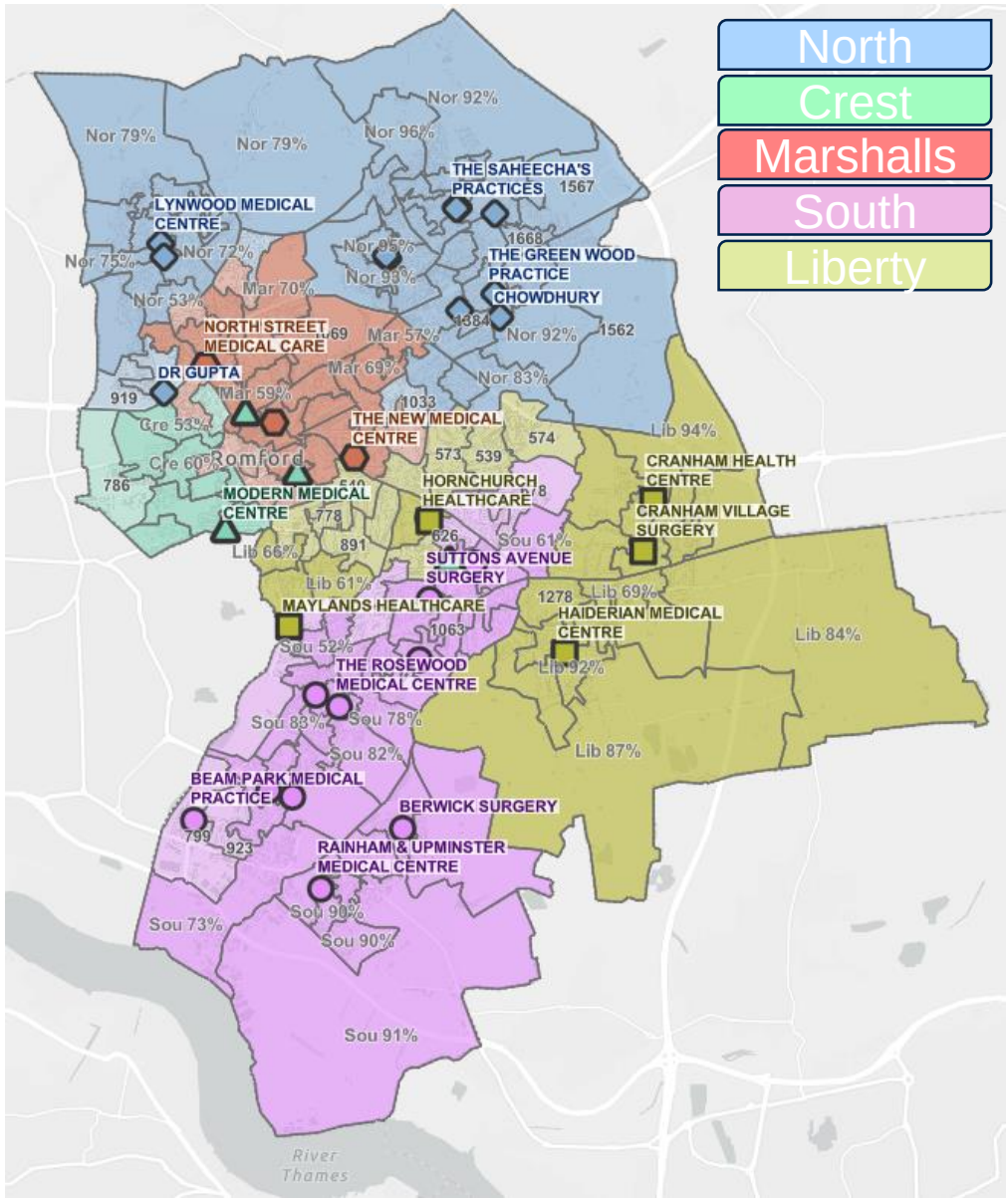
- Following initial conversations with ICB primary care colleagues, this was a rough mapping of the existing PCN boundaries
- Broadly showing where the majority of the practices within the PCNs fall under

Recommendation: greater than 50% patients in LSOA
3 Localities & 5 Neighborhoods



- Where a PCN has greater than 50% of patients in the LSOA, the LSOA has been assigned to the respective PCN
- Where there are gaps, no respective PCN has more than 50% of patients within the LSOA
- The colour-coded shapes represent GP practices and are aligned to their contractual PCN
- Some practices therefore appear to fall under the footprint of another PCN, however this is because the LSOA of the practice location has less than 50% of patients

Recommendation: greater than 50% patients in LSOA combined with patient count
3 Localities & 5 Neighbourhoods



Where no PCN has a greater than 50% of patients in an LSOA, it has been allocated to the PCN with the highest count of patients

3 Localities:

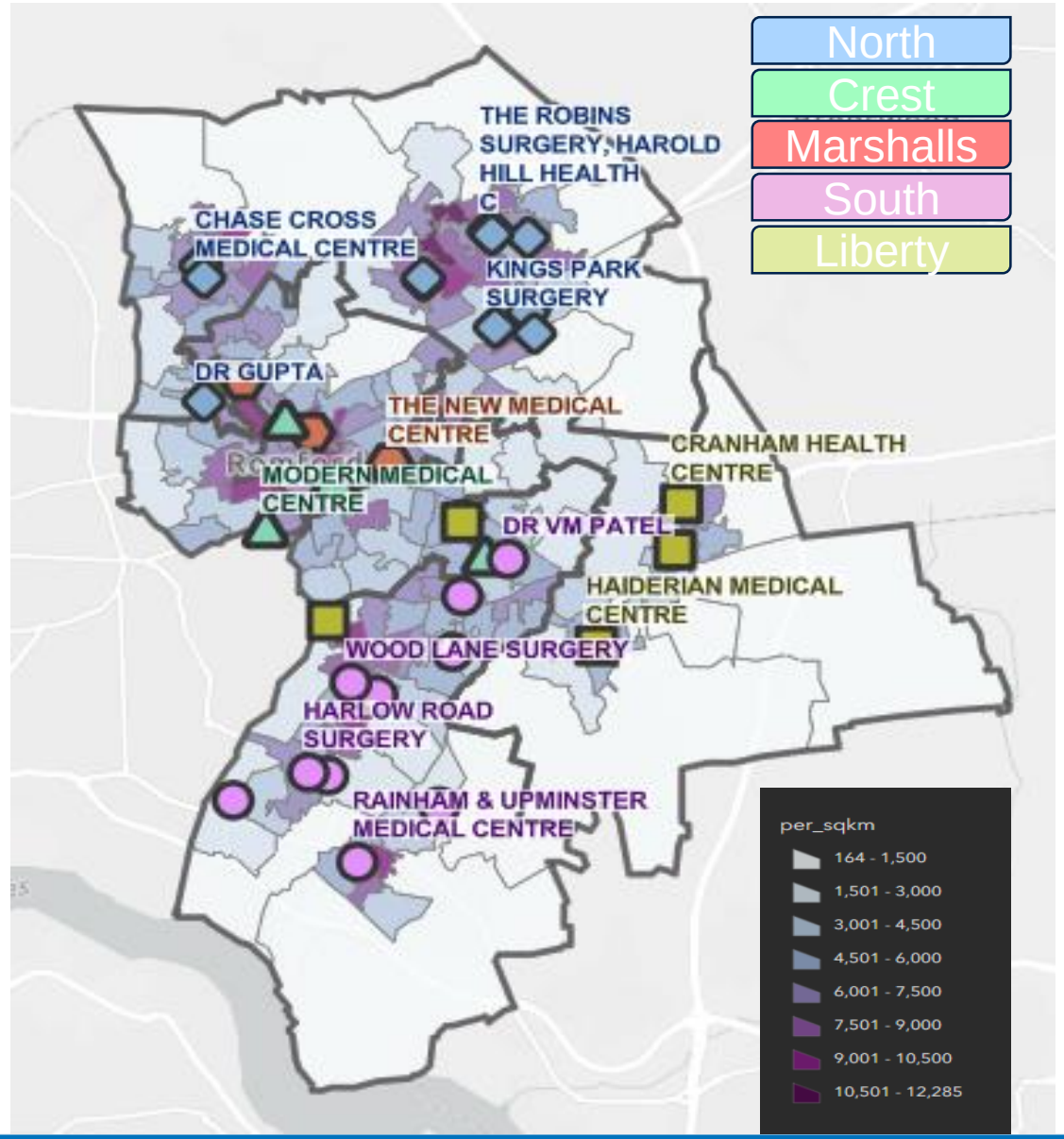
- North – covering North PCN practices
- Central – covering Marshalls & Crest PCN practices
- South – covering South & Liberty PCN practices

5 Neighbourhoods:

- North – covering North PCN practices
- Crest – covering Crest PCN practices
- Marshalls – covering Marshalls PCN practices
- South – covering South PCN practices
- Liberty – covering Liberty PCN practices

Caveat – proposed starting point which will evolve through population demand and subject to change according to INT maturity

Proposal: INT Boundaries by Population Density
3 Localities & 5 Neighborhoods



Population Density per square metre:

pcn	per_sqkm
Havering Marshall PCN	5,060.7
Havering Crest PCN	4,718.3
Havering North PCN	2,584.4
Havering South PCN	2,308.8
Havering Liberty PCN	1,474.5

Forecasted Population Growth in Havering:

- The future population of Havering is forecasted to increase with an additional 12,000 homes around central Romford over the next 10 years
- This is estimated to be an additional 30,000 residents, excluding population growth elsewhere of the borough

Rationale

- Similar set up to exemplar Neighbourhoods that already operate in other parts of the country e.g. Manchester, Cambridge & Peterborough, City & Hackney, Buckinghamshire
- Neighbourhoods would serve populations up to circa 100,000 which is in line with NEL guidance on national benchmark population sizes
- The proposal is based on mapping of existing resources as majority of teams that lend themselves to Neighbourhood working are already operating geographically based around these footprints e.g.

Teams that are currently/soon to be set up to operate from (North – North PCN, Central – Marshalls & Crest PCNs, South – South & Liberty PCNs) footprint

- NELFT - Mental Health & Wellness Teams
- NELFT - Talking Therapies
- NELFT - Community Nursing
- LBH – Adult Social Care * currently restructuring to align

Teams that are currently set up to operate from North, Marshalls, Crest, South & Liberty PCN footprint

- NELFT - Learning
- NELFT - Psychological Professions in Mental Health Wellness Team
- NELFT - Early Intervention In Psychosis Teams
- NELFT - Older Adult Mental Health Team
- NELFT - Memory Service
- NELFT - Community Cardiac
- NELFT - Community Diabetes Team
- NELFT - Community Respiratory Service
- NELFT – Integrated Community Matron
- NELFT – Community Night Service
- NELFT – Community Oncology
- General Practice – Additional Role Reimbursement Staff

- Utilising natural pre-existing structures allows ‘boundaries’ to be more easily understood by stakeholders
- In line with London Target Operating Model proposal that “It is much easier to begin by enabling people to work together differently, rather than to start with trying to reconfigure organisations”
- Meets national guidance that will allow health and social care to work together within boundaries that won’t prevent seamless joined up care – current social care teams are restructuring to support this

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Implications and Risks for London Borough of Havering

September 2025

Risks / Implications

Area	Risk/Implication
Influence	With the development of Integrated Neighbourhood Teams, there is the opportunity for the London Borough of Havering to come forward as a partner in the proposed ‘Integrator’ function. This would enable the Local Authority to continue to drive towards closer integration and continue to directly influence the development of services going forwards. The London Borough of Havering has already initiated discussion with partners around this opportunity
Work to date and progress	The Havering Integrated Team at place has delivered some amazing work together that will serve as a solid foundation going forwards. It’s crucial that key aspects of this such as the Live Well Havering programme (which to date has been largely funded by NHS Monies, but which LBH colleagues are seeking to progress and fund) are able to continue, alongside positions and work like the jointly funded Supported Housing role. The Live Well Havering programme has revitalised the council’s relationship with the community and voluntary sector, and will be the key delivery programme for prevention into the future. There are risks that, given the council’s financial constraints, programmes like this could suffer with the potential reduction in resource at the Havering team at Place.

Risks / Implications

Area	Risk/Implication
Relationships	Relationship between the Council and NHS – as described above, the Havering Team at place has fostered ever closer relationships and working practices between NHS commissioners, providers, the Community and Voluntary Sector, and Havering Council. The Jointly appointed Havering Director of Partnerships, Impact and Delivery has spearheaded this. Given that there will be a likely reduction in the number of staff, and therefore resource at place, there is the potential that the impact / influence between the NHS and Council could be impacted.
Integrated Care Board 50% reduction and implications for the Havering Team at Place	The London Borough of Havering is already working to mitigate the immediate implications of the NHS 10 Year Plan, that require NHS North East London to undertake a restructure within 2025/26, delivering a 50% running cost reduction. This has implications for the Havering Integrated Team at place (NHS Commissioners and LBH Commissioners from what was previously the Joint Commissioning Unit). The Team has been successfully working as a joint entity for over a year. The implications of the significant running cost reduction requirement for NHS North East London is that the resource at Havering Place will reduce significantly on the NHS side. The London Borough of Havering are responding by planning a restructure for the staff employed by the Council, to be run concurrently with the NHS consultation, to ensure that the commissioning team structure is not destabilised by the reductions within the NHS Team.

Risks / Implications

Area	Risk/Implication
Progress in reducing Health Inequalities	The Havering Integrated Team at Place has led a significant amount of work, with associated investment, in addressing Health Inequalities in Havering. This has included, but not limited to, a significant amount of work around hidden Carers, including development of the Carers strategy, establishment of the Carers Board, and co-production with local carers, reducing barriers in access to care for those who are deaf or who communicate differently, a significant amount of engagement and co-production with local people, Funding for the Live Well Havering programme. The Health Inequalities Programme budget comes to an end in March 2026, and there is no indication yet of whether the Integrated Care Board, in it's new form from April 2026, will continue to fund this programme. The Havering Integrated Team at place has driven the work around this, and, with a potential reduction in the number of staff within the team relating to the restructure on the NHS side, could also significantly reduce capacity to continue to drive forward this work around addressing health inequalities.
Experience and Knowledge loss	The Havering Integrated Team at Place is comprised of a number of experienced staff who have built a wealth of knowledge and connections over a number of years. There is a risk that we will lose some of this local knowledge and connections as a result of the ICB staff consultation. It is crucial that we build in a transition period to the new model (post consultation), to ensure that this learning and knowledge can be shared with Local Authority staff and NHS Staff who remain working at Place.

Risks and Implications

Area	Risk/Implication
Co Production	Co-production with local people – The Havering Integrated Team at place has driven a significant amount of co-production and engagement with local people; delivering Live Well Havering outreach evets, developing case studies to drive improvements in service delivery and integration, coproduction around the Havering Carers strategy, work with local deaf people and those who communicate differently, development with local people of the Autism strategy. This engagement has been used as evidence on behalf of the London Borough of Havering as co-production during recent CQC and OFSTED visits. There is a risk that, with reduced capacity at place, and loss of connections and knowledge from staff moving on, that the ability of partners to continue this coproduction will be reduced.
Financial / Resource	There are financial implications for the Local Authority as the ICB becomes a ‘strategic commissioner’ and the new NHS landscape places more impetus on NHS Providers to deliver transformation. There have been no guarantees in the 10 year plan around continued joint funding for Prevention.
	The Better Care Fund will be restructured from 2026/27 to align with new commissioning and neighbourhood plans. Local Authorities, in particular Havering, are already face over-spending pressures on adult social care budgets, rising costs (inflation, Living Wage, NICs), and public health grant cuts. The Local Government Association has indicated that there is a need for a parallel 10-year adult social care plan, financial and systemic misalignment will undermine NHS aims.

Risks and Implications

Governance and Democratic Oversight

Potential decommissioning of Healthwatch – the government have suggested that they are in the process of streamlining oversight on Quality of health services and have indicated that this could signal the end of Healthwatch England. We're not currently sure what the implications of this are for Healthwatch Havering. Healthwatch Havering are key local partners and have worked closely with the Havering Partnership to drive improvements for local people, including a significant amount of work to improve outcomes for those who are Deaf / communicate differently, and other key initiatives. They are champions locally in terms of shining a light on the needs of local people, and working with partners to address health inequalities and barriers to care. The 10 year plan suggests that the functions of Healthwatch will be absorbed into Integrated Care Boards and other bodies, so it's essential that locally we continue to ensure that the needs of local people are championed.

The Havering Place based Partnership Board and Partnership governance has been a key set of forums that have brought partners together locally to share resources, unblock issues, identify joint priorities, and deliver integration and improved outcomes for local people. With a reduction in resource at Havering Place and within the Integrated Care Board, and potential changes to our local landscape with Healthwatch and changes to the way our Providers operate, this governance structure will need to be reviewed and adapt, to ensure that forums remain in Havering where partners are able to come together to effect real change and champion Havering's cause within the content of North East London and wider.

There is indication that Mayors (or their delegates) will replace local authority representatives on Integrated Care Boards (ICBs). Health scrutiny committees and Integrated Care Partnerships (ICPs) may be abolished, tightening accountability outside local authority structures. Health and Wellbeing Boards will retain advisory roles, but may have less real authority under the new model.