

NHS Kent and Medway Integrated Care Board Part 1 to be held on:

Tuesday, 3rd February 2026 at 10:00 am

Agenda

Notice on meeting etiquette

10:00

For Noting

We would like to take the opportunity to remind members, reporting officers and observers that:

- The meeting will be recorded for the benefit of the minute taker to ensure the accuracy of transcribed notes. As such, they are not subject to Freedom of Information legislation. The recording will not be played for the interest or benefit of any third party, person not in attendance or to verify the correctness of the record.
- To aid accurate representation of discussions within the minutes, attendees are requested to refrain from holding private conversations, introduce themselves prior to speaking and avoid rapid exchange of discussion.
- Where the meeting is held virtually, the chat function (of Microsoft Teams or equivalent platform) will be turned off. Should you wish to speak please use the 'raise hand' function.
- Reporting officers should refrain from using abbreviations, until they are given in full in the first instance.
- Questions from members of the public will be invited at the end of the meeting and should relate to items on the agenda only. The Chair will exercise their right to not take any questions which do not relate to the agenda. Questions from the public are welcome on any subject, but these should be sent to the ICB and will be forwarded to the appropriate department to respond.
- The amount of time dedicated to questions from the public in the board meeting is set out in the agenda and if questions are not completed in that time, members of the public will be invited to submit any further questions relating to the agenda in writing. Contact details can be found on the ICB website. If any one person or topic is dominating the questions time and other people have questions to ask, the question-and-answer session will move on.

1.0 Welcomes and introductions

10:00 (5m)

For Noting

2.0 Apologies for absence

10:05

For Noting

3.0 Quorum

10:05

For Noting

4.0 Declarations of members' interests

10:05

For Noting

A new online [Declaration of Interests Form](#) must be submitted:

1. If you change roles / responsibilities.
2. If you have a new interest to declare.
3. If a declared interest has ceased.

NOTE: Attendees without nhs.net email, please report any changes to our Compliance Team at kmicb.compliance@nhs.net

 [4.0 ICB Board Register - February 2026.pdf](#)

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5.0	Minutes of the meeting on Tuesday, 4 November 2025	10:05 (2m)
	<i>For Approval</i>	
	 5.0 Minutes (Part 1) ICB Board 4 November 2025 DRAFT v3.pdf	Page 4
6.0	Actions and matters arising	10:07 (3m)
	<i>For Discussion</i>	
	 6.0 Action Log Board Feb 26.pdf	Page 19
7.0	Chair's Report	10:10 (10m)
	<i>For Information</i>	
	Lead: Cedi Frederick, Integrated Care Board Chair - NHS Kent and Medway	
	 7.0 Chairs report.pdf	Page 20
8.0	Chief Executive Officer's Report	10:20 (15m)
	<i>For Information</i>	
	Lead: Adam Doyle, Chief Executive Officer - NHS Kent and Medway	
	 8.0 CEO report.pdf	Page 23
9.0	Board Assurance Framework and Corporate Risk Register	10:35 (15m)
	<i>For Assurance</i>	
	Lead: Natalie Davies, Executive Director System Improvement - NHS Kent and Medway	
	 9.0 Committee Front Sheet -BAF and CRR February 2026.pdf	Page 28
	 9.1 SBAR - BAF and CRR report January 26.pdf	Page 31
	 9.2 Appendix 1 - ICB BAF January 2026 - Master.pdf	Page 35
	 9.3 Appendix 2 - ICB CRR January 2026.pdf	Page 55

Objective one - We will work with the NHS system to improve healthcare for our population

10.0 2025/26 Q1 ICB NHS Oversight Framework Contextual Metrics 10:50 (10m)

For Information

Lead: Natalie Davies, Executive Director System Improvement - NHS Kent and Medway

□ *10.0 ICB_NOF_Contextual_Metrics_coversheet.pdf*

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□ *10.1 Q1 ICB NHS Oversight Framework Contextual Metrics.pdf*

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11.0 2026/27 finance and operational planning (verbal update) 11:00 (15m)

For Information

Leads:

- Ivor Duffy, Chief Finance Officer - NHS Kent and Medway
- Ed Waller, Deputy Chief Executive and Chief Commissioning Officer

Objective three - We will develop a workforce where colleagues feel valued, we celebrate diversity and are fair and inclusive

12.0 Transition Update Report 11:15 (10m)

Lead: Natalie Davies, Executive Director of System Improvement and Transition Director - NHS Kent and Medway

□ *12.0 Front Sheet Transition Update Board Report Feb 020226.pdf*

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□ *12.1 Transition Update for ICB Board Feb 26 FINAL.pdf*

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13.0 Board Charter 11:25 (10m)

For Approval

Lead: Cedi Frederick, Integrated Care Board Chair - NHS Kent and Medway

□ *13.0 Board Coversheet - Board Charter and cultural pledges.pdf*

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□ *13.1 Appendix 1 - NHS K&M Board Charter version 2.pdf*

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□ *13.2 Appendix 2 - Board Pledges.pdf*

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14.0 Annual Emergency Preparedness Resilience and Response (EPRR) Assurance Ratings 11:35 (10m)

For Assurance

Leads:

- Ed Waller, Deputy Chief Executive and Chief Commissioning Officer
- Matthew Drinkwater, Deputy Director of EPRR - NHS Kent and Medway

 **14.0 Front Cover ICB LHRP EPRR Assurance 202526 Final Draft MD 190126.pdf**

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 **14.1 2025-26 EPRR Assurance NHS KM FINAL 201125.pdf**

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 **14.2 Assurance Process.pdf**

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15.0 Briefing note from the following Committees 11:45 (20m)

For Noting

15.1 Inequalities Prevention and Population Health Committee 12:05

For Noting

Lead: Gurvinder Sandher, Non-Executive Member - NHS Kent and Medway

 **15.1 ICB Board Update January 2026 IPPH.pdf**

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15.2 Integrated Care Partnership 12:05

For Noting

Lead: Ed Waller, Deputy Chief Executive and Chief Commissioning Officer

 **15.2 ICP Update for Feb Board.pdf**

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15.3 Improving Outcomes and Experiences Committee 12:05

For Noting

Lead: Dr Hugh McIntyre, Non-Executive Member - NHS Kent and Medway

 **15.3 IOEC Board Report Nov 25 v2.pdf**

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15.4 Productivity and Investment Committee 12:05

For Noting

Lead: Peter Harrison, Non-Executive Member - NHS Kent and Medway

15.5 Audit and Risk Committee 12:05

For Noting

Lead: Elizabeth Butler, Non-Executive Member - NHS Kent and Medway

15.5 NHSKM ICB Board Audit and Risk Committee Jan 26.pdf

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15.6 People Committee 12:05

For Noting

Lead: Angela McNab, Non-executive member - NHS Kent and Medway

15.6 Board report on People Committee 16 Dec 25.pdf

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16.0 Questions from members of the public pertaining to the agenda 12:05 (5m)

For Noting

17.0 Close 12:10

For Noting

KENT AND MEDWAY ICB BOARD

DECLARATIONS OF INTEREST REGISTER - FEBRUARY 2026



Kent and Medway

Name	Position	Role	Declaration of Interest	Type of Interest	Direct or Indirect	Date From	Date To	Mitigating Actions Taken
Members								
Cedi Frederick	Member of Kent and Medway ICB Board	Chair, ICB Board	<p>Owner of Article Consulting LTD Owner of Consiliaris Digital LTD with shareholding >5%* Co-Chair of Inspire for Black Londoners</p> <p><i>Collectively referred to as Sage Homes</i> Director of Sage Green Homes Limited Director of Sage Shared Ownership Limited Director of Sage Places Limited</p> <p>Health and Europe Centre Member of NHS Assembly Kent Ambassador Special Advisor – Housing and Inequalities, Good Governance Institute</p> <p>*Consiliaris Digital Systems Limited is a digital health tech start-up company limited by shares and it is a social enterprise. It is going through the legal and registration process and Social Enterprise UK is assisting and advising. The objective of Consiliaris Digital System Limited is to work with and within developing countries, primarily Africa to improve the health of disadvantaged communities. There are no interests or plans to work with the NHS</p>	<p>Financial Financial Non-Financial Professional</p> <p>Non-Financial Professional Non-Financial Professional Non-Financial Professional</p> <p>Non-Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional</p>	<p>Direct Direct Direct</p> <p>Direct Direct Direct</p> <p>Direct Direct Direct Direct</p>	<p>11/08/14 26/02/21 Jul-2023</p> <p>21/06/21 21/06/21 21/06/21</p> <p>06/07/22 10/07/23 26/10/23 Feb 25</p>	<p>Ongoing Ongoing Ongoing</p> <p>Ongoing Ongoing Ongoing</p> <p>Ongoing Ongoing Ongoing</p>	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Adam Doyle	Member of Kent and Medway ICB Board	Chief Executive Officer	<p>1. Spouse is a Headteacher of a High School in London. 2. Member of the Sciana, the Health Leaders Network which brings leaders in health and health care policy and innovation across Europe. The Sciana network is supported by a partnership between the Health Foundation (UK), Careum Stiftung (Switzerland) and the Robert Bosch Stiftung (Germany) in collaboration with Salzburg Global Seminar.</p>	<p>1. Non-Financial Personal 2. Non-Financial Professional</p>	<p>1. Indirect 2. Direct</p>	<p>1. Jul 2022 2. Jul 2022</p>	<p>1. Ongoing 2. Ongoing</p>	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Angela McNab	Member of Kent and Medway ICB Board	Non-Executive Member	<p>Non-executive Director and member of the Board at Dimensions (not for profit social care provider) Trustee of Discovery (not for profit social care provider – part of Dimensions Group) Shareholder in Rapidehealth (digital developer) Strategic Non-Decision Making Adviser to Director of Strategy - NHS Queen Victoria Hospital Trust Project Lead for the s.136 digitisation Member of the Independent Reconfiguration Panel which advises Sec of State on service reconfiguration/change Interim Chair of Queen Victoria NHS hospital</p>	<p>Financial Financial Financial Financial Financial Professional Professional</p>	<p>Direct Direct Direct Direct Direct Direct</p>	<p>Sept-2020 Jan-2021 Apr-2021 Aug-2023 Mar-2024 Jan-2026</p>	<p>Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing</p>	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Elizabeth Butler	Member of Kent and Medway ICB Board	Non-Executive Member	<p>Independent member of the Audit & Risk Committee of the General Dental Council Non-Executive Director Cora Healthcare Ltd (no shares) Trustee and Chair of Audit & Risk Committee Royal British Legion Special Advisor Risk & Finance to World Federation of Medical Education Principal EJ Butler Chartered Accountant Pension with PricewaterhouseCoopers Daughter is a clinical psychologist with Oxleas NHS Foundation Trust Son works for RSM Son works for Cooper Parry</p>	<p>Financial Professional Financial Professional Non-Financial Professional Financial Professional Financial Professional Financial Professional Non-Financial Personal Non-Financial Personal Non-Financial Personal</p>	<p>Direct Direct Direct Direct Direct Direct Indirect Indirect Indirect</p>		<p>Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing</p>	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Hugh McIntyre	Member of Kent and Medway ICB Board	Non-Executive Member	<p>Consultant Physician for East Sussex Healthcare Trust Frailty Lead East Sussex Healthcare Trust Editorial Board and Reviewer at The European Journal of Heart Failure, British Journal of Cardiology</p> <p>Medical Examiner at East Sussex Hospitals Trust</p> <p>Occasional Advisory Roles to Independent Healthcare and Pharmaceutical Companies</p>	<p>Financial Financial Non Financial</p> <p>Financial Professional</p>	<p>Direct Direct Direct</p> <p>Direct</p>	<p>01/10/1996 01/01/2017 January 2015</p>	<p>Ongoing Ongoing Ongoing</p> <p>Ongoing</p>	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.

Name	Position	Role	Declaration of Interest	Type of Interest	Direct or Indirect	Date From	Date To	Mitigating Actions Taken
Dr Jonathan Bryant	Member of Kent and Medway ICB Board	GP Partner Member	Primary Care Clinical Lead for Cancer, NHS Kent and Medway ICB Primary Care Medical Director, East Kent Health and Care Partnership GP Partner, New Lyminge Surgery GP Partner, White House Surgery Member Practice of Folkestone, Hythe and Rural Primary Care Network Clinical Director of Programme, Targeted Lung Health Checks, EKHUFT Clinical Director, Invicta Health CIC Representative, LMC, East Kent HCP Shareholder (< 5%) Channel Health Alliance Shareholder (< 5%) Invicta CIC Spouse is GP Partner at New Lyminge Surgery Spouse is involved in fundraising for Shine Cancer Support (registered charity) and Brainstrust (registered charity)	Financial Professional Financial Professional Financial Professional Financial Professional Financial Financial Professional Financial Professional Non-Financial Professional Financial Financial Financial Professional Financial Professional	Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Indirect Indirect	March 2023 Oct 2023 2013 2013 2018 2023 2023 2023 2016 2016 2013 2023	Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Ed Waller	Member of Kent and Medway ICB Board	Deputy Chief Executive and Chief Commissioning Officer	Lifetime Member, Diabetes UK Wife is employed by King's College Hospital FT	Non-Financial Personal Financial Professional	Direct Indirect		Ongoing Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Indiana Pearce	Member of Kent and Medway ICB Board	Chief People and Culture Officer	Work on behalf of NHS Surrey Heartlands, NHS Sussex and NHS Kent and Medway.	Non-Financial Professional	Direct	Jan-26	Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Participants								
Pauline Smith	Permanent Participant of Kent and Medway ICB Board	Voluntary and Community Sector Representative	Chief Executive, CXK Ltd	Non-Financial Personal	Direct	Feb 2017	Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Bali Rodgers	Permanent Participant of Kent and Medway ICB Board	People and Communities Board Champion	CEO of Safer Communities Alliance Founder Refocus Project Ltd - Crime prevention DGS - Patient Experience Forum Kent partnership Infrastructure support member	Financial Professional Financial Professional Non-Financial Personal	Direct Direct Direct Direct		Ongoing Ongoing Ongoing Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Natalie Davies	Permanent Participant of Kent and Medway ICB Board	Executive Director for System Improvement	Member of an Academy Trust (charged with overseeing Governance)	Non-Financial Personal	Direct	Dec 2022	Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.

Minutes of the Part 1 Kent and Medway Integrated Care Board

Date: Tuesday, 4 November 2025 at 10.00 am

Location: Board Room, Gail House, Lower Stone Street, Maidstone

Chair: Cedi Frederick

Present:

Name	Job title	Organisation
Cedi Frederick	Chair	ICB Board
Dr Jonathan Bryant	GP Partner Member	ICB Board
Elizabeth Butler	Non-Executive Member	ICB Board
Adam Doyle	Chief Executive	ICB Board
Ivor Duffy	Chief Finance Officer	ICB Board
Dr Lee-Anne Farach	Local Authority ICS Partner Member (Medway)	ICB Board
Peter Harrison	Non-Executive Member	ICB Board
Kate Langford	Chief Medical Officer	ICB Board
Paul Lumsdon	Chief Nurse	ICB Board
Dr Hugh McIntyre	Non-Executive Member	ICB Board
Angela McNab	Vice-Chair & Non-Executive Member (Chair)	ICB Board
Gurvinder Sandher	Non-Executive Member	ICB Board
Sheila Stenson	Community and Mental Health ICS Provider Partner Member	ICB Board
Ed Waller	Chief Strategy and Partnerships Officer	ICB Board
David Whittle	Local Authority ICS Partner Member (Kent)	ICB Board

Other attendees:

Name	Job title	Organisation
Mandy Cordwell	Notetaker	NHS Kent and Medway
Natalie Davies	Chief of Staff	NHS Kent and Medway
Mike Gilbert	Executive Director of Corporate Governance and Change-25 Transition Director	NHS Kent and Medway
Francesca Guy	Head of Corporate Governance – Committees	NHS Kent and Medway
Jackie Huddleston	Director of System Coordination, Kent & Medway, SCAS and Regional Oversight	NHS England (South East)
Bali Rodgers	People and Communities Champion	NHS Kent and Medway

Apologies:

Name	Job title	Organisation
Pauline Smith	Voluntary and Community Sector Representative	ICB Board
Jonathan Wade	Acute Hospitals ICS Provider Partner Member	ICB Board

Minutes:

Item	Minute	Action owner
1.0	<p>Welcome and introductions</p> <p>In addition to the welcome extended to everyone, the Chair, on behalf of the Board, welcomed Adam Doyle, recently appointed Chief Executive of the ICB, to the meeting. The Chair also offered a warm welcome to Jackie Huddleston, Director of System Coordination, Kent and Medway, SCAS and Regional Oversight, NHSE, who attended the meeting as an observer.</p>	

	<p>The Chair referenced the notice on meeting etiquette and informed members of the public that questions related to the meeting agenda would be taken at the end of the meeting.</p>	
2.0	<p>Apologies for absence</p> <p>Apologies for absence were NOTED.</p>	
3.0	<p>Quorum</p> <p>The Chair confirmed that the meeting was quorate.</p>	
4.0	<p>Declarations of members' interests</p> <p>Board members were asked to consider whether they had any additional interests to declare (or amendments required to their existing interests listed on the register), or any other relevant interest in connection with any item(s) on the agenda. If so, members should identify the relevant agenda item and the nature of their interest.</p> <p>The Chair NOTED that there were no declarations of interests raised over and above those already recorded and there were no conflicts of interest in respect of business covered by the agenda.</p>	
5.0	<p>Minutes of the previous meeting</p> <p>The Chair thanked Angela McNab for chairing the last meeting in his absence.</p> <p>The minutes of the previous meeting held on Tuesday, 2 September 2025, were APPROVED.</p>	
6.0	<p>Actions and matters arising</p> <p>Actions. The Board NOTED that the Commissioning Plan had been included on the Board Forward Planner. Ivor Duffy advised that an update on actions assigned to the Integrated Quality Performance Report would be provided under item 12 of the agenda.</p> <p>Matters Arising: The Board NOTED that there were no matters arising.</p>	
7.0	<p>A Focus on Digital Data and Technology Strategy</p> <p>The 'focus on' item allows the Board to undertake a deep dive into areas of significant concern or challenge for the ICB and the wider system. At this meeting, the focus was on the Digital Data and Technology Strategy.</p> <p>The Chair welcomed Vivek Singh, Chief Technology Officer, to the Board.</p> <p>Vivek Singh led the Board through the presentation titled 'Kent and Medway Digital, Data and Technology Strategy 2025–2029: A summary of our approach'. The presentation outlined the vision, priorities, and delivery plans for digital transformation across the system.</p> <p>At the end of the presentation, Board members were invited to consider and discuss the three questions detailed in the presentation which covered: key areas, challenges, and opportunities for embedding digital innovation, as well as how to align the digital agenda with system-wide strategies and priorities.</p>	

An update was sought by Paul Lumsdon on how the NHS app's usage would further enhance patient experience and the app's functionality expanded beyond repeat prescription ordering.

Key features of the NHS app, Vivek Singh responded, were enabled and driven nationally. At a local level, integration of patient portals for the population of Kent and Medway was crucial for increased utility and uptake. Vivek emphasised the importance of feature-rich integration and campaigns that would encourage a significant shift towards digital channels.

The need for a robust communications and engagement strategy to support digital adoption, to ensure the public was aware of the app's capabilities and improvements, was highlighted by Ivor Duffy.

Peter Harrison reflected that the strategy did not appear significantly different from previous versions that he had seen over the years and called for a clear, operational plan with visibility on solution components, particularly the Federated Data Platform. In addition, Peter emphasised the need for a disciplined execution, especially related to the decommissioning of legacy IT systems, to avoid repeated contract extensions.

The question of whether the timeline could be more ambitious and brought forward was raised by Gurvinder Sander, who emphasised the involvement of the voluntary sector, faith sector organisations and smaller groups that supported minority communities to develop the strategy.

In response to the feedback provided by Peter Harrison and Gurvinder Sandher, Ivor Duffy indicated that a more detailed plan would be presented to the Board in March. The plan would address the pace and ambition, and he confirmed ongoing efforts to engage charities and faith groups in its mobilisation.

The strategy was welcomed by Dr Hugh McIntyre, but he felt that the strategy was less ambitious than earlier drafts. Dr McIntyre emphasised the need for a unified system architecture to enable strategic commissioning and highlighted concerns about data quality and interoperability across Kent and Medway.

Clarification was sought by David Whittle on the balance between national and local mandates, the agility of governance to keep pace with sector developments and the investment profile, including ownership and decision-making over funding. In particular, would the investment profile match the strategy's ambitions?

Ivor Duffy explained that investment would be addressed in the forthcoming plan, with funding coming from both national sources and local organisations. Efforts were underway to harmonise contracts and set a strategic direction for collective action across the system.

Mental health, Angela McNab observed, was not sufficiently referenced in the strategy and they requested that future operational plans included examples relevant to this patient population, given the specific challenges and opportunities for digital in mental health.

Sheila Stenson echoed the need for digital to underpin system-wide outcomes and highlighted the importance of levelling up digital maturity across community and mental health services.

The question of whether lessons had been learned from previous attempts to deliver integrated patient records, was raised by Elizabeth Butler, who also

raised concerns about practical issues with the NHS app, such as access when changing GP practices.

Kate Langford described the progress of tagging patients (grouping patients by needs) and making care records visible across providers. In terms of a reach across social care, Kate Langford added that the integration of social care data was a governance challenge rather than an insurmountable barrier.

The link with social care was also raised by Dr Lee-Anne Farach, who highlighted the risk of social isolation for those unable to engage digitally. Dr Farach questioned whether dual systems would be required for the foreseeable future.

Ivor Duffy responded that some social care data was already included in datasets and that plans always considered those less digitally enabled.

Whilst he supported the strategy, Dr Jonathan Bryant emphasised the mission-critical nature of system reliability and cited the number of lost appointments due to system failures.

Bali Rodgers advocated for early and ongoing involvement of patients and communities in the strategy's development. Bali highlighted the importance of personal insights and the challenges patients faced in managing their own information across different systems.

The Chair agreed that community voices must influence the process from the outset, not as an afterthought.

Prior to concluding the discussion, the Chair invited the Chief Executive to reflect on the presentation and subsequent discussion.

The Chief Executive expressed appreciation for the work undertaken to develop the strategy and asked that the Board's thanks be passed on to all involved. Four main areas were identified for further consideration by the executive group:

1. **Credibility and Pace:** The Chief Executive noted a gap between the pace of ambition discussed and the practical realities of delivery, and emphasised the need to clarify what could realistically be achieved within a one to three-year cycle.
2. **Community Engagement:** It was highlighted that engaging communities from the outset was essential, and consideration should be given to how this could be collectively framed going forward.
3. **System Governance and Agreement:** The Chief Executive observed that, while the presentation was delivered on behalf of all chief information officers, there was a need to ensure collective agreement and sign-off from relevant organisations to provide assurance. Attention would be given to system governance and the reasons why the current plans had not yet received full endorsement.
4. **Clear Narrative:** The importance of developing a clear and understandable narrative for the strategy was emphasised, both for internal stakeholders and, most importantly, for the wider community.

The Chief Executive concluded by stating that the executive group would reflect on how best to describe and communicate the strategy going forward, and reiterated his thanks to Vivek Singh and all contributors for their efforts.

At the end of the discussion, the Chair thanked, on behalf of the Board, Vivek Singh and the team for their work to date on producing the strategy, and looked forward to further presentations to the Board. In addition, the Chair acknowledged the importance of the points raised by the Board and indicated

	<p>that further discussions would be held as the Board continued to focus on strategic commissioning.</p> <p>ACTION:</p> <ul style="list-style-type: none"> • A more detailed operational plan, which included an update on the investment strategy, pace and ambition, to be presented to the Board in March 2026. 	Ivor Duffy / Vivek Singh
8.0	<p>Questions from members of the public pertaining to the focus item</p> <p>Question raised during the meeting by Cllr Angela Harrison: How would the Board ensure that people who are digitally excluded—whether due to poverty, lack of access to devices, or other barriers—are not left behind as digital health services expand? The concern expressed by Cllr Harrison was that a two-tier health service would be created, with some able to access digital tools and others unable to do so.</p> <p>Ivor Duffy confirmed that all future plans and strategies would include measures to ensure no one was left behind. The Board was committed to bringing everyone along, which included those who were currently digitally excluded, and would continue to work with partners to address these issues.</p> <p>Written questions received in advance of the meeting from Paul Stephens. Ivor Duffy explained that detailed responses to Paul Stephen's questions had been provided on the website.</p> <p>Question 1: Quality of data is very important to enable the plan to work, historical data is locked in PDFs in GPs data repositories, Kent EMS. A recent national report by Healthwatch estimated that 26% of patient data is inaccurate and some do not even relate to that patient, some is even missing. Data is key to enable future systems to be effective and timely especially in respect of prevention. As we move forward it is hoped that data accuracy will improve. What is being done to ensure historical data of yesterday and in the past is accurate and what measures will be in place to ensure accuracy is a cornerstone for the future?</p> <p>Three key actions outlined by Ivor Duffy included:</p> <ul style="list-style-type: none"> • Clinicians were being enabled to use data to review practice records, quickly highlighting and remedying data issues. • Software is being trialled to review entire clinical records and flag issues for rapid correction. • The four acute providers have formed a joint clinical coding group to improve data quality within clinical records across acute trusts. <p>Question 2: How will you ensure there are fallback systems to ensure 'continuity of business/service', recent high-profile systems have been taken down because of a system failure (simple aspect of IP address server failure for example) or a cyber-attack. This becomes very important when virtual beds are being monitored and systems go down. It is a dynamic process that needs real time data and could result in deaths if not managed.</p> <p>Ivor Duffy stated that business continuity and cybersecurity were central to commissioning decisions. Organisations were required to have high-level business continuity, cyber policies, and systems in place. The Board has adopted a zero trust security model and Defender One principles across the region. Cybersecurity was being addressed both strategically and operationally to ensure patient safety was not compromised.</p>	

9.0	<p>Chair's Report</p> <p>In his verbal update to the Board, the Chair stated that he had been invited and had accepted the opportunity to continue in his role of Chair for a further three years.</p> <p>With the renewal of the Chair's appointment and the recent appointment of Adam Doyle as Chief Executive, the Chair considered that the Board had a refreshed mandate moving forward. The Chair informed the Board that Adam Doyle's appointment had been very well-received by staff.</p> <p>Reflecting on the past three years, the Chair acknowledged that significant work had been undertaken by the organisation, the Board and the wider system, but he emphasised the need to accelerate progress.</p> <p>The Chair observed that, although the past few years had been challenging, the introduction of the ICB blueprint, the regional group blueprint, and the medium-term plan had provided much greater clarity for the organisation. He emphasised the importance of using these developments to fundamentally reshape the organisation and contribute to wider system transformation.</p> <p>The Board was updated on the Chair's continued ongoing discussions with the chairs of local trusts, which noted a shared recognition of the need to do things differently to deliver high-quality, consistent, and safe care for the people of Kent and Medway. The Chair referenced the Integrated Quality and Performance Report to be presented later in the meeting that highlighted areas that required improvement and set the agenda for future work.</p> <p>Since the Board had last met, most of the meetings attended by the Chair had been internal and related to reorganisation. The Board's attention was drawn to the Black History Events that the Chair had participated in across Kent and Medway and London. The Chair expressed pride in the work being done by trusts to recognise Black History Month and the support for staff voices and allies across the system.</p> <p>The Chair confirmed his appointment as the chair of the NHS Kent and Medway joint committee. The joint committee would continue to work with the Chief Executive and senior colleagues to coordinate efforts across the system.</p> <p>Finally, the Chair expressed, on behalf of the Board, thanks to Paul Bentley for his service as Chief Executive of the ICB over the past three years.</p> <p>The Board NOTED the verbal update presented for INFORMATION.</p>	
10.0	<p>Chief Executive's Report</p> <p>The Chief Executive introduced and summarised the report, which was presented to the Board for INFORMATION.</p> <p>Reflecting on his initial weeks since he joined the organisation on 15 October 2025, the Chief Executive expressed his sincere gratitude for the warm welcome received from colleagues, staff and partners across the organisation and system.</p> <p>The Chief Executive was candid to the Board about the significant challenges the organisation faced and had identified four key areas:</p>	

<p>1. Financial Position: The financial situation was described as very serious, with substantial shortfalls in the current year's plan and ongoing deficits from previous years.</p> <p>2. Operational Pressures: Elective waiting lists were reported as high and rising faster than in comparable regions. There was also an increase in the number of patients waiting in corridors and for over 12 hours in emergency departments, exceeding expected levels for the time of year.</p> <p>3. Culture and Leadership: The Chief Executive referenced the need for cultural change, particularly in leadership across the system. Feedback from staff engagement events indicated a requirement to address how leadership was experienced and delivered, with a commitment to call out poor behaviours and foster a more positive culture.</p> <p>4. Governance: Internal and external governance arrangements were described as sometimes confused, duplicative, and lacking clear purpose. The Chief Executive emphasised the need for greater clarity and alignment in decision-making structures.</p>	
<p>Despite these challenges, the Chief Executive expressed confidence in the ability to address them, and drew on his personal previous experience in similar situations. The importance of honesty and openness was emphasised, and he invited scrutiny and challenge from Board members to ensure a shared understanding of the issues and a collective commitment to improvement.</p> <p>The report also highlighted the need for a system improvement plan and called for clarity on system-wide improvement objectives and governance structures.</p> <p>Attention was drawn to ongoing system performance reviews, which included recent month 6 reviews with NHS England for all acute trusts and the ICB. The Chief Executive noted a focus on winter preparedness, with early warning signs in care pathways being closely monitored.</p> <p>The Chief Executive also referenced the new medium-term planning requirements, and described them as an opportunity for the organisation and system to reset and clarify objectives. The intention was to implement a three-year transformation programme focused on reset, recovery, and transformation.</p> <p>In closing, the Chief Executive reiterated a commitment to learning, transparency, and collective action, and welcomed questions, comments, and observations from Board members.</p> <p>The Chair invited questions and comments. Peter Harrison thanked the Chief Executive for their candour and transparency; concepts, he reflected, which were warmly welcomed.</p> <p>The Board NOTED the Chief Executive's report.</p>	

11.0 Month 6 Board Finance Report

Ivor Duffy summarised the month 6 Finance report, presented for **ASSURANCE**, to the Board.

The month 6 financial position for the ICB and system reported a year-to-date variance of £11.7m, primarily driven by Medway NHS Foundation Trust (MFT) and the ICB.

Savings of £142m had been delivered, but a significant proportion was backloaded to the latter part of the year, which resulted in a flagged system risk of £144m to NHSE.

Although agency spend was better than planned, bank spend was over budget, and overall staffing costs had flatlined rather than reduced as planned.

The financial pressure was expected to increase towards year-end. A risk-adjusted forecast and a roadmap to break-even had been developed, which required further stretch plans and difficult decisions required to meet NHSE's expectations. All actions would be subject to the appropriate governance and equality impact assessments (EQIA).

Medicines optimisation in primary care to manage the high and growing cost of medicines, Kate Langford explained, was one area of focus to ensure that patients received the most clinically effective and cost-effective treatment. Efforts were underway to maximise value and repurpose incentive schemes for prescribing, the aim being long-term savings whilst managing immediate budget pressures. Kate Langford commended the team's agile response to the challenges they had been set.

Dr Hugh McIntyre queried how the impact of financial decisions on quality and performance would be made visible to the Board. Ivor Duffy responded that organisations would conduct EQIAs for any proposed changes, and outcomes would be reviewed at both provider and system level. Paul Lumsdon added that EQIAs were reviewed by himself, Kate Langford and the relevant service, and would be presented through the Improving Outcomes and Experience Committee. Provider changes would be reviewed by their respective boards.

In providing an update on governance and delegation, the Chief Executive reported that the Financial Recovery Group had been refreshed to clarify internal statements and drive progress towards the agreed £12 million surplus plan. Interim plans were being developed across the system, with NHS providers required to do likewise. Meetings with Chief Finance Officers were being held to assess financial risk and exposure, with financial recovery plans to be written for NHS Kent and Medway. The scheme of reservation and delegation would be reviewed to ensure appropriate committee oversight and Board visibility of re-forecasted plans.

Reassurance was sought by Elizabeth Butler that mechanisms existed for making difficult decisions. She expressed concern about the drive and determination to act rather than continually reforecast. The Chief Executive acknowledged the challenge, noting that gaps remained in the financial plan and that both tactical and strategic decisions would be required. He emphasised the need for thoughtful action, balancing quick cuts with long-term sustainability, and highlighted the exposure from acute contracting. The executive team was tasked with bringing options within two weeks for Board discussion.

The Chair raised the issue of delegation for urgent decisions, noting that the timing of Board meetings might not align with decision-making needs. The Chief Executive confirmed that the scheme of delegation was under review to ensure decisions were made with appropriate visibility and assurance.

Clarity on the respective responsibilities of trusts and the ICB, given recent half-year reviews, was sought by the Chair. The Chief Executive explained that trusts were accountable for delivering agreed plans within their affordability envelopes, with deficit support funding contingent on meeting targets. The ICB was responsible for living within its contracted budget and holding providers to account for commissioned services. A new contracting approach was being

	<p>developed to clarify under-commissioning and non-delivery, to ensure accurate diagnosis and targeted action.</p> <p>The Chair concluded that all organisations within the system had committed to deliver, and the expectation was that they would take necessary actions to meet those commitments.</p> <p>The Board NOTED the Month 6 Board Finance report.</p>	
12.0	<p>August 2025/26 ICB Integrated Quality and Performance Report</p> <p>Ivor Duffy introduced the Integrated Performance Report (IPR) for August 2025/26 to the Board for ASSURANCE.</p> <p>As previously advised, the Board NOTED that Board sub-committees had considered and discussed performance issues in detail and any concerns, as appropriate, would be escalated through the respective sub-committees chairs' reports.</p> <p>Key areas of concern and improvement were highlighted and Ivor Duffy invited executive colleagues to contribute, where appropriate, to the update and subsequent discussion.</p> <p>Areas of concern included diagnostic six-week waits, 65+ week waits, and the significant financial challenges within the ICB. Positive performance was noted in A&E four-hour targets and reductions in 18-week waits. The report also included counter-measure summaries, which detailed the actions taken to address performance.</p> <p>Ed Waller explained the approach in response to the NHSE aim to eliminate 65-week waits by 21 December 2025, and highlighted the operational plans with acute trusts and emphasised the importance of mutual aid between trusts. Out of the three trusts in Kent and Medway with 65-week waits, whilst two trusts aimed for zero 65-week waits, challenges remained at MFT, particularly in ENT. Ed emphasised the importance of ongoing vigilance beyond the deadline and outlined plans to address risk cohorts and to reduce 52-week waits.</p> <p>Diagnostic pressures were attributed to increased demand in audiology and cardiology. Within audiology, the service delivery element was related to a 'look back' at paediatric audiology in some of the trusts in Kent and Medway, as part of a national programme, and capacity issues at MFT related to ENT. Cardiology service delivery elements were compounded by workforce shortages and increased demand. Endoscopy performance had been driven by the inability to shift patients to alternative pathways as planned.</p> <p>Within primary care, Ed Waller reported progress against long waits for dental procedures under general anaesthetic, with additional capacity being provided. Another area of success recorded was related to the number of general practice appointments provided within 14 days. For those general practices where underperformance had been identified (20 practices), support measures had been implemented, which included participation in the South East Region Project 100 programme (a programme that provided tailored support to general practice to make changes and improvements).</p> <p>The reasons behind the increased twelve-hour waits, particularly at East Kent Hospital University NHS Foundation Trust (EKHUFT) were queried by Angela McNab. Paul Lumsdon noted a rise in attendances and the use of temporary escalation areas and added that all trusts had activated winter plans to manage urgent care pressures. Schemes included prevention, hospital at home, virtual</p>	12

wards, and protocols to ensure patient safety and dignity in temporary areas. Ed Waller added that rising influenza rates might be a contributing factor to increased attendances.

Dr Hugh McIntyre cautioned against a trade-off of four-hour targets at the expense of longer waits, and he urged the executive and quality teams to monitor the potential for harm during winter pressures.

Attendances and patient acuity, the Chief Executive confirmed, had increased (attendances up by 2.2%). The three main issues that he felt that had affected flow were: delayed discharge before midday, waits for adult social care and onward NHS care, all of which had increased recently. He stipulated that improved analysis and data-driven action would be included in future reports, and the distinguishing of commissioner responsibilities from provider expectations.

The Chair questioned whether the report provided sufficient assurance to the executive, noting the need for improvement in future iterations. The Chief Executive stated that he was not wholly assured by the report in its current format and emphasised the need to refine the report in order to provide clear actions and accountability.

Social care capacity and the role of local authorities to reduce delayed discharges was raised by the Chair. The Chief Executive and Ed Waller described the ongoing work with councils and partners to optimise bed capacity and care packages, particularly at MFT and in mental health. Structural challenges in residential care home beds were noted, and efforts to improve joint working and trusted assessment models in mental health were being discussed with both local authorities and Kent and Medway Mental Health NHS Trust (KMMHT).

The Chair also asked about engagement with external providers that had offered solutions. Whilst Paul Lumsdon confirmed his openness to offers of help from external providers, Ed Waller emphasised the priority to optimise existing capacity before external options were considered.

The Board **NOTED** the August 2025/26 Integrated Performance Report.

13.0	<p>Planning Update</p> <p>Ed Waller introduced the report presented to the Board for INFORMATION.</p> <p>With reference to the recently published medium-term planning framework, the Board NOTED that for the first time in several years, the organisation would be able to undertake medium-term planning for the next three years, supported by a strategic 10 year plan strategic plan.</p> <p>Ed Waller outlined the quantitative ambitions for delivery and described the financial allocations: three years for revenue and four years for capital. Initial submissions were scheduled for December, with final submissions due in February 2026. These would encompass both operational planning for 2026/27 and a medium-term vision for system development.</p> <p>Unlike previous years, organisations within the system would submit their own plans directly to NHSE, while internal work would ensure alignment across trusts and the ICB. Ed Waller emphasised the importance of clinical change and quality of care, and referenced the commissioning intentions document,</p>	
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<p>which, although delayed, had been drafted and shared with system colleagues to guide detailed planning discussions.</p> <p>The longer planning timeframe was welcomed by Kate Langford, who observed that the redesign of clinical services in line with the ten-year plan required more than a single year to achieve meaningful change. Kate Langford highlighted the opportunity to strengthen out-of-hospital services to relieve pressure on acutes.</p> <p>The Chair acknowledged the report and raised the issue of system transformation over the next three years. He expressed reservations about the term 'transformation', and questioned whether its full implications were understood. The Chair queried whether commissioning intentions should be set for three years, rather than one, to provide a clear direction for resource allocation and to avoid destabilising the acute sector.</p> <p>Ed Waller responded that the commissioning intentions document did indeed have a longer time horizon, but was also time-critical for operational planning in the coming year. He described the axes of transformation outlined in the ten-year plan and planning framework, which included neighbourhood health initiatives and pathway redesign to improve patient journeys. Ed Waller cited opportunities for service redesign in areas such as Musculoskeletal health (MSK), dermatology, and community services, all of which were addressed in the commissioning intentions draft.</p> <p>The Chair reiterated the need for the organisation to 'go further and faster', and sought assurance that the ICB was committed to accelerated progress. Progress over the previous three years had been limited and he emphasised the importance of using the new framework to drive improvement.</p> <p>Leveraging data and digital technologies, the Chief Executive stated, to inform decision-making and to rebuild strategic commissioning capability had to be conducted at pace. He emphasised the need for commitment from all provider organisations and local partners, and highlighted the importance of cultural and governance changes to support transformation. The first year, the Chief Executive suggested, should focus on stabilisation and resetting, while building a transformation programme for agreement and implementation within the three-year timeframe.</p> <p>In concluding the discussion, the Chair reflected that the assurance sought by the Board was an understanding of the direction for years two and three, and welcomed the opportunity to reset the conversation with the arrival of the Chief Executive. On behalf of the Board, the Chair thanked the Chief Executive and Ed Waller for their contributions.</p> <p>The Board NOTED the Planning update.</p>	
<p>14.0 Change-25 ICB Transition Programme – Highlight Report</p> <p>The Board considered and discussed the report presented by Mike Gilbert for ASSURANCE.</p> <p>Key points of the report were highlighted to the Board and comments and observations invited.</p> <p>The ongoing uncertainty regarding funding for redundancies and the future direction of the reorganisation remained. Despite this, the organisation continued to work collaboratively with NHSE, regional partners and local South East ICBs on scenario planning for changes, both with and without additional funding.</p>	

<p>Work to streamline governance arrangements had commenced, with a focus on functions that might be shared across more than one ICB and the prioritisation of such collaborative efforts.</p> <p>The executive team structure consultation had commenced and the process was expected to be brief with the outcome anticipated by the end of the year.</p> <p>Mike Gilbert reflected on and emphasised the ongoing uncertainty and anxiety experienced by staff. The range of support available to line managers, senior leaders and staff potentially affected by organisational continued to expand, and included both immediate support and preparation for opportunities outside the organisation.</p> <p>Whilst Elizabeth Butler acknowledged the sensitivity of the issue, she sought clarification on the steps and safeguards put in place to ensure fair and transparent treatment of staff, particularly for those members of staff with protected characteristics, throughout the process.</p> <p>In his response, Mike Gilbert outlined several actions that had been undertaken:</p> <ul style="list-style-type: none"> • The programme had commenced with an Equality and Quality Impact Assessment (EQIA), with further assessments conducted, which included one linked to the Mutually Agreed Resignation Scheme (MARS). • The organisation continued to work closely with staff networks and the insight and involvement group, as well as trade union colleagues, to ensure inclusive decision-making. • Lessons learned from previous reorganisations were being incorporated, and the Cultural Review action plan was being used to identify and implement necessary adaptations. • Transition directors had engaged with other ICBs to share and adopt best practices. <p>The Chair expressed satisfaction with the employment hub initiative and enquired whether opportunities offered by the Kent Housing Association were being routed through CSK. Mike Gilbert confirmed that such opportunities were being considered by the People and Culture workgroup, and that external agencies had graciously offered support to staff.</p> <p>The Board NOTED the Change-25 ICB Transition Programme – Highlight Report.</p>	
<p>15.0 ICB Freedom to Speak Up (FTSU) Mid-Year update and Freedom to Speak Up Policy</p> <p>The Chair, on behalf of the Board, welcomed Joy Fuller, recently appointed Interim FTSU Guardian to the meeting. Mike Gilbert introduced the mid-year FTSU report, which covered the period from 1 April to 30 September 2025. He highlighted the alignment of FTSU work with the ongoing Cultural Review and its Implementation Steering Group. The Board NOTED that recommendations from the report would be integrated into the broader cultural action plan.</p> <p>Joy Fuller presented the report and summarised the following key points:</p> <ul style="list-style-type: none"> • Seven concerns had been raised with the Guardian or Ambassadors during the reporting period; all were considered closed, as they had been resolved through local resolution or signposting. 	

- The main themes of concerns included breakdowns in relationships between colleagues and line managers, and issues relating to HR processes. All concerns had been escalated appropriately for review and resolution.
- The FTSU Guardian and Ambassadors had undertaken a range of engagement activities, which included team meetings, staff network events, and participation in the Cultural Review and Change 25 programmes, to promote a culture of speaking up.
- Priorities for the next six months included further raising the profile of FTSU, expanding the Ambassador network and supporting the implementation of cultural review actions.
- The report concluded with several recommendations, which included early intervention in relationship breakdowns, targeted training for managers, promotion of open communication, and continued investment in staff networks.

Gurvinder Sandher queried whether data was kept on the grades of staff who had raised concerns. From his experience in other sectors, issues often arose at lower management levels. Joy Fuller responded that, while individual bandings were not recorded (to preserve anonymity), staff group data was reported nationally. The Board were advised that ongoing work to simplify and clarify routes for raising concerns, which included the development of a one-page infographic.

Both Gurvinder Sandher and Bali Rodgers raised the importance of ensuring all staff, regardless of grade or background, felt confident to speak up. Mike Gilbert agreed and emphasised the need for psychological safety and reassured the Board that raising concerns would not impact staff futures, particularly during organisational change.

Angela McNab and Sheila Stenson questioned whether the reduction in concerns raised was linked to organisational changes, and sought assurance that the situation would continue to be monitored. Angela McNab also endorsed the recommendations and suggested that encouragement for training in resilience and conflict resolution should be strengthened and potentially linked to appraisals and objectives.

The report's recommendations on training were strongly endorsed by Elizabeth Butler, who highlighted the need for investment in developing managers' skills and expressed concern that training budgets were often vulnerable to financial cuts.

The Chair acknowledged the challenge of delivering training within budget constraints and suggested that a range of delivery methods be considered. The Chief Executive agreed to take away the broader question of expectations for good management and how best to support leadership development across the organisation.

In consideration of the report's recommendations, Joy Fuller explained that changes to the FTSU policy were solely related to updated contact detail.

Subject to strengthened commentary around staff being encouraged to undertaken training, the Board **ENDORSED** the recommendations of the FTSU Mid-Year report and **APPROVED** the updated FTSU policy.

16.0	<p>Briefing Notes from the following Committees</p> <p>Briefing notes provided by the Board's sub committees were presented to the Board for INFORMATION:</p>	
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16.1	<p><u>Inequalities, Prevention and Population Health Committee (IPPHC):</u> The committee, Gurvinder Sandher advised, had been assured by the work being undertaken in maternity, although the committee had suggested specific targeted work to further improve maternity outcomes for Black, Asian and minority ethnic women. The Chair offered to share the learning that he had obtained from work undertaken in London that he had been involved in.</p> <p><u>Improving Outcomes and Experience Committee (IOEC)</u> Dr Hugh McIntyre thanked Angela McNab, who had chaired the last meeting in his absence. The Board NOTED that, as per Sheila Stenson's feedback, the Assertive Outreach had not yet been implemented and was scheduled to be implemented in February 2026.</p> <p><u>Productivity and Investment Committee (PIC):</u> To supplement the report presented, Peter Harrison provided an update on the subsequent meeting attended by both the Chair and Chief Executive. The Chief Executive had acknowledged the escalated concerns, and both Peter Harrison and the Chief Executive recognised the committee's improved alignment.</p> <p><u>People Committee (PC):</u> Angela McNab confirmed that there was nothing further to share or escalate to the Board.</p> <p>The Board NOTED the Briefing Notes from committees.</p>	
17.0	<p>Questions from members of the public pertaining to the agenda</p> <p>The Chair invited questions from members of the public related to the agenda.</p> <p>Cllr Angela Harrison acknowledged the organisation's current financial situation and questioned whether the strategic plan for Kent and Medway was designed to ensure the financial success of local trusts and expressed apprehension that the region might be supporting London trusts by routinely sending patients there. Whilst the principle of patient choice was acknowledged, Cllr Harrison observed that, in practice, referrals to London trusts were often initiated by consultants rather than by the patient. She emphasised the high calibre of clinicians in Kent and Medway and suggested that efforts should focus on strengthening local services rather than to the benefit of external organisations. Cllr Harrison concluded by asking whether the primary objectives should be to reinforce the resources and capabilities within Kent and Medway.</p> <p>Ed Waller acknowledged that there were valid clinical reasons why patients from Kent and Medway received care in London trusts, particularly where specialist (tertiary) centres in London provided the closest or most appropriate treatment. He emphasised that it was important to retain access to such centres for those patients who needed their services. However, he agreed that the system could do more to support patients to make informed choices, such as better information to advise patients about the services available within Kent and Medway. He highlighted the need to ensure that local services were as attractive as possible, for example by addressing waiting times.</p> <p>Looking to the future, Ed Waller suggested that the system should consider which services currently accessed in London could potentially be provided within Kent and Medway. He cautioned against being overly ambitious or extending beyond what was feasible, but recognised that there were areas where local provision could be improved, to reduce the need for patients to travel. He concluded that these considerations should form part of ongoing transformation plans for the region.</p>	

	The Chair thanked Cllr Harrison for her question and Ed Waller for his response.	
18.0	Close The Chair thanked members of the Board, Executive Directors and members of the public who had attended the meeting (in person or virtually) and closed the meeting.	

Cedi Frederick

Chair

NHS Kent and Medway Integrated Care Board
Action log - February 2025

Action ref.	Item (ref. minutes)	Date	Action	Lead	Deadline	Progress	Status	Date closed
05/25	7.0 A Focus on Digital Data and Technology Strategy	04/11/2025	A more detailed operational plan, which included an update on the investment strategy, pace and ambition, to be presented to the Board in March 2026.	Ivor Duffy / Vivek Singh	Mar-26	On forward planner for March 2026 Board meeting.	Open	

Chair's Report – For Information

1. Introduction

1.1. The purpose of my report is to update the Board on my reflections regarding our organisation, the wider Kent and Medway health and care system, and developments across the NHS. Since the November 2025 Board meeting, most of my focus has been on internal support for the organisation, alongside participating in NHS England and NHS Confederation discussions related to national changes affecting the NHS and ICBs.

2. My Personal Reflections on 2025

2.1. For this first report of the year, I want to reflect briefly on 2025 – a year of significant national policy change and operational pressure across the NHS. During the year, a number of major national initiatives and reforms were introduced, including:

- The Government's Fit for the Future 10-Year Health Plan for England
- The decision to bring NHS England into the Department of Health and Social Care, alongside a major reduction in ICB running costs and the introduction of ICB clustering
- The Model ICB Blueprint
- The Model Region Blueprint
- The Medium-Term Planning Framework
- The Strategic Commissioning Framework
- A series of funding, digital and contracting changes impacting primary care, workforce, acute, mental health, community, voluntary sector, community pharmacy and dental services

2.2. All of this took place alongside stretching in-year operational and statutory requirements.

2.3. In my end-of-year message to staff, I acknowledged that 2025 was a demanding period for our organisation and our people. Some challenges were within our control, and we must learn from them. Others were driven by national decisions and uncertainty that affected the entire NHS.

2.4. Much of the year was spent managing the impact of bringing NHSE into DHSC and the requirement to reduce ICB running costs by around 50%. Understandably, the prolonged uncertainty created anxiety for staff while they continued to deliver against significant performance expectations.

2.5. Throughout, I consistently thanked colleagues for their commitment to their roles, to this organisation, and to the Kent and Medway system. Their professionalism has been



exceptional. As we reached the end of the year, we were finally able to move forward with clarity on the organisational restructuring.

- 2.6. On behalf of the Board, I want to formally thank Mike Gilbert for his leadership as Transition Director during this period. Mike retired in December 2025 with our sincere appreciation.

3. Looking Forward

- 3.1. The Board has already heard, and will continue to hear, about the strategic clarity now established for the ICB and our wider system. The Reset, Recovery and Transformation programme provides a robust, evidence-based System Improvement Plan that is both challenging and achievable, and has the support of our NHS partners and NHS England.
- 3.2. I can confirm that I am now chairing the NHS Joint Committee responsible for overseeing collective delivery of this plan.
- 3.3. An essential part of our work as we move forward is supporting the newly formed Executive Team and our new Chief Executive Officer as they lead the organisation into its next phase. Ensuring they have the right environment, governance, and system relationships to succeed is a key priority for us all.
- 3.4. The responsibility for delivery sits with all of us. The task ahead is significant, but it also represents an important opportunity for the system to reset and move forward with renewed purpose.

4. Supporting our BAME Colleagues

- 4.1. Board members will be aware of the tensions experienced locally and nationally following the “Operation Raise the Colours” campaign and associated demonstrations. These events created understandable concern, particularly among ethnic minority communities. Many of us have heard directly from staff and community groups about their experiences, both online and in public spaces.
- 4.2. On behalf of the NHS, I attended meetings convened by the Medway African and Caribbean Association, bringing together local authorities, Kent Police, the voluntary sector and others to support reassurance within communities. Following this, I convened a dedicated NHS-focused meeting with Kent Police and NHS colleagues from across Kent and Medway.
- 4.3. Kent Police have been consistently supportive and constructive. However, it is clear that approaches to supporting NHS staff who experience racial abuse vary across organisations.
- 4.4. We have agreed to prioritise work to develop a consistent, system-wide approach so that staff receive timely, coordinated support regardless of where they work. While tensions have eased recently, we must remain prepared and ensure robust processes are in place should circumstances change.

5. Governance

- 5.1. As previously reported, national expectations are that ICB governance arrangements will need to be streamlined and proportionate following organisational restructuring. Over recent weeks, I have met with Committee Chairs and members of the Executive Team to

consider how we ensure our future governance model is efficient, effective and aligned with national direction.

- 5.2. These discussions have been constructive, focused on ensuring strong assurance and clear decision-making while reducing unnecessary complexity. I will bring final proposals for the Board's consideration at our March meeting.

CEO Report – Reset, Recovery and Transformation

1. Introduction

- 1.1. A major area of focus since the November Board meeting has been the re-forecasting of our financial position as an ICB and across the wider Kent and Medway system. Working closely with NHSE and system finance colleagues, we have refreshed our expected outturn for 2025/26, reviewed underlying cost pressures and demand trends, and aligned activity planning assumptions for 2026/27. This more accurate financial baseline is now underpinning our system planning, risk assessment and recovery conversations.
- 1.2. Alongside this, I have worked the with the executive team to focus on strengthening operational delivery, improving the quality and discipline of our commissioning approach, supporting system partners through critical operational challenges, and advancing the organisational restructure that positions us to operate as a modern strategic commissioner. On 26 January, we formally launched our organisational consultation. During this period, I also reshaped elements of the executive leadership team, attended the Q2 NHSE Assurance Meeting, commissioned an external review of procurement and contracting, and represented the ICB at both Kent County Council HOSC and Medway Council HASC.
- 1.3. A continued priority has been visible system leadership, and I undertook a number of service visits including to Maidstone community mental health services, the Medway Emergency Department (ED), and Estuary View Medical Centre. These visits offered clarity on the lived experience of frontline staff and patients, and fed directly into the commissioning and transformation actions outlined below.

2. Pillar 1 – Commissioning to Deliver Operational Performance and Robust Planning

- 2.1. Commissioning work this period has centred on strengthening the system's operational performance. Nowhere has this been more pressing than in East Kent, where the internal flow challenges at the William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) have required sustained, detailed coordination between commissioning, clinical leadership and provider teams. Both hospitals continue to face high levels of demand, with prolonged waits, complex clinical needs, and significant discharge delays creating an unstable operational environment.
- 2.2. These pressures have challenged the consistency of clinical standards during the first 48 hours of hospital care – a critical period for safety and flow. Our focus has therefore been on improving escalation discipline, strengthening frailty and respiratory pathways, and ensuring that front-door processes are capable of reducing avoidable admissions.



- 2.3. Our commissioning and clinical teams are now working directly with NHS England to provide enhanced support to WHH and QEQM. This includes strengthened joint oversight of improvement plans, targeted work to reduce long-stay patients, stabilising same-day emergency care, and improving the interface between acute, community and primary care services. This work is aligned with system-wide actions to increase the capacity of neighbourhood teams, improve community pathways, and unlock flow across the wider system.
- 2.4. Alongside this urgent care work, the system has initiated a Quarter 4 Electives Recovery Sprint, bringing together providers, commissioners and system improvement teams to accelerate progress on the elective backlog. The sprint is focused on theatre utilisation, outpatient productivity, improved demand-and-capacity planning, and better use of community diagnostic and day-surgery capacity. This work is running at pace across all providers with strengthened escalation and assurance.
- 2.5. Primary care commissioning has also moved forward. The early findings from the National Association of Primary Care (NAPC) review of primary care in Kent and Medway have highlighted a need for clearer estates planning, stronger MDT capability and more consistent operating models across practices. This is directly informing our neighbourhood development approach, commissioning intentions, and future investment priorities.
- 2.6. A major commissioning priority this period has been the transfer of children's mental health services from North East London NHS Foundation Trust (NELFT) to Kent and Medway Mental Health NHS Trust (KMMH). This significant and sensitive transition is designed to achieve better clinical governance, improved local alignment, and stronger continuity of care for children and young people. The transfer is being overseen closely by the Deputy Chief Executive, supported by detailed monitoring of workforce movements, caseload transfers, safeguarding considerations, risk management, digital readiness, estates implications and communication with families and referrers. Ensuring a safe, stable and high-quality transition remains a central commissioning requirement.
- 2.7. My service visits have reinforced these commissioning actions. The Medway Emergency Department visit highlighted sustained escalation pressure and workforce strain. The visit to Maidstone community mental health services underscored the need for strengthened integration, estate solutions and workforce stability. At Estuary View Medical Centre, the operational link between primary care estates, access pressures and rising patient complexity was clear. These insights have guided commissioning decisions and reinforced the system's shift toward a neighbourhood-led commissioning model.
- 2.8. The System Improvement Group has advanced commissioning-led business cases across acute demand, discharge redesign, elective optimisation, and community mental health capacity. This ensures commissioning decisions remain grounded in operational reality.

3. Pillar 2 – Delivering a Transformation Strategy Aligned with the NHS 10-Year Plan

- 3.1. Our transformation work has centred on confirming a shared strategic direction for the system. Across all NHS organisations in Kent and Medway, there is now strong alignment that the future operating model must be built around neighbourhoods as the fundamental delivery unit. These discussions have emphasised the role of neighbourhood-level integration, prevention and early intervention, digitally enabled care, and a shift of activity out of acute settings wherever safe and feasible.

- 3.2. This collective agreement has shaped our emerging five-year system strategy, which confirms neighbourhoods as the load-bearing component of the future system. NHS Partners have aligned on the need for consistent neighbourhood master plans, stronger outcome frameworks, and clear accountability for demand management and community-based delivery. A key enabler is the commitment to shared data, digital interoperability and more consistent use of population health management approaches across all 42 neighbourhoods.
- 3.3. In the System Plan Review with NHSE, we tested our financial and operational assumptions for 2026/27. The discussion highlighted the importance of realistic workforce, demand and productivity assumptions, stronger commissioner-provider cohesion, and clearer system discipline around planning and reporting. This work is now informing our refreshed approach to contracting, performance management and financial recovery.
- 3.4. In agreement with NHS England, we have commissioned an independent review of the drivers of the financial deficit, which also includes an assessment of the financial governance arrangements for the ICB and partner organisations. This review aims to ensure that robust governance structures are in place and that financial processes are transparent and accountable across the system.
- 3.5. Once completed, the findings and recommendations from this independent review will be formally reported to the Board in February. This will provide the assurance and evidence base needed to ensure our three-year plan is targeted at the correct priority areas, is responsive to emerging risks and opportunities, and is capable of delivering sustainable improvement across the system. The review's outputs will directly inform our commissioning intentions, investment decisions, and transformation priorities for the coming years.
- 3.6. As we progress our new system strategy—centred on neighbourhood-led delivery, strengthened primary care, redesigned intermediate care, and a clearer acute operating model, we are also clarifying the future of the Health and Care Partnerships (HaCPs). As we transfer HaCP staff from the ICB into provider organisations through formal workforce processes, we will be stabilising the current way of working with district councils, VCSE partners and primary care while we design the right spatial levels for integrated care. Over February and March, we will work with partners to determine the most coherent geographical footprints for neighbourhoods, how local government and VCSE partners align, and how the current HaCP arrangements fit within this future model. By the end of March, we will complete this work to ensure we have a clear, sustainable architecture for integrated care that supports population-level change and aligns transformation resource with delivery.

4. Pillar 3 – Enabling the ICB's Transition to a Strategic Commissioner

- 4.1. The launch of the organisational restructure consultation on 26 January is a critical step in our maturation as a strategic commissioner. The proposed operating model is designed to simplify structures, strengthen accountability, and align the organisation to its statutory duties, commissioning priorities and financial requirements.

The new Executive Team structure comprises:

- Deputy Chief Executive and Chief Commissioning Officer
- Chief Medical and Outcomes Officer
- Chief Nursing, Experience and Quality Officer

- Chief People and Culture Officer
- Chief Finance Officer
- Executive Director of System Improvement
- Director of Communications
- Company Secretary

4.2. I am pleased to welcome Jonathan Wilson as our new Chief Finance Officer. Jonathan brings substantial financial leadership experience and will play a central role in strengthening planning, accountability and recovery across the system. I would also like to express my sincere thanks to Ivor Duffy, whose steadiness, professionalism and dedication have been deeply valued.

4.3. I am also pleased to confirm that Clare Robson will join the ICB as Company Secretary next week, strengthening our governance, assurance and Board support functions.

4.4. A major component of the restructure is the voluntary redundancy programme, for which we have approved 119 applications. Managing this process fairly, transparently and compassionately remains essential. All decisions are being made against the proposed future structure, with the intent to minimise compulsory redundancies and protect statutory duties, operational delivery and strategic capacity.

4.5. Recruitment into the new structure will take place using a competency-based assessment process, ensuring the organisation is staffed with individuals whose skills, behaviours and values support the ICB's purpose and long-term ambitions.

4.6. Throughout this period, we have continued to work with NHSE to ensure our internal transformation aligns with wider regional expectations around financial recovery, transformation delivery and planning discipline.

4.7. In addition, in collaboration with the Audit Committee, I have commissioned a comprehensive review of our contracting and procurement processes. This review aims to ensure that our approaches remain robust, transparent and aligned with best practice, supporting both value for money and effective risk management across the organisation. The review is being conducted by an independent team and will examine all stages of the procurement lifecycle, with particular focus on compliance, governance controls and the practical application of our policies. The findings and recommendations will be formally reported to the Board by mid-February. This will provide us with a clear set of actions to further strengthen our systems and help embed a culture of continuous improvement in our contracting and procurement activities.

5. Pillar 4 – Resetting Our Culture to Ensure Kindness, Compassion and Modern Ways of Working

5.1. Cultural renewal remains a central priority. I continue to lead weekly CEO briefings, offering staff clarity on the restructure, VR processes, redeployment pathways and senior leadership expectations. These sessions have reinforced transparency, consistency and psychological safety.

5.2. Engagement with the Staff Partnership Forum (SPF) has been constructive and essential. Staff and trade union representatives have contributed detailed feedback on consultation timing, impact on staff groups, TUPE considerations and lessons learned from previous organisational changes. Their input is being incorporated into our consultation approach and communications.

- 5.3. The Staff Network development work is also central to building a more inclusive and supportive organisational culture. Networks continue to provide safe spaces for discussion, representation and shared learning during a period of significant change.
- 5.4. Leadership strengthening has continued, including interim financial arrangements and more robust weekly finance oversight with NHSE to ensure consistent governance and risk management.
- 5.5. Financial recovery remains challenging. The re-forecasting exercise has clarified the scale of underlying risk and provided a more realistic foundation for 2026/27 planning. We continue to strengthen contract oversight, ensuring commissioner and provider assumptions align and that performance and productivity are scrutinised more consistently.

6. Forward Look (to end March 2026)

- 6.1. Over the next two months, my priorities include:

- Delivering the organisational consultation with clarity, fairness and compassion
- Supporting the safe transfer of children's mental health services to KMPT/KMMH
- Strengthening operational delivery at Medway, WHH and QEQM
- Driving the Q4 Electives Recovery Sprint
- Embedding strengthened contract oversight and financial governance
- Finalising the neighbourhood-based system strategy with partners
- Completing key elements of the 2026/27 operating plan

- 6.2. We are making meaningful progress across several key areas, yet there remains a significant amount to achieve as we approach a particularly challenging 2026/27. Our continued efforts are laying a stronger foundation, but the scale of work ahead demands ongoing focus and resilience.

Title of meeting:	NHS Kent and Medway Integrated Care Board (Part 1)	Date: 3 February 2026
Title of report:	Board Assurance Framework and Corporate Risk Register Report	
Reporting officer:	Natalie Davies, Executive Director of System Improvement	
Lead member:	Natalie Davies, Executive Director of System Improvement	
Freedom of information (FOI) status:	This paper is disclosable under the FOI Act	

Purpose: This paper is for

Assurance	✓	Decision	Information	Discussion	✓
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Report summary:

The attached report provides the Board with the current Board Assurance Framework (BAF) and Corporate Risk Register (CRR), detailing changes since they were last reported to the Board in September.

Board Assurance Framework

Appendix one provides the January 2026 version of the ICB BAF. The BAF was discussed by the Audit and Risk Committee on 4 December 2025 and was further refined following feedback from the Committee.

The Board is asked to note that work is currently being undertaken to develop a new board assurance framework for 2026/27 that will align with the new organisational objectives.

Corporate Risk Register

Appendix two provides the January 2026 version of the ICB CRR, describing the most significant operational / tactical risks.

Proposal and/or recommendation:

The Board is asked to:

1. Note the Board Assurance Framework (Appendix one)
2. Note the Corporate Risk Register (Appendix two)
3. Consider whether there are any additional significant risks areas that should be assessed.
4. Note that work is currently being undertaken to develop a new board assurance framework for 2026/27 that will align with the new organisational objectives.



Our objectives:			
1. We will work with the NHS system to improve healthcare for our population.	✓	3. We will develop a workforce where colleagues feel valued, we celebrate diversity and are fair and inclusive.	✓
2. We will deliver sustainable services within our 2025/26 spending targets.	✓	4. We will reduce healthcare inequalities for the people of Kent and Medway.	✓

Identified risks, issues and mitigations:			
Risk/Issue impact areas			
<input checked="" type="checkbox"/> Financial <input checked="" type="checkbox"/> Patient <input checked="" type="checkbox"/> Staff <input checked="" type="checkbox"/> Services <input checked="" type="checkbox"/> Reputational			
The report provides details of significant strategic risks to the achievement of the organisation's objectives and the most significant operational / tactical risks.			

Resource implications and finance approval:			
None			

Sustainability considerations:			
None			

Public and patient engagement considerations			
The CRR and BAF are reported to the ICB Board which is held in public. Board papers are published on the ICB website.			
No engagement with patients and public is planned in connection with this paper.			

Equality Impact Assessment			
Has an equality assessment been undertaken?			
<input type="checkbox"/> Yes (please attach the action plan to this paper)			
<input checked="" type="checkbox"/> Not applicable - governance paper reporting on risks to strategy, delivery plans and objectives which would have their own equality and diversity assessments.			

Legal implications			
None.			

Report history / committees reviewed			
Prior to this report, the BAF and CRR were reported to the February 2025 Board meeting.			
Next steps:			
Ongoing implementation of the Risk Management Strategy.			

Appendices:			
<ul style="list-style-type: none"> • Appendix 1 – Full ICB Board Assurance Framework • Appendix 2 – ICB Corporate Risk Register 			

List staff contributing to the paper and any conflicts of interest (COI) identified:

David Sibley, Compliance Manager
No conflicts of interest.

For further information or for any enquiries relating to this report please contact:

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January 2026

Board Assurance Framework (BAF) and Corporate Risk Register (CRR)

Situation

This report provides an update on the key changes to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) since it was last reported to the Board in September 2025. The Board is asked to **NOTE** the report for assurance.

Background

The BAF provides assurance that any risks which may impact on the achievement of the ICB's corporate objectives are being appropriately managed and highlights, where necessary, any gaps in controls or assurance and the associated actions to address these. This version of the BAF is based on the 2025/26 organisation objectives, following Board approval of these in February 2025.

The CRR describes significant tactical and operational risks which have the potential to impact on the delivery of the corporate objectives and other priorities in the longer term if unmitigated.

Risks are reported to committees and reviewed by risk owners, as per the Risk Management Strategy. Key changes to both the BAF and CRR, since the September 2025 Board meeting, are described within the 'assessment' section of this report.

Assessment

Board Assurance Framework

Table 1 provides a summary of key changes to strategic risks since the September 2025 Board meeting.

Since the Board last met **BAF3: Delivery of ICS Financial Plan** has materialised and will be reviewed considering the 2026/27 Shared Delivery and Operating Plans and development of the system medium term financial strategy. It has been left in the BAF due to the significance of the issue and the proposed actions to manage the impact and address the underlying issues.

Table 1: Summary of key changes to strategic risks since September 2025

Summary of strategic risk	Risk grade
BAF1: Delivery of Kent and Medway NHS Strategy (Including Long Term Sustainable Financial Plan)	Risk rating remains the same
BAF2: Delivery of Operational Plan 25/26	Risk rating has reduced
BAF3: Delivery of ICS Financial Plan	Risk has materialised

Summary of strategic risk	Risk grade
BAF4: ICB Transition (Change-25)	Risk rating remains the same
BAF5: Medway Foundation Trust (MFT) Quality, Performance and Finance Risks	Risk rating remains the same
BAF6: ICB Culture Review	Risk rating remains the same

Table 2 highlights the BAF risks in relation to the ICB corporate objectives, recognising that a number of the risks have interdependencies with various objectives, in addition to the main related objective. The table also shows those risks considered to be:

- **ICB Risks:** where the ICB has direct ownership of controls and mitigations to manage the risk identified.
- **ICS Risks:** where effective management of the risk identified requires system wide ownership of controls and mitigations.

Table 2 – BAF risks related to ICB Corporate Objectives

ICB Objective / BAF Rating	Obj. 1 NHS System Integration and Delivery	Obj. 2 Finance	Obj. 3 Workforce	Obj. 4 Health Inequalities
ICB specific risks				
BAF4: ICB Transition (Change-25)			15	
BAF6: ICB Culture Review			15	
K&M integrated care system risks				
BAF1: Delivery of Kent and Medway NHS Strategy (Including Long Term Sustainable Financial Plan)	16			Also impacts on objective
BAF2: Delivery of Operational Plan 25/26	12	Also impacts on objective	Also impacts on objective	
BAF3: Delivery of ICS Financial Plan (risk has materialised)		20		
BAF5: Medway Foundation Trust (MFT) Quality, Performance and Finance Risks	Also impacts on objective	20		

Appendix 1 provides the full Board Assurance Framework as at December 2025.

Corporate Risk Register (CRR)

The CRR details the most significant operational / tactical risks. Four of the seven risks previously reported to the Board continue to meet the threshold for inclusion on the CRR. The three risks which no longer meet the threshold to be reported or have been closed are as follows:

- **1587:** Risk that the ICB is unable to meet its statutory health responsibilities for Looked After Children within Kent and Medway

A paper on statutory initial health assessments was taken to Executive Committee on 17 December where decisions were made and actions agreed to develop a new delivery model for initial health assessments (IHA). Work has also been undertaken with the two local authorities (LAs) on managing the start of the IHA pathway, and attendance, with the view of creating a Memorandum of Understanding (MoU) between the ICB and the two LAs. Performance reporting to be more detailed to ensure clearer understanding of the responsibilities and accountability.

The risk scoring has been reduced to 12 (3 x 4) and will continue to be reported to the Improving Outcomes and Experience Committee

- **1566:** Risk that All Age Continuing Care (AACC) does not achieve the identified savings of £24 million in 2025/26.

The risk scoring has reduced to 12 (3 x 4) and will continue to be reported to Productivity and Investment Committee.

- **1527:** Poor Organisational culture and staff morale within the ICB

This risk is a duplication of new risk BAF6: ICB Culture Review and has subsequently been closed.

Table 3: Summary of operational / tactical risks on the CRR

Summary of risk	Current rating
DDaTRR048: Digital Delivery and Technology vacancies	16
CRR8: Access to Mental Health Acute Inpatient Beds	16
1584: Risk that the ICB does not have an agreed Kent and Medway ICS Digital, Data and Technology Strategy	16
1565: Risk that the NHS in Kent and Medway will exceed its total workforce spending plan (including substantive, bank and agency costs) which is set at £2,256m	16

Appendix two provides details of the full ICB CRR.

Recommendations
<p>The Board is asked to:</p> <ol style="list-style-type: none"> 1. Review the Board Assurance Framework (Appendix one) 2. Review the Corporate Risk Register (Appendix two)

3. Consider whether there are any significant risks or issues in terms of controls and assurance that they feel should be further assessed.

David Sibley
Compliance Manager
January 2026

Risk Appetite Statements

Risk Appetite	Description
None	We have no appetite for decisions or actions that will impact in anyway – avoid risks at all costs and all decisions taken to remove the risk.
Minimal	We are only willing to accept the possibility of very limited risk and will avoid decisions or actions that may result in heightened risk unless absolutely essential.
Cautious	We are prepared to accept the possibility of limited risk. Our preference is for safe delivery options, but we are able to tolerate low level risk and uncertainty. Every decision will be with the aim of mitigating the risk.
Open	We are willing to consider all potential delivery options and choose while providing an acceptable level of reward. Take a greater degree of risk and tolerate higher uncertainty to achieve a bigger reward.
Seek	We are eager to be innovative and to choose options offering greater rewards but have greater inherent risk. Eager to take on risk to achieve strategic objectives.
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust. Will choose the option with the greater reward and will accept any loss for the price of the reward.

Risk Thresholds

Using the above framework the following thresholds are proposed, firstly as a trigger to be presented to, and considered by, each relevant ICB committee and second as trigger to be presented to the ICB Board.

Domains	Risk Appetite	Committee Threshold	Board Threshold
Clinical quality, safety, and patient experience	Cautious	8	15
People: Workforce	Open	12	16
Performance: Operational Performance	Cautious	10	15
Transformation: Innovation and Transformation	Seek	16	20
Financial: Financial Risk and Value for Money	Cautious	10	15

Regulatory: Compliance and Regulatory Risk	Cautious	8	15
Reputational: Reputational Risks and Partnerships	Open	12	16

The risk thresholds for the Board would not prevent a risk below this threshold being reported should it be considered that it merits being brought to the attention of the Board due to its significance or likely probability that the risk score would potentially increase rapidly.

Please note that whilst consideration of Reputational Risk is important it should not be the catalyst for action rather it should be viewed as the resulting outcome of non-delivery of the ICB's objectives.

BAF1: Delivery of Kent and Medway NHS Strategy (Including Long Term Sustainable Financial Plan)															
Objective: 1. We will work with the NHS System to improve healthcare for our population															
Objective: 4. We will reduce healthcare inequalities for the people of Kent and Medway															
Strategic Risk: Delays to the delivery of the NHS Strategy as a result of capacity and capability constraints across the health system.															
IF due to other critical pressures our NHS system is unable to allocate sufficient time and resource to deliver the NHS Strategy		THEN we will be unable to achieve our four core objectives and address the issues identified in the Case for Change			RESULTING IN poorer health access, experience, and outcomes; unsustainable services, and a disengaged and unprepared workforce.			DEFINED BY poor outcomes, lack of adherence to national performance measures and increased financial cost/non-delivery of financial targets.							
Lead Executive		Lead Teams			Lead Assurance Committee			Date Added to BAF							
Chief Strategy and Partnerships Officer Chief Finance Officer		Strategy and Partnerships Finance			Inequalities, Prevention and Population Health Committee Improving Outcomes and Experience Committee Productivity and Investment Committee			Jul-25							
Inherent Risk Rating		Current Risk Rating			Target Risk Rating			Risk Appetite	Status (In / Out Appetite)						
I	L	Rating	I	L	Rating	I	L	Rating	OPEN 16	IN					
4	4	16	4	4	16	4	2	8							
Risk Analysis			Q3 24/25		Q4 24/25		Q1 25/26		Q2 25/26	Q3 25/26	Q4 25/26				
Rating			N/A		N/A		16		16	16	16				
Key Controls / Positive Assurances in Place						Gaps in Control and / or Assurance									
Key Controls <ol style="list-style-type: none"> System Improvement Group meeting and Joint Committee standing agendas based on the System Improvement Plan pillars. SROs (CEO and exec) and programme support assigned to each pillar. Regular workshops and project/working group meetings established to ensure exec ownership of delivery plans. 						Gaps in control <ol style="list-style-type: none"> Driver of the deficit and financial governance review to report end Jan 2026. See BAF 3. Gaps in assurance <ol style="list-style-type: none"> Metrics in the Five-Year Plan need to be aligned with the developing Strategic Commissioning Performance Report. ICB operating model and cost reduction programme may affect the resource available to coordinate and deliver this work. 									

<p>4. Delivery plans are continuing for the original NHS Strategy themes and will be mapped to the System Improvement Plan if appropriate.</p> <p>5. System partners are engaged in the development and delivery of the plan to avoid concentration of ownership and workload in the ICB.</p> <p>6. Acute Provider Collaborative reset includes alignment of reporting across duplicative groups.</p> <p>Positive Assurances</p> <ol style="list-style-type: none"> 1. System Improvement Plan agreed by members of the System Improvement Group. 2. Recognised as a key responsibility and report of the System Improvement Group and Joint Committee 3. EY commissioned to undertake drivers of the deficit review for end January 2026 and financial governance review. The DoD review will inform planning, and both are an important underpinning for financial recovery. 	<p>3. The scale of the system financial deficit (see BAF3) risks materially affecting the delivery timetable for the wider strategy. It also increases the risk of significant regulatory action which would reduce the ICS' agency to implement the strategy.</p>
<p>Mitigating Actions to Address Gaps</p> <p>Confirm key delivery metrics as part of medium term (3-5) year planning, and align these with ICB and system strategies and plans</p> <p>Embed new ICB operating model and align to system improvement plan, which will confirm resourcing arrangements and clarify any gaps to delivery</p>	<p>Target Date</p> <p>Feb 26</p> <p>Mar-26</p>
<p>Current Performance - Highlights</p> <ul style="list-style-type: none"> • The NHS Strategy will be replaced by the Five-Year Strategic Plan and the System Improvement Plan. This terminology is therefore no longer in use. However, the challenges remain and therefore the risk will be left on the BAF until it is reviewed for 26/27 when the Five-Year Strategic Plan is set. • All programmes across the ICB, and Acute Provider Collaborative aligned to reduce duplication, accelerate sharing of learning and minimise impact of future ICB cost reductions, for example the endoscopy network and the Acute Provider Collaborative endoscopy programme. • System Improvement Plan detailed delivery planning in progress, aligned to the developing five-year plan. • The scale of change required alongside critical pressures on NHS services means the risk remains high despite the mitigating actions and some aspects, such as the financial impact have materialised – see BAF 3. 	

BAF2: Delivery of Operational Plan 25/26															
Objective: 2. We will ensure consistent delivery of core targets, redesigning the way we deliver healthcare in targeted pathways and areas.															
Strategic Risk: There is a risk that the critical deliverables in our Operational Plan will not be met															
IF we do not meet the key targets and standards set out in the annual operating plan			THEN the people of Kent and Medway will not be receiving the care we planned			RESULTING IN poorer access to services, experience, and clinical outcomes, plus: potential sanctions and increased monitoring or intervention from our regulators			DEFINED BY (but not exclusively) the measures in our Integrated Performance Report and the national Performance Assurance Framework						
Lead Executive			Lead Teams			Lead Assurance Committee			Date Added to BAF						
Chief Delivery Officer Chief of Staff			Delivery teams System Workforce team			Improving Outcomes and Experience Committee People Committee			Jul-25						
Inherent Risk Rating			Current Risk Rating			Target Risk Rating			Risk Appetite	Status (In / Out Appetite)					
I	L	Rating	I	L	Rating	I	L	Rating	CAUTIOUS 15	IN					
4	4	16	4	3	12	4	2	8							
Risk Analysis			Q3 24/25		Q4 24/25	Q1 25/26		Q2 25/26	Q3 25/26	Q4 25/26					
Rating			N/A		N/A	16		16	16	12					
Key Controls / Positive Assurances in Place						Gaps in Control and / or Assurance									
Key Controls						Gaps in control									
1. Regular EMT focus on winter/UEC, elective long waits and financial delivery. 2. 2025/26 Annual Operational Plan 3. Kent and Medway NHS Strategy 4. The UEC programmes of work are aligned to the UEC plan 25/26 and the UEC operational planning guidance as set out by NHSE. 5. General Practice action plans and strategy 6. Dental Delivery Commissioning Plan 7. Establishment of System Planning & Performance Group (SSPG) to oversee planning across the system with senior leaders from all Trusts.						1. Further industrial action (Resident Doctors) could result in cancellation of outpatient and elective procedures and longer waits impacting performance and financial positions in Trusts across the system. 2. Identification of a large number of ENT patients at MFT and DGS in the autumn not previously treated: significant improvement to the treating of these patients will result in less than 150 breaching 65 week wait by December deadline, but still not meeting zero target.									

<p>8. Oversight of primary care measures via the primary care strategic oversight committee (PCSOC)</p> <p>9. Discharge & Admissions group including Newton commissioned via the Better Care Fund support programme focused on MFT discharge processes and pathways, this is progressing well.</p> <p>Positive Assurances</p> <ol style="list-style-type: none"> 1. Targets are monitored through various boards and early indications of variance from the plan is possible. 2. The plan has been agreed at board level at Trusts and by the ICB demonstrating collective ownership of the targets and plans in place to meet them. 3. Regular meetings with provider leadership teams through monthly COO's meetings and quarterly contract meetings which look at quality, performance and financial position. 4. Operational Planning BAF for NHSE was completed and submitted post-approval of the plan by Trust and ICB Boards as part of the final submission along with an EQIA. 5. Tier 1 support from NHSE for EKHUFT still ongoing 6. Successful UEC capital bids – potential for improvements in SDEC. 7. Main cancer pathways challenges are Breast & Colorectal – additional funding through the CA and through Tiering are supporting short term initiatives to address this. 8. IQPR discussed at committees including IOEC and Strategic Commissioning group. 9. IOEC reports and minutes. 10. NHSE Discharge and Admissions Group (DAG) 11. NHSE Elective weekly Sprint meeting 12. 999/111 Transformation Board 13. Southeast Temporary Staffing Collaborative 14. Chief People Officer Group in place, sharing progress made against workforce plans. 15. Workforce Financial Recovery Group with deliverables in place to reduce pay bill. 16. Introduction of System Planning & Performance Group to develop and monitor plans year round. 17. Implementation of national GP contract requirements in October 2025 requiring online consultation access in GP core hours – practices being supported to implement the requirements 18. EMT SCS have approved targeted investment to tackle the GA 52-week backlog 	<p>3. National gap in resource for audiologists alongside a Kent & Medway wide paediatric recall has now been widened this has caused wider gap to the DM01 performance.</p> <p>4. All Trust are meeting their activity plans overall but are not meeting the 18-week RTT targets set</p> <p>5. RTT 65+ week position is improving, but risk that target will not be achieved by December deadline</p> <p>6. 52+ week-long waiters is away from target mainly due to MFT position, this is being addressed in Q4 and then ongoing with the additional ENT capacity</p> <p>7. Whilst patient satisfaction of general practice has improved (no set target) the rate is still below to national average</p> <p>8. MFT is currently in Tier 1 for Elective Performance – including Cancer for its FDS position</p> <p>9. MFT & EKHUFT are outliers in the 12-hr in department metric (physical and mental health patients)</p> <p>10. Long length of stay remains an issue at MFT and EKHUFT</p> <p>11. Below national average for % of patients with hypertension treated according to NICE guidance</p> <p>12. Workforce utilisation above plan</p> <p>13. Dental treatments under general anaesthetic are captured via the community dental service dashboard and not through RTT so current issue with a backlog in 52 week waits</p> <p>Gaps in assurance</p> <ol style="list-style-type: none"> 1. Lack of evidence of collaborative approach to discharges across the acute and community providers resulting in delays to discharges and disruption to flow. 2. Financial expectations for the system to deliver the FRP projects and 5% efficiencies in provider trusts poses a significant risk to the overall financial position of the system. 3. Competing priorities and projects mean that resources can be stretched thin and with Change 25 looming personnel and resources could be stretched further as such full delivery
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	<p>across all transformation projects may not be possible.</p> <p>4. Currently block contracts are not delivering the levels of activity required to meet plan</p> <p>5. Acute providers not yet guaranteeing theatre slots for dental treatment under GA</p>
Mitigating Actions to Address Gaps	Target Date
Community services redesign implementing standardised care through Transfer of Care Hubs	Q4
Industrial Action Plan in place to manage the risk of disruption to services through regular touchpoint meetings chaired by ICB executives and review of Trust self-assessments.	Q3/Q4
NHSE considering suspending DMO1 for audiology	Q2 (Left from last time as no update provided by NHSE as yet)
RTT 65+ week position additional capacity in the acute is stood up and closely monitored by lead commissioners	Q3/4
Additional triage model being implemented for ENT and explored to be rolled out across all specialties	Q4
Implement standardised specifications for 25/26 across acute sites for SDEC, VW, SPOA – ensuring compliance against national standards and best practice	This is being put into the contract offers for the Acute Providers and Demand Management & Discharge and Flow business cases for 26/27
Roll out of Bed Management System in EKHUFT and DVH – scoping exercise underway with NHSE colleagues to identify operational impact on 4- and 12-hour performance and Temporary Escalation Spaces (TES)	Scoping has started in DVH in Q4, EKHUFT to follow
MFT action plan to address cancer FDS position which is being monitored through the Tiering process and supported by the Cancer Alliance	Ongoing
Targeted support to practices identified through the GP resilience matrix as being outliers on performance	Started Q2, running through to Q4
CVD Prevention - Local Incentive Scheme for practices agreed, remuneration for lipid & BP optimisation, establishing CVD champions and Targeted support for bottom 50 practices.	All due to start by end of Q3
ICB looking at recovering costs of non-completed activity against Indictive Activity Plans	Q3/Q4
Current Performance – Highlights	
<ul style="list-style-type: none"> • New ICB Integrated Assurance Management Group to be established in December 2025 as a management committee of EMT; with accountability for overseeing delivery of performance and quality standards, and directing mitigating commissioning actions as appropriate. • Review of Integrated Quality Performance Report underway, to ensure it is fit for purpose going forwards – links to development and assurance of medium term plan (2026-29), annual operating plan (2026/7), system development plan (2026/7), and ICB corporate plan (2026/7) 	

- Continued good performance for 4hr UEC waiting times and ambulance handover delays, but ongoing work required to reduce 12 hour waits.
- Seasonal variations to acute attendances and admissions over winter has happened as forecast.
- 2hr performance for Urgent Community Response consistently delivering national standard of 80%
- Good control and grip in place for eliminating 65 week elective waits and 52 week waits, but risk remains that December zero 65 week wait requirement will not be achieved
- MFT have seen significant improvement in their FDS position from 53% in May to 79% in November
- MTW, EKHUFT and KMPT have concluded staff consultations which will support delivery of planned workforce reductions (c.200 posts). MTW are implementing Phase 2 of their workforce reduction plans,
- To facilitate the additional ENT activity additional GPeR sessions have been stood up, additional consultant led community services started in Q2 and MFT have brought in additional insourcing and addition diagnostic capacity has been stood up.
- Overall experience in GP satisfaction improved between 2023 and 2025 from 65% to 70%
- Commissioned 5905 additional urgent dental appointments to ensure delivery of the K&M share of the government's commitment to additional 700,000 appointments – delivery commenced Q4
- As at November 2025 71107 urgent dental appointments delivered
- MTW, EKHUFT and KMPT have concluded staff consultations which will support delivery of planned workforce reductions (c.200 posts). MTW are implementing Phase 2 of their workforce reduction plans, and DGT and MFT are seeking to reduce headcount through mutually agreed recognition schemes (MARS).
- Enhanced workforce pay controls continue to be in place and learning shared through Chief People Officer forums.
- Kent and Medway Workforce Passport and staff sharing agreement in place
- Trusts are performing well against turnover trajectories outlined in their operational plans.

BAF3: Delivery of ICS Financial Plan															
Objective: 2. We will deliver sustainable services within our 2025/26 spending targets															
Strategic Risk: There is a risk that the ICB will not deliver its financial plans (including cost savings plans) during the current year															
IF the ICS fails to deliver its financial plan			THEN this will represent an overuse of public funds			RESULTING IN possible regulatory action and a requirement to repay the overspend which will result in reduced funding for patient services in future years			DEFINED BY revenue outturn						
Lead executive			Lead teams			Lead assurance committee			Date added to BAF						
Chief Finance Officer			Finance			Productivity Investment Committee (PIC)			Jul-25						
Inherent risk rating			Current risk rating			Target risk rating			Risk appetite		Status (in/ out appetite)				
I	L	Rating	I	L	Rating	I	L	Rating	CAUTIOUS 15		OUT				
4	5	20	4	5	20	4	2	8							
Risk Analysis			Q3 24/25		Q4 24/25		Q1 25/26		Q2 25/26	Q3 25/26	Q4 25/26				
Rating			N/A		N/A		20		20	20	20				
Key controls/ positive assurances in place						Gaps in control and/ or assurance									
Key controls						Gaps in control									
<ol style="list-style-type: none"> PMO and system financial recovery governance in place including CEOs meetings, FRP exec and weekly CFO meetings. Monthly financial reporting at organisation and ICS level. System financial recovery programme established. Led by Miles Scott (CEO, MTW) and Ivor Duffy (CFO, ICB) with exec MDT involvement from across the ICS. EKHUFT has a financial recovery plan. ICB enhanced budget reporting in place FRP exec and CEO meetings are operational. Double-lock approvals and post-implementation reviews in place at system level. Workforce controls are in place and workforce resourcing board oversees delivery of agreed improvements. Akeso commissioned to provide interim support. 															
						<ol style="list-style-type: none"> Insufficient capacity to deliver the programme of systems savings. Plans were not fully developed at the start of the year which creates triangulation risk between finance, workforce, and activity plans. Detailed work programme for the system financial recovery programme requires completion. MFT remains in the recovery support programme and the Trust does not have a recovery plan. Plan in place to manage, however not within direct control of ICB and Trusts therefore unmitigated residual risk. EKHUFT recovery plan does not achieve balance and MFT recovery plan draft has not been received. 									

<p>9. Adrian Roberts commissioned by NHSE to support the system understanding the underlying deficit ahead of the medium-term financial plan submission.</p> <p>10. System savings schemes have PODs developed/ in development with named SROs.</p> <p>11. EY commissioned to undertake a</p> <p>Positive assurances</p> <p>12. East Kent was removed from NHS England's recovery support programme in August 2025.</p> <p>13. The ICS CFO is leading work to respond to the ask from NHSE England for an updated risk assessed position by the end of September. The ICS CEOs are being briefed on the position and the proposed response on the 20th of September 2025.</p> <p>14. Financial recovery plan framework in place.</p> <p>15. Internal audit reviews of compliance with HFMA controls checklist & Akeso reviews of compliance with workforce controls.</p> <p>16. PMO is supporting SROs of system savings to develop plans which will then assess triangulation implications</p> <p>17. MFT have procured external support for financial recovery.</p> <p>18. ICB agreement to extend the Akeso system support due to lack of sufficient system resources to exit the support.</p> <p>19. Experienced CFO commissioned by NHSE to assess the underlying position.</p> <p>20. EY review of the system efficiency plan to test robustness of the data reported in IFRs and consistency of reporting.</p>	<p>Gaps in assurance</p> <p>1. The ICS is in the process of reforecasting as part of M9. This is to a deficit of £198.0m, of which £49.3m relates to lost deficit support funding and £148.7m relates to adverse performance against plan. This is a materialised risk.</p>
<p>Mitigating actions to address gaps</p> <p>Processing of reforecast</p> <p>External support for drivers of the deficit review from EY to issue first report to support the final planning submission.</p> <p>System financial recovery director being recruited</p> <p>Response to the EY drivers of the deficit review to inform the final plan and the recovery plan actions. The scale of the deficit in the ICS means it is likely a further submission will be required.</p>	<p>Target date</p> <p>January 2026</p> <p>January 2026</p> <p>January 2026</p> <p>February 2026</p>

Current performance – highlights

This risk has materialised and will be reviewed in light of the 2026/27 Shared Delivery and Operating Plans and development of the system medium term financial strategy. It had been left in the BAF due to the significance of the issue and the proposed actions to manage the impact and address the underlying issues. The incoming ICB CEO wrote to all ICS NHS CEOs on the 11th of November 2025 setting out the scale of the issues and the next steps. The letter detailed the outline of next steps and an ask to either agree to these or to respond with a counteroffer within a week. The next steps included, but were not limited to: procuring additional support, addressing the behaviours and processes which have inhibited recovery and placing the ICS in financial recovery.

The system undertook an assessment of the risk-adjusted forecast outturn in November 2025. This identified a net forecast adverse variance to plan of £139.7m. The ICB CEO met with NHS England on the 11th of December 2025 to discuss the scale of the issue and the planned next steps. In M9 the ICS is reforecasting to a deficit of £198.0m which is composed of the £139.7m RAFOT risk, £49.3m of lost DSF which is not included in the RAFOT and a further £9.0m of deterioration which is driven by a £9.6m late adverse movement in MFT.

Key next steps are recruiting a system financial recovery director and ensuring the EY drivers of the deficit review is sufficiently concluded by the end of January 2026 to inform the final plan submission.

BAF4: ICB Transition															
Objective: 1. We will work with the NHS system to improve healthcare for our population.															
Strategic Risk: There is a risk that the reduction in ICB operating costs will impact on the ability of the organisation to effectively commission care services and deliver its statutory and mandated duties.															
IF the ICB is not able to transition to an effective strategic commissioning organisation in a timely fashion it will impact operational efficiency and staff morale			THEN there is a risk that the organisation will not meet its statutory or mandated duties and achieve its strategic and corporate objectives			RESULTING IN a deterioration of service commissioning outcomes and assurance, non-delivery of patient care standards and regulatory action			DEFINED BY a deterioration in Staff Survey and workforce metrics such as sickness, NHS National Oversight Framework (NOF) ratings and patient access and quality standards and increased patient complaints.						
Lead Executive			Lead Teams			Lead Assurance Committee			Date Added to BAF						
Transition Director (Director of Corporate Governance)			Executive Team			ICB Transition Committee			May-25						
ICB People Committee															
Inherent Risk Rating			Current Risk Rating			Target Risk Rating			Risk Appetite	Status (In / Out Appetite)					
I	L	Rating	I	L	Rating	I	L	Rating	SEEK 20	IN					
5	4	20	5	3	15	5	2	10							
Risk Analysis			Q3 24/25		Q4 24/25		Q1 25/26		Q2 25/26	Q3 25/26	Q4 25/26				
Rating			N/A		N/A		15		15	15	15				
Key Controls / Positive Assurances in Place						Gaps in Control and / or Assurance									
Key Controls and Assurances in place						Gaps in control and assurance:									
<ul style="list-style-type: none"> Model ICB Blueprint, NHS Ten Year Plan and Model region blueprint published ICB Transition Director and supporting governance arrangements in place, including succession plan for new Transition Director ICB Transition Committee and Remuneration Committee in place, with regular briefings to Board Regular updates to People Committee and Audit Committee for assurance purposes South east ICB Transition Directors forum in place 						<ul style="list-style-type: none"> Limited output to date from national review of the 18 functions to be transferred from ICBs Potential delays in transferring services to local partners, may require additional internal action, impacting on the ability of the organisation to effectively deliver key services Awaiting change in statutory legislation to enable transfer of accountabilities – timetable not yet known New ICB Operating Model currently in development 									

<ul style="list-style-type: none"> • Comms and Engagement Transition Plan in place • ICB Staff Insight and Improvement Group established – all staff networks invited • Routine reporting at Staff Partnership Forum, Staff Engagement Group, and monthly all-staff briefings • Effective engagement with staff side unions • System Partnership Review completed and recommendations agreed. • Chair and chief executive appointments confirmed • Executive director consultation concluded • NHSE South-east assurance workshop – June 25 • NHSE south-east development workshop – November 25 • ICB Transition detailed action plan and risk register in place • £16.2m redundancy funding allocated to Kent and Medway ICB • Confirmed directive to deliver £19 per head by April 2026 • Pan ICB shared functions: principles and decision tree agreed <p><u>January 2026 (new controls and assurance)</u></p> <ul style="list-style-type: none"> • Organisational structure and consultation document finalised for approval- supported by Transition Committee • Agreed destination for AACC, Meds Ops, Cancer Network/Alliance • Agreed principle for HaCP staff transfer • Additional Voluntary Redundancy Scheme confirmed 	<ul style="list-style-type: none"> • Staffing structures not finalised – out to consultation • Uncertainty regarding future delivery solutions for existing CSU commissioned services
Mitigating Actions to Address Gaps	Target Date
Voluntary redundancy programme currently underway. Outputs of this will inform requirements for any compulsory redundancies	Complete December 2025
Confirmation of executive team appointments	Complete December 2025
Confirm priority functions for potential sharing across SE ICBs, and confirm arrangements for these (phase 1 functions)	Complete – confirm functions January 2026 – confirm arrangements linked to local staffing structures March 2026 – finalise arrangements
ICB staffing structures in development based on MDT model of working – expect these to be finalised in readiness for formal consultation in New Year	Complete for consultation January 2026

Business case development and due diligence to transfer AACC and elements of medicines optimisation team to local provider	January 2026 (for consultation and TUPE – Feb to Mar 26)
ICB Operating Model and corporate operating plan to be developed and approved	Operating Model – January 2026 Complete for consultation 2026/27 Operating Plan – March 2026

Current Performance – Headlines
<p>See previous BAF reports for historical headlines.</p> <p>The organisational transition programme continues to progress at pace, with several significant milestones reached during December and early January.</p> <p>The Voluntary Redundancy (VR) scheme has closed, with 161 applications, 143 approved, and almost 120 people signing to leave the organisation.</p> <p>Work continues to meet the financial requirement of delivering £19 per head; current modelling subject to consultation indicates a position of £18.61 dependent on a number of moderate risk assumptions.</p> <p>On 22 December, NHSE published its current position on the Model ICB, confirming that 14 of the 18 functions originally proposed for transfer will now remain with ICBs. Four functions remain under review for potential transfer.</p> <p>The Data and Digital Review (HIN-led) has completed with a recommendation for a shared service model across Kent & Medway, Surrey, and Sussex, and wider southeast shared-service potential under consideration.</p> <p>Pan-ICB discussions continue, although progress varies across southeast workstreams, including EPRR, Digital, and others.</p> <p>Work to transfer the AACC team and elements of the Medicines Optimisation team focused on primary care to a local provider by 1 April 2026 is in the due diligence phase of the project with dedicated oversight in place.</p> <p>Preparation for organisational consultation has advanced, including the finalisation of key documents, engagement planning, and dependencies across programme areas.</p> <p>ICB consultation launch is scheduled for 26 January 2026, subject to final confirmation.</p> <p>The Transition risk environment remains challenging, with several risks rated 16 or above, including:</p> <ul style="list-style-type: none"> • Impact on critical corporate priorities • Funding of effective structures for the new organisation • Delay to programme implementation and the associated effect on staff morale • Uncertainty in national redundancy agreements <p>Despite these pressures, programme controls remain robust, with oversight through Transition Committee, Executive Team, and southeast ICB collaboration structures. All risks have mitigation plans aligned to the transition programme implementation roadmap.</p> <p>All risks have mitigations in place, in line with ICB Transition Programme implementation plan</p>

BAF5: Medway NHS Foundation Trust (MFT) Leadership, Quality, Performance and Finance Risks															
Objective: 2. We will make sure consistent delivery of core targets, redesigning the way we deliver healthcare in targeted pathways and areas.															
Strategic Risk: There is a risk that the Trust will be unable to secure strong and sustained leadership, and work with local partners to consistently deliver core performance, finance and quality standards and implement effective organisational transformation. There is also a risk of adverse impacts on the quality of care, operational performance, and financial sustainability for both MFT and the wider Kent and Medway system.															
IF MFT are unable to effectively implement sustained improvements due to a lack of strong, permanent leadership, operational pressures, workforce, and capacity constraints and limited clinical engagement; and, there is insufficient capacity of the wider system to support local transformation			THEN the delivery of core performance, finance and quality standards in the Trust may be compromised			RESULTING IN sustained performance failure, deterioration in care quality and staff wellbeing, and exceeding available financial resources.			DEFINED BY missed targets (e.g. A&E, RTT, 62-day cancer), patient complaints/incidents, non-delivery of financial plan and potential liquidity crisis and cessation of capital plan.						
Lead Executive			Lead Teams			Lead Assurance Committee			Date Added to BAF						
ICB Chief Finance Officer			ICB Directorates of the CNO, Finance and Delivery teams			Improving Outcomes and Experience Committee Productivity and Investment Committee			Jul-25						
Inherent Risk Rating			Current Risk Rating			Target Risk Rating			Risk Appetite	Status (In / Out Appetite)					
I	L	Rating	I	L	Rating	I	L	Rating	CAUTIOUS 15	OUT					
4	5	20	4	5	20	3	2	6							
Risk Analysis			Q3 24/25		Q4 24/25		Q1 25/26		Q2 25/26	Q3 25/26	Q4 25/26				
Rating			N/A		N/A		20		20	20	20				
Key Controls / Positive Assurances In Place						Gaps in Control and / or Assurance									
Key Controls						Gaps in control									
<ol style="list-style-type: none"> 1. Trust is in national NHSE Recovery Support Programme 2. Trust is in the process of commissioning a significant external consultancy support package which has been done in conjunction with NHSE and the ICB. 						<ol style="list-style-type: none"> 1. Lack of permanent, strong, and sustained leadership at an executive level 2. Insufficient capacity of the local health and care system to support clinical improvement and transformation at the Trust 3. Insufficient workforce and clinical time within the Trust for transformation 									

<p>3. Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust Strategic Review commenced, with agreed external support.</p> <p>4. National and regional coordination with ICB engagement in local delivery plans</p> <p>5. Quarterly contract meetings</p> <p>6. Clinical Effectiveness and Outcomes Group (CEO) established at MFT</p> <p>7. Divisional recovery and improvement plans aligned to trust-wide targets</p> <p>8. Weekly PTLs and outpatient transformation programme established to drive initiatives around PIFU and virtual clinics</p> <p>9. Dedicated elective and cancer recovery groups</p> <p>10. Finance and Performance Committee oversight of CIP</p> <p>11. Patient Safety Incident Response Framework (PSIRF) launched with an aim to understand how incidents happen, identify learning and improvement</p> <p>12. ICS cash working group in place</p> <p>13. Trust will be onboarded to the NHSE Maternity and Neonatal Enhanced Support and Oversight process in collaboration with the ICB</p> <p>Positive Assurances:</p> <ol style="list-style-type: none"> 1. Internal Performance Board minutes 2. Divisional assurance returns 3. NHSE/ICB oversight and support (Cancer, Elective and UEC) 4. Extensive consultancy support secured to aid financial recovery 5. The Trust has secured additional cash support from NHSE, however this is being managed monthly so is an ongoing project. 	<p>4. Limited specialty-level analytics for redesign decisions</p> <p>5. Under-developed financial governance and capacity with limited ownership of budgets across the organisation.</p> <p>6. Inconsistent change adoption across specialties</p> <p>7. ENT is one of the specialties with a significant backlog and long waits, requiring targeted intervention to ensure timely access to care and to meet elective recovery trajectories. Risks and impact of the issue is being assessed. Care outcomes, operational and financial impacts are all likely.</p> <p>8. Cancer waiting and treatment times remain an area of focused attention, with sustained efforts across the system to improve performance against national standards. Actions include targeted recovery plans for key tumour sites, increased diagnostic capacity, and strengthened pathway oversight to reduce delays and improve patient outcomes</p> <p>9. Implications of a possible liquidity crisis require further work to identify and plan a response. This will include significant actions such as the possible cessation of the capital plan.</p> <p>10. M9 reforecast deteriorated by £9.6m very late in the process which strong evidence of poor financial forecasting and controls.</p> <p>Gaps in assurance</p> <ol style="list-style-type: none"> 1. Risk of transformation being deprioritised due to daily operational pressure 2. Changes in NHSE RSP national approach are expected and the impact on MFT is not yet fully understood.
Mitigating Actions to Address Gaps	Target Date
Improve real-time reporting tools and dashboards	On-going
Current Performance – Highlights	
<p>The Trust needs to be able to detail a first stage of recovery and a timetable to develop and deliver a comprehensive plan. CEO level discussion is considered necessary to expedite this.</p>	

The Trust is reforecasting in M9. It agreed a deficit of £47.3m, of which £16.5m relates to DSF. The Trust increased the forecast deficit by £9.6m in the week of the reforecast which is evidence of weak financial controls and forecasting.

The Trust has developed and submitted to NHSE an initial financial recovery plan, this was also submitted as part of its additional cash application. The Trust applied for £30m additional cash in January of which £8.5m is owed to DGT, this was approved. £12.1m additional cash has also been approved for February.

A supplier, PA consulting has been identified to provide external support for financial recovery through joint Trust, ICB and NHSE process:

1. Strengthened Grip and Control Measures

The Trust has revisited various “grip and control” documents and used these to reassess its processes and enhanced expenditure controls where applicable have been applied, including stricter approval processes for non-pay spend and a recruitment freeze.

The Trust are in the process of implementing more robust control of medical rosters – linked to job planning and improvements thereon – to have better transparency and control of costs associated with that staff group. There are also fortnightly monitoring of financial performance and efficiency identification/delivery via the Sustainability Recovery Group.

2. Difficult Decisions

The Trust Executive and Board have scrutinised a long list of difficult decisions to address the financial challenge. Some have been rejected but a number are proceeding, including the recent launch of a Mutually Agreed Resignation Scheme. Other decisions considered include exit plans for all agency (including clinical), enhanced controls over additional sessions, reduction of bank rates, removal of staff benefits and consideration of safer staffing on wards.

3. Oversight and Assurance

The Trust continues in the highest level of Oversight scrutiny and presented its YTD position and RAFOT to regional NHSE colleagues. The Trust has also engaged external support to assist in its financial recovery process.

BAF6: ICB Cultural Review															
Objective: 3. We will develop a workforce where colleagues feel valued, we celebrate diversity and are fair and inclusive.															
Strategic Risk: There is a risk that the ICB fails to adequately address the recommendations in the cultural review and fails to develop an inclusive culture, where colleagues feel valued, and diversity is celebrated. This risk links to the implementation of the Change 25 transition programme.															
IF the ICB fails to adequately address the recommendations in the cultural review			THEN there is a risk that staff morale will deteriorate			RESULTING IN increased staff turnover, lack of productivity, lack of progress in implementing strategic goals and loss of corporate memory.			DEFINED BY increased vacancy rates and poor staff survey results .						
Lead Executive			Lead Teams			Lead Assurance Committee			Date Added to BAF						
Chief Culture and People Officer			Executive Team			ICB People Committee			Oct-25						
Inherent Risk Rating			Current Risk Rating			Target Risk Rating			Risk Appetite	Status (In / Out Appetite)					
I	L	Rating	I	L	Rating	I	L	Rating	SEEK 20	IN					
5	4	20	5	3	15	5	2	10							
Risk Analysis			Q3 24/25		Q4 24/25		Q1 25/26		Q2 25/26	Q3 25/26	Q4 25/26				
Rating			N/A		N/A		15		15	15	15				
Key Controls / Positive Assurances in Place						Gaps in Control and / or Assurance									
Key Controls <ul style="list-style-type: none"> Cultural review Implementation Group established chaired by Chief Executive Networks established and supported Appointment of Freedom to Speak up Guardian and Speak Up process Pulse Survey process introduced monthly Inclusion support through Absolute Diversity established Regular briefings to People Committee and ICB Board Cultural Review finalised and circulated to all staff. Cultural Review Action Plan presented to the Board in September 2025 Exec Director leads attend staff network groups Absolute Diversity appointed to lead on the EDI aspect of Cultural Review 						Gaps in control: <ul style="list-style-type: none"> Significant organisational change underway impacting on the ability to implement some recommendations and agree actions in response to others. New ICB Operating Model currently in development Uncertainty regarding future delivery solutions for existing CSU commissioned services Gaps in assurance: <ul style="list-style-type: none"> Staff survey results from 2023/24 and subsequent pulse survey results indicate that NHS Kent and Medway are performing at below average levels for equality & diversity, inclusion and engagement when compared with the 									

<p>Positive Assurances</p> <ul style="list-style-type: none"> • Pulse Survey results from months 1 to 4 and a framework for team discussion in place • Transition Committee and People Committee minutes • Culture Review Implementation Steering Group (CRISG) meeting notes and action log • Gender pay gap reporting and disability pay gap reporting published with action plan in place. • Annual staff survey and regular ICB pulse survey results reported to People Committee with identified actions • Achievement of PSED - Sep 2024 audit of ICBs • HR policies align to compassionate and just learning culture with supporting training and development • Behaviours Framework endorsed by Board, ExCo and SLT, refined by engagement with the organisation and launched January 2026 	<p>national average for ICBs – Cultural Review Action Plan to address this.</p>
<p>Mitigating Actions to Address Gaps</p>	<p>Target Date</p>
<p>Hold a Board facilitated workshop to discuss the Culture Review and develop a Board Charter (on ways of working) and personal pledges.</p>	<p>January 2026</p>
<p>Roll out Compassionate Conversations through Change training and learning sets as part of cultural competence mandated leadership development programme</p>	<p>January to April 2026</p>
<p>Update all HR processes (recruitment and appraisal) and managers' toolkit to reflect the Board Charter and values.</p>	<p>March to June 2026</p>
<p>Complete first round of mandatory leadership coaching for all senior leaders.</p>	<p>September 2026</p>
<p>EDI work with Absolute Diversity to support cultural competence programme and implementation of new structures</p>	<p>July 2026</p>
<p>Current Performance – Headlines</p>	
<p>The Cultural Review Implementation Steering Group (CRISG) has met four times since October. Membership has been reviewed and adjusted to ensure balanced and proportionate representation. Monthly pulse survey is now in its fifth cycle, with questions aligned to the cultural review sought outcomes and a supporting team discussion framework. Results illustrate small incremental progress to November with a decline in December attributed to launch of new ways of working (return to the office), executive team consultation and voluntary redundancy scheme. ExCo, People Committee and Board receive updates on progress.</p> <p>CRISG identified six high impact actions that aim to have the most significance in making progress towards the culture we want.</p>	

Latest headlines

- Board Workshop held 2 December. Board Charter and personal pledges developed to be signed off at Extra-ordinary Board on 21 January 2026.
- Executive team consultation completed and implemented from 5 January 2026 with a development plan and measures of success agreed by Remuneration Committee
- Voluntary redundancy scheme complete with 120 colleagues exiting March to June 2026 allowing colleagues to make a decision on their future.
- Preparations in place for consulting with the organisation on future structures from w/c 26 January 2026
- Six high impact actions agreed with CRISG, published and underway.
- Behaviour framework finalised and launched, alongside a statement of intent developed by CRISG.
- Mandatory culturally competent leadership training programme launched running from January to April 2026
- New ways of working launched December 2025 with implementation by April 2026
- Monthly Pulse Survey showed positive improvement in all questions in October and November in comparison to the baseline results from September, with a decline in December.
- Significant programme of work dedicated to supporting staff through change including outplacement support and employment hub continues, with support from Department of Work and Pensions
- Support Circles for managers and senior leaders continue (117 attendees to date)

Risk, Controls and Actions Report - 21/01/2026

Register: Corporate

Status: Open

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Risk Area	Control Description	Risk Rating	Action Description	Risk Review Narrative																											
<p>Ref: DDaT RR048</p> <p>Title: Digital Delivery and Technology Vacancies</p> <p>There is a risk that: Level 4 ICB financial regime and recently announced pausing of all recruitment is causing blockages to recruitment to the substantial number of vacancies within GPIT/Technology and Digital Delivery Teams and also affects the level of Clinical Safety Officer Resources required to support key projects</p> <p>Leading to: an inability to oversee delivery of GPIT services, management of supplier contracts (including new contracts) and provide the level input required for key projects.</p> <p>Resulting in: being unable to achieve transformational objectives, actively manage the ICBs contract portfolio, deliver business as usual services (GPIT) and provide the delivery assurance required, which is increasing (supporting DDaT Board and enhanced governance structures, and Frontline Digitisation Oversight Group)</p> <p>Risk Owner: David Hadley</p> <p>Committee: Digital and Data Board</p> <p>Directorate/Function: Digital Data and Technology</p>	<p>Prioritise key projects and flex resources across teams where appropriate</p> <p>Submit requests to approve recruitment to priority vacant posts once recruitment is allowed, currently paused due to ICB cost reductions</p>	<p>Risk Category: Operational / Programme (People/Staff)- Human Resources / Organisational Development / Staffing / Competence</p> <p>Residual</p> <table border="1"> <tr> <td>Likelihood</td> <td>Impact</td> <td>Total</td> </tr> <tr> <td>4</td> <td>4</td> <td>16</td> </tr> <tr> <td>Yellow</td> <td>Yellow</td> <td>Red</td> </tr> </table> <p>Inherent</p> <table border="1"> <tr> <td>Likelihood</td> <td>Impact</td> <td>Total</td> </tr> <tr> <td>3</td> <td>4</td> <td>12</td> </tr> <tr> <td>Green</td> <td>Yellow</td> <td>Amber</td> </tr> </table> <p>Target</p> <table border="1"> <tr> <td>Likelihood</td> <td>Impact</td> <td>Total</td> </tr> <tr> <td>2</td> <td>4</td> <td>8</td> </tr> <tr> <td>Green</td> <td>Yellow</td> <td>Amber</td> </tr> </table>	Likelihood	Impact	Total	4	4	16	Yellow	Yellow	Red	Likelihood	Impact	Total	3	4	12	Green	Yellow	Amber	Likelihood	Impact	Total	2	4	8	Green	Yellow	Amber	<p>Prioritise key projects and flex resources across teams where appropriate</p> <p>Planned completion date: 31st Mar 2026</p>	<p>Risk Reviewed 16/01/2026 Risk and scoring reviewed. Still unable to progress recruitment due to ICB recruitment freeze and upcoming staff consultation, launches 26/01/2026. Continue to prioritise key projects and flex resources across teams where appropriate. Digital delivery team losing two further members of staff due to resignation and VR - 70% vacancy rate. Scoring reviewed and remains the same, and likely to remain so until consultation completes.</p> <p>28/10/2025. Risk and scoring reviewed. Still unable to progress recruitment due to ICB recruitment freeze. Continue to prioritise key projects and flex resources across teams where appropriate. Resources are now further constrained as one further</p>
Likelihood	Impact	Total																													
4	4	16																													
Yellow	Yellow	Red																													
Likelihood	Impact	Total																													
3	4	12																													
Green	Yellow	Amber																													
Likelihood	Impact	Total																													
2	4	8																													
Green	Yellow	Amber																													

member of the GPIT team has left the ICB. Vacancies across the GPIT/Delivery team now over 50%, with a team that is considerably smaller than other comparable to other ICBs even when fully recruited to. Scoring reviewed and remains the same, and likely to remain so until Change 2025 project completes.

Risk Area	Control Description	Risk Rating	Action Description	Risk Review Narrative																											
<p>Ref: CRR8</p> <p>Title: Access to Mental Health Acute Inpatient Beds (Urgent and Emergency Care: CRFD)</p> <p>There is a risk that: Due to an increased number of patients clinically ready and fit for discharge</p> <p>Leading to: the ICB is unable to meet the needs of patients requiring access to mental health services, then people are waiting for admission in environments that are clinically unsafe</p> <p>Resulting in: resulting in poor outcomes, possible major injury and others not receiving care in the right place at the right time</p> <p>Risk Owner: Ed Waller</p> <p>Committee: Improving Outcomes and Experience Committee</p> <p>Directorate/Function: Adult Mental Health</p>	<p>Provider Quality Meetings</p> <p>Mental Health, Learning Disabilities and Autism Provider Collaborative Board oversight of mental health programme.</p> <p>Investment in community crisis alternatives. Piloting of Transfer of Care Hub. System Patient Flow Improvement Plan led by Mental Health Provider Trust. Daily Health and Social Care Clinically Ready for Discharge Reviews.</p> <p>Development of a Mental Health and Housing Strategy</p> <p>3 year In Patient Quality Improvement action plan. Monthly assurance meetings are in place and we have completed four of the fifteen year 1 actions. We are in the process of developing our year 2 plan. We have engaged with NHSE to schedule quarterly assurance meetings.</p> <p>HACT expert housing consultants have concluded phase 1 (scoping) of the development of a mental health and housing strategy. Phase 2 (reporting key findings and opportunities) will be completed by end of January. Phase 3 development of the strategy is on</p>	<p>Risk Category: (Patient/People Outcomes) Impact on the safety of patients, staff or public (physical/psychological harm)</p> <p>Residual</p> <table border="1"> <thead> <tr> <th>Likelihood</th> <th>Impact</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>4</td> <td>4</td> <td>16</td> </tr> <tr> <td>Yellow</td> <td>Yellow</td> <td>Red</td> </tr> </tbody> </table> <p>Inherent</p> <table border="1"> <thead> <tr> <th>Likelihood</th> <th>Impact</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>4</td> <td>4</td> <td>16</td> </tr> <tr> <td>Yellow</td> <td>Yellow</td> <td>Red</td> </tr> </tbody> </table> <p>Target</p> <table border="1"> <thead> <tr> <th>Likelihood</th> <th>Impact</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>2</td> <td>3</td> <td>6</td> </tr> <tr> <td>Green</td> <td>Green</td> <td>Yellow</td> </tr> </tbody> </table>	Likelihood	Impact	Total	4	4	16	Yellow	Yellow	Red	Likelihood	Impact	Total	4	4	16	Yellow	Yellow	Red	Likelihood	Impact	Total	2	3	6	Green	Green	Yellow	<p>Development and distribution of Setting Expectations Policy for socialisation with KMMH In Patient Units</p> <p>Planned completion date: 31st Mar 2026</p>	<p>Risk Reviewed 20/01/26 - Significant system-wide work is underway across Kent and Medway to address persistent patient flow challenges within adult mental health inpatient pathways. Current pressures are recognised as being driven primarily by delayed discharge for patients who are clinically ready for discharge, non-purposeful short-stay admissions, gaps in supported accommodation and housing pathways, and variable robustness and confidence in community mental health provision, rather than by insufficient core inpatient bed</p>
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schedule for completion by end March 2025.

KMPT, supported by the ICB, continues to make improvements to their internal flow processes. These improvements include refining their 'Red to Green process', working with teams to ensure understanding of threshold for admission, establishing a Transfer of Care Hub and having Home Treatment clinicians conduct daily in-reach to inpatient wards.

Framework Transformation, Mental Health Together (MHT). A Primary Care action plan has been developed to support the management of mental health in primary care through understanding demand, capacity and risk, extending ARR, improving communication.

KMPT's High Intensity user Project is working with stakeholders in the wider urgent and emergency care system to establish effective management of frequent attenders at A&E's and repeat S136 to reduce the number of short stay in patient admissions and improve patient flow.

Extension of the Safe Havens is underway with the mobilisation of a co-located haven on the William Harvey Hospital site – planned go live date 26 February. A second crisis house opened in Ashford on 28 November. Initial uptake of this service was low however this has improved with 60% occupancy rate. Work is underway with stakeholders to embed the service within the MHUEC system. For the period 01/04/2024 – 31/12 2024 the Medway Crisis House had 193 residents staying for a period of up to 7 days. Patient Flow remains a Red Risk within the Provider Collaborative and a high red risk on Decision Time within the ICB.

ICS action plan in place:
Senior social care DTOC lead
Market engagement of supported living providers
20/08/24 Work in progress with KMPT re

In response, the system has established a coordinated programme of immediate and medium-term actions involving the ICB, Kent and Medway Mental Health NHS Trust, Adult Social Care and wider partners. This includes strengthened joint oversight of patient flow and bed utilisation, enhanced assurance processes around admission decision-making, and targeted work to improve admission avoidance and post-discharge support through the refinement of community mental health pathways aligned to the Community Mental Health Transformation Framework and Neighbourhood Mental Health model

KMMH - KMICB
Commissioning
inte...

step down/D2A beds. MADE events attended with providers. Housing strategy in process with external providers to increase housing availability for patients Mental Health discharge challenge Implementation of the inpatient quality framework and action plan. Crisis Recovery house Save Havens Mental Health and Housing Strategy development See and Treat Hear and Treat Revised CRFD weekly meeting Use of Private Bed Clinical risk assessment and clinical management of individual placements

Specific actions underway include joint work to reduce delayed discharge through improved discharge planning, closer collaboration with Adult Social Care on Care Act assessments and funding decisions, and the development of more effective step-down and community alternatives to inpatient care. The system is also addressing non-purposeful admissions through enhanced gatekeeping, strengthened crisis alternatives, and improved clinical confidence in managing higher-risk cohorts within community settings. In parallel, work is progressing to improve data quality, transparency and shared system intelligence to support timely decision-making and proactive management of flow pressures.

While these actions are expected to improve flow and reduce reliance on out-of-area placements over

time, the interdependencies across health, social care, housing and community provision mean that the risk cannot be fully mitigated in the short term. The risk therefore remains under active system management, with clear governance, defined workstreams and ongoing monitoring to ensure that mitigations continue to be implemented at pace and that further escalation occurs where progress is insufficient.

Risk Area	Control Description	Risk Rating	Action Description	Risk Review Narrative																																				
Ref: 1584 Title: Lack of ICS Digital and Data Strategy There is a risk that: we do not have an agreed Kent and Medway ICS Digital, Data and Technology Strategy Leading to: we will not have an agreed documented approach to deliver the ICS's priorities for digitally enabled health and care with buy-in from all stakeholders and agreement on the necessary investments to have a sustainable and affordable delivery plan Resulting in: failures to achieve the system digital transformation required take advantage of technology innovation to support system wide transformation programmes to deliver improved models of care and support citizens to manage their health and wellbeing through digital channels; and to deliver the ICS's digital convergence agenda to deliver less fragmented and more effective digital solutions at reduced cost and risk; and to increase the ICS's digital maturity as defined by	<p>Information on the status of the ICS Digital and Data Strategy will go to the DDaT Management Group, it is proposed that the Group's remit is to oversee the sustainable and affordable delivery of the ICS Digital and Data Strategy</p> <p>Individual programme groups currently in place to develop individual workplans:</p> <ul style="list-style-type: none"> • Digital and Data Strategy and Delivery Group • Shared Data and Analytics Board • Information Governance and Data Forum • KM Digital Directors and Group • Digital Innovation Leadership • Key programme groups such as KMCR, maternity, diagnostics <p>DDAT Management Group established</p>	<p>Risk Category: (Corporate & Finance) Programme delivery</p> <table border="1" data-bbox="1147 922 1327 1017"> <tr> <th colspan="3">Residual</th> </tr> <tr> <td>Likelihood</td> <td>Impact</td> <td>Total</td> </tr> <tr> <td>4</td> <td>4</td> <td>16</td> </tr> <tr> <td>Yellow</td> <td>Yellow</td> <td>Red</td> </tr> </table> <table border="1" data-bbox="1147 1017 1327 1112"> <tr> <th colspan="3">Inherent</th> </tr> <tr> <td>Likelihood</td> <td>Impact</td> <td>Total</td> </tr> <tr> <td>4</td> <td>4</td> <td>16</td> </tr> <tr> <td>Yellow</td> <td>Yellow</td> <td>Red</td> </tr> </table> <table border="1" data-bbox="1147 1144 1327 1239"> <tr> <th colspan="3">Target</th> </tr> <tr> <td>Likelihood</td> <td>Impact</td> <td>Total</td> </tr> <tr> <td>1</td> <td>4</td> <td>4</td> </tr> <tr> <td>Green</td> <td>Yellow</td> <td>Yellow</td> </tr> </table>	Residual			Likelihood	Impact	Total	4	4	16	Yellow	Yellow	Red	Inherent			Likelihood	Impact	Total	4	4	16	Yellow	Yellow	Red	Target			Likelihood	Impact	Total	1	4	4	Green	Yellow	Yellow	<p>Development and approval Digital and Data Strategy</p> <p>Planned completion date: 31st Mar 2026</p>	<p>Risk Reviewed 20/01/2026 Risk and scoring reviewed. Plan is in place to provide an updated strategy for approval to the ICB Board at March 2026 meeting.</p> <p>Strategy to be reviewed by the DDaT Management group on 26/01/2026.</p> <p>Strategy updated following comments from ICB Board Part 1 [Public] "Focus on ..." item on 4/11/2025. Latest version has been circulated to stakeholders for review:</p>
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the annual national Digital Maturity Assessment

Risk Owner: Ivor Duffy**Committee:** Digital and Data Board**Directorate/Function:** Digital Data and Technology

* Kent and Medway
Digital and Data
Involvement Group
(patient and public
engagement)

* Kent and Medway
provider Directors of
Digital and Data to
circulate and obtain
approvals from
individual providers

* Kent and Medway
Chief Clinical
Information
Officer/Chief Nursing
Information Officers

* Clinical Safety
Officer Forum

* NHS England South
East Region Digital
Team

* NHS Kent and
Medway ICB
Strategic
Commissioning and
Delivery teams

60

01/12/2025 Risk and
scoring reviewed.
Plan is in place to
provide an updated
strategy to the ICB
Board at the March
2026 meeting.

28/10/2025 Risk and
scoring reviewed.
Draft strategy
summary has now
been completed and
is being submitted for
consideration by the
ICB Executive
Management Team
(29/10/2025) and the
ICB Board
(4/11/2025, Part 1
[Public] "Focus on ...")

item). Feedback and comments will be incorporated into a final version that will be tabled at February ICB Board for approval.

Risk Area	Control Description	Risk Rating	Action Description	Risk Review Narrative																																				
<p>Ref: 1565</p> <p>Title: Total Workforce Pay Costs</p> <p>There is a risk that: the significant level of workforce saving, as set out in our 25/26 operational plans, is not delivered due to the scale of reductions required and other unplanned workforce impacting issues i.e. industrial action, lack of redundancy funding etc.</p> <p>Leading to: financial pressures</p> <p>Resulting in: an inability to deliver a balanced financial plan and/or our required service delivery would be unaffordable</p> <p>Risk Owner: Natalie Davies</p> <p>Committee: Productivity and Investment Committee, Kent & Medway People Committee</p> <p>Directorate/Function: People</p>	<p>Agreed workforce controls in place across all Trusts and ICB, based on national policy and best practice - with CPO sharing of successes/challenges</p> <p>Chief People Officers regularly review agency spend as part of local Board and system group discussions and assess the need for further short or long term actions</p> <p>NHS strategy and Financial Recovery Programme includes workforce elements, including workforce reduction and optimisation programme and monitoring of provider CIP delivery through joint governance reporting into Trust and ICB executives</p> <p>ICB has funded a partnership with the South East Temporary Staffing Collaborative and co-leading regional solutions to reduce agency spend including implementation of bank and agency rate cards, in addition to providing intensive support to Trusts as required</p> <p>Workforce Financial Recovery Group in place led by Chief of Staff and CPO SRO to share information and make shared decisions in relation to agency spend and workforce controls</p> <p>System dashboard implemented giving pay spend and utilisation (WTE), and CIPs, detailed by Trust, and is regularly shared through governance groups</p>	<p>Risk Category: (Corporate & Finance) Finance (system values)</p> <table border="1" data-bbox="1163 461 1365 493"> <tr> <th colspan="3">Residual</th> </tr> <tr> <td>Likelihood</td> <td>Impact</td> <td>Total</td> </tr> <tr> <td>4</td> <td>4</td> <td>16</td> </tr> <tr> <td>Yellow</td> <td>Yellow</td> <td>Red</td> </tr> </table> <table border="1" data-bbox="1163 557 1365 588"> <tr> <th colspan="3">Inherent</th> </tr> <tr> <td>Likelihood</td> <td>Impact</td> <td>Total</td> </tr> <tr> <td>4</td> <td>4</td> <td>16</td> </tr> <tr> <td>Yellow</td> <td>Yellow</td> <td>Red</td> </tr> </table> <table border="1" data-bbox="1163 699 1365 731"> <tr> <th colspan="3">Target</th> </tr> <tr> <td>Likelihood</td> <td>Impact</td> <td>Total</td> </tr> <tr> <td>3</td> <td>4</td> <td>12</td> </tr> <tr> <td>Green</td> <td>Yellow</td> <td>Amber</td> </tr> </table>	Residual			Likelihood	Impact	Total	4	4	16	Yellow	Yellow	Red	Inherent			Likelihood	Impact	Total	4	4	16	Yellow	Yellow	Red	Target			Likelihood	Impact	Total	3	4	12	Green	Yellow	Amber	<p>Development and implementation of a regional agency medical rate card</p> <p>Planned completion date: 31st Mar 2026</p> <p>Trust MARs schemes and expedited local consultations to deliver workforce reductions</p> <p>Planned completion date: 31st Mar 2026</p>	<p>Risk Reviewed 16/01/26 - Month 09 YTD total pay variance is £11.8m above plan, with £9.7m above plan on substantive, £2.5m above plan on bank and £0.5m below plan on agency spend. The adverse position is being driven by MFT, EKHUFT and MTW.</p>
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Title of meeting:	NHS Kent and Medway Integrated Care Board (Part 1)	Date: 3 February 2026
Title of report:	NHS Oversight Framework ICB Contextual Metrics	
Reporting officer:	Natalie Davies, Executive Director of System Improvement	
Lead member:	Natalie Davies, Executive Director of System Improvement	
Freedom of information (FOI) status:	This paper is disclosable under the FOI Act	

Purpose: This paper is for (please tick)

Assurance	Decision	Information	<input checked="" type="checkbox"/>	Discussion	
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Report summary:

NHS Kent and Medway Integrated Care Board is presented with the ICB's Q1 performance against NHS Oversight Framework (NOF) contextual metrics.

For information only, the Board is also presented with the Q2 provider segmentation data as Appendix 2. However, the focus of the report and for Board discussion are the ICB contextual metrics.

Executive Committee:

The paper was presented to the ICB Executive Committee on 16 January 2026.

The Executive Committee accepted the reported performance position and noted that overall performance was unacceptable.

The Committee agreed that the first iteration of the ICB's Strategic Commissioning Performance Report (SCPR) would be produced for the February 2026 Executive Committee meeting and to March 2026 ICB Board.

The initial SCPR will align with the commissioning levers from the 2026/27 planning round, identifying which ICB contextual metrics will be affected, and which lack improvement plans.

The Executive Committee agreed that there will be a future review point, after the ICB five-year strategy has been signed-off, to highlight where metrics align or where they are different to the ICB NOF contextual metrics. This will identify how the measurement of metrics within the five-year strategy will be aligned to the NOF and incorporated into the SCPR.

Q1 ICB Contextual Metrics:

Performance against the ICB contextual metrics will be updated via the 'Model Health System' in line with provider updates but will be reported a whole quarter in arrears compared to providers.



As such, this report is divided into two sections to reflect both the most current performance and the national position published on the Model Health System.

- Table 1 –Model Health System (national published data)
- Table 2 – Local assessment (latest published data as of 7 January 2026), not yet reported on Model Health System

Proposal and/or recommendation:

The Board is asked to consider the following:

1. Note the ICB's reported performance position against the NHS Oversight Contextual Metrics at Q1.
2. Note that the first iteration of the SCPR will be presented at Board on 03 March 2026 which will highlight those metrics that will be actively impacted as a result of commissioning levers agreed through the ICB's 2026/27 planning process.

Our objectives: Tick the objectives the report aims to support.

1. We will work with the NHS system to improve healthcare for our population.	✓	3. We will develop a workforce where colleagues feel valued, we celebrate diversity and are fair and inclusive.	✓
2. We will deliver sustainable services within our 2025/26 spending targets.	✓	4. We will reduce healthcare inequalities for the people of Kent and Medway.	✓

Identified risks, issues and mitigations:

Not applicable

Resource implications and finance approval:

Not applicable

Sustainability considerations:

Not applicable

Public and patient engagement considerations

Not applicable

Equality, health inequalities and quality impact assessment

Has an equality assessment been undertaken?

Yes (please attach the action plan to this paper)

Not applicable – paper provided for committees information.

Legal implications

Not applicable

Report history / committees reviewed

The paper was reviewed at the Executive Committee on 16 January 2026

Next steps:

First iteration of the SCPR to be presented to the Executive Committee on 11 February 2026 and ICB Board on 03 March 2026.

Appendices:

Appendix 1 – Glossary

Appendix 2 – Quarter 2 Provider Segmentation (for information)

List staff contributing to the paper and any conflicts of interest (COI) identified:

No conflicts of interest noted.

- ICB Oversight Department
 - Clare White, Senior System Oversight Manager
 - Emeka Madueke, Oversight Programme Manager
 - Dan Seymour, Deputy Director of Oversight
- ICB Analytics Department
 - Ian Roberts, Head of Performance Analytics

For further information or for any enquiries relating to this report please contact:

Marc Farr, Chief Data and Analytical Officer, marc.farr@nhs.net

Gerrie Adler, Director of Oversight; gerrie.adler1@nhs.net

Kent and Medway ICB NHS Oversight Framework, ICB Contextual Metrics Q1 2025/26

January 2026

Model Health System Update

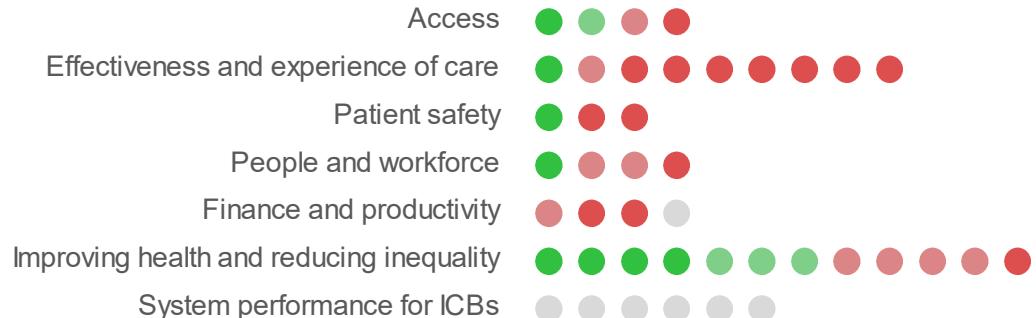
ICB Contextual Metrics

This report provides an update on the NHS Oversight Framework (2025/26) ICB Contextual Metrics.

- **Table 1 - outlines ICB Q1 contextual metric performance as it is currently published on Model Health System.** This data is currently restricted to the NHS and not visible to the public.
- **Table 2 - provides the most up-to-date performance, based on local assessment of published data, which is not yet reported on Model Health System**
- A summary position for both is provided on the first page of this report.

ICB Contextual Metrics Summary

ICB MHS Summary



Of 42 total metrics:

- 8 Green (19.0%)
- 4 Green/Amber (9.5%)
- 9 Amber/Red (21.4%)
- 14 Red (33.3%)
- 7 No RAG (16.7%)

ICB Local Summary



Of 42 total metrics:

- 7 Green (16.7%)
- 10 Green/Amber (23.8%)
- 6 Amber/Red (14.3%)
- 10 Red (23.8%)
- 9 No RAG (21.4%)

Key:

G	● RAG: Upper quartile. Very good performance relative to local target or national distribution benchmarking
G/A	● RAG: Between the median to upper quartile. Good performance relative to local target or national distribution benchmarking
A/R	● RAG: Between the lower quartile to median. Poor performance relative to local target or national distribution benchmarking
R	● RAG: Lower quartile. Poor performance relative to local target or national distribution benchmarking

Table 1 - NHS Oversight Framework (2025/26) ICB Contextual metrics

**Kent and Medway Q1 Position
(as published on Model Health System)**

Kent and Medway Q1 Position (as published on Model Health System)

No.	Domain	Domain Sub-Group	Metric	ICB Lead	Data Frequency	Latest Data Period	Performance	National Quartile	National Average	National Rank	Peer Rank
1	Access	Elective care	Annual change in the size of the waiting list	Director of Elective Care	Monthly	Jun-2025	-1.34%	A/R ●	-2.74%	28/42	5/6
2		Cancer Care	Percentage of all cancers diagnosed at stage 1 or 2 (Band Score)	K&M Cancer Alliance Director	Monthly	Mar-2025	2	G/A ●	2	24/42	5/6
3		Primary care	Growth in number of urgent dental appointments provided versus target	Director of Primary and Community (Out of Hospital) Care	Monthly	Apr-2025	111.70%	G ●	94.25%	1/42	1/6
4			Percentage of patients to describe booking a general practice appointment as easy	Director of Primary and Community (Out of Hospital) Care	Monthly	Jun-2025	61.30%	R ●	73.25%	41/42	6/6
5	Effectiveness and experience of care	Discharges	Acute bed days per 100,000 people	Director System Commissioning and Operational Planning	Quarterly	Q1 2025/26	128.67	G ●	138.04	11/42	3/6
6		Inpatients (Mental Health)	Change in the number of inpatients who are autistic or have a learning disability	Director System Commissioning and Operational Planning	Quarterly	Q1 2025/26	55	A/R ●	35	30/42	4/6
7		Discharges	Average number of days from discharge ready date and actual discharge date	Director System Commissioning and Operational Planning	Monthly	Jun-2025	1.30	R ●	0.77	38/42	4/6
8	Community Health Services	Community Health Services	Percentage of continuing healthcare referrals completed in 28 days	Director of Primary and Community (Out of Hospital) Care	Quarterly	Q1 2025/26	54.63%	R ●	79.23%	38/42	5/6
9		Inpatients (Mental Health)	Percentage of inappropriate out of area placement adult acute mental health bed days	Director System Commissioning and Operational Planning	Quarterly	Q1 2025/26	12.33%	R ●	3.83%	41/42	5/6
10		Effectiveness	Percentage of patients who receive all 8 diabetes care processes	Director of Primary and Community (Out of Hospital) Care	Quarterly	Mar-2024	51.40%	R ●	61.50%	38/42	6/6
11	Prevention		Percentage of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Director of Primary and Community (Out of Hospital) Care	Quarterly	Q4 2024/25	41.84%	R ●	48.98%	39/42	6/6
12			Percentage of hypertension patients treated to target	Director of Primary and Community (Out of Hospital) Care	Quarterly	Q4 2024/25	67.61%	R ●	70.1%	39/42	6/6
13	Patient experience		Percentage of patients with a preferred general practice professional reporting they were able to get an appointment with that professional	Director of Primary and Community (Out of Hospital) Care	Monthly	Jun-2025	57.3%	R ●	66.6%	34/42	5/6
14		Patient safety	NHS Staff Survey – raising concerns sub-score	Director of People and Culture	Annually	2024	5.72	R ●	6.45	40/41	5/6
15			Number of neonatal deaths and stillbirths per 1,000 total births (banded score)	Director of Strategic Change and Population Health	Annually	2023	2.00	G ●	3.00	3/42	2/6
16	Primary care		Percentage of children (aged 0 – 9) prescribed antibiotics in the last 12 months	Director of Strategic Change and Population Health	Monthly	Jun-2025	27.6%	R ●	27%*	15/42	3/6
17		People and workforce	Sickness absence rate	Director of People and Culture	Quarterly	Q1 2025/26	2.02%	G ●	3.01%	2/42	1/6
18	People and workforce		NHS staff survey engagement theme sub-score	Director of People and Culture	Annually	2024	6.03	R ●	6.63	41/42	5/6
19			NHS staff survey education and training theme score - "we are always learning" section score	Director of People and Culture	Annually	2024	4.90	A/R ●	5.19	30/42	4/6
20	Primary care		GP leaver rate	Director of Primary and Community (Out of Hospital) Care	Quarterly	Q1 2025/26	6.85%	A/R ●	6.48%	27/42	4/6

Together, we can

Kent and Medway Q1 Position (as published on Model Health System)

No.	Domain	Domain Sub-Group	Metric	ICB Lead	Data Frequency	Latest Data Period	Performance	National Quartile	National Average	National Rank	Peer Rank
21	Finance and productivity	Finance	Planned surplus/deficit	Director of Finance	Monthly	Jun-2025	0.26%	R	0.00%	35/42	6/6
22			Variance year-to-date to financial plan	Director of Finance	Monthly	Jun-2025	0.00	A/R	0.00	N/A	N/A
23			Combined finance score	Director of Finance							
24		Productivity	Implied productivity level (year-to-date compared to previous year)	Director of Finance	Monthly	Jun-2025	0.76%	R	2.37%	33/42	6/6
25	Improving health and reducing inequality	Improving population health	Time spent in good health, before people develop their first significant long term health condition	Director of Strategic Change and Population Health	Annually	Mar-2024	51.08	G/A	50.75	18/42	4/6
26a	Primary prevention		Cervical screening coverage for females aged 25-64 within the target period	K&M Cancer Alliance Director	Monthly	Jun-2025	71.70%	G/A	71.66%	21/42	2/6
26b			Bowel screening coverage in the last 30 months aged 60-74	K&M Cancer Alliance Director	Monthly	Mar-2024	72.96%	A/R	73.02%	23/42	6/6
26c			Breast screening coverage in the last 36 months for females aged 53-70	K&M Cancer Alliance Director	Monthly	Mar-2024	71.56%	G/A	71.46%	21/42	4/6
27			Percentage of pregnant women who quit smoking (Banded estimate score)	Director of Strategic Change and Population Health	Monthly	Sep-2024	3	G	2	6/42	1/6
28			Percentage of patients supported by obesity programmes (Proportion of people taking up lifestyle/behavioural programmes to reduce obesity) -Banded score	Director of Strategic Change and Population Health	Quarterly	Q1 2025/26	3.44	G	3.12	10/42	1/6
29			MMR vaccine uptake rate - Percentage of children to receive two doses of MMR vaccine before their 5th birthday	Director of Strategic Change and Population Health	Quarterly	Mar-2025	85.10%	A/R	87.9%	32/42	5/6
30	Inequalities		Deprivation and ethnicity gap in pre-term births score (composite scored band)	Director of Strategic Change and Population Health	Quarterly	Q4 2024/25	3	R	2	32/42	5/6
31			Deprivation gap in early cancer diagnosis	Director of Strategic Change and Population Health	Quarterly	Q4 2024/25	8.18%	A/R	7.24%	28/42	6/6
32a			Deprivation gap in myocardial infarction admissions (rolling annual)	Director of Strategic Change and Population Health	Monthly	Jun-2025	30.21%	A/R	28.34%	25/42	3/6
32b			Deprivation gap in stroke admissions (rolling annual)	Director of Strategic Change and Population Health	Monthly	Jun-2025	14.44%	G	27.29%	5/42	1/6
33			Percentage of annual health checks completed for patients with a learning disability or who are autistic (Banded score)	Director System Commissioning and Operational Planning	Monthly	Q1 2025/26	1	G	1	1/42	1/6
34	System performance for ICBs	Urgent and emergency care	Has the system been in the lowest quartile for 4 hour UEC performance for each of the last three months?	Director System Commissioning and Operational Planning	Quarterly	Q1 2025/26		N/A	N/A	N/A	N/A
35		Elective care	Has the system been in the lowest quartile for 18-week performance for each month of the last quarter?	Director of Elective Care	Quarterly	Q1 2025/26		N/A	N/A	N/A	N/A
36	Cancer Care		Has the system been in the lowest quartile for 62-day performance for each month of the last quarter?	K&M Cancer Alliance Director	Quarterly	Q1 2025/26		N/A	N/A	N/A	N/A
37			Is the system in the lowest quartile for overall primary care patient satisfaction?	Director of Primary and Community (Out of Hospital) Care	Quarterly	Q1 2025/26		N/A	N/A	N/A	N/A
38			Is the system's proportion of annual physical health checks for those with severe mental illness completed in the last year below 60%?	Director System Commissioning and Operational Planning	Quarterly	Jun-2025		N/A	N/A	N/A	N/A
39	Finance		Is the system projecting an annual deficit of over 2.5% or a deficit below 2.5% that is over 1% off plan?	Director of Finance	Quarterly	Q1 2025/26		N/A	N/A	N/A	N/A

* Fixed national England target expected at or below 27%

Table 2 - NHS Oversight Framework (2025/26) ICB Contextual metrics

**Kent and Medway most up-to-date local assessment
(published data, which is not yet reported on Model Health System)**

Kent and Medway most up-to-date local assessment

(published data, which is not yet reported on Model Health System)

No.	Domain	Domain Sub-Group	Metric	ICB Lead	Data Frequency	Latest Data Period	Performance	SPC Variation Icon	National Quartile	National Average	National Rank	Peer Rank
1	Access	Elective care	Annual change in the size of the waiting list	Director of Elective Care	Monthly	Oct-2025	-1.74%	G/A	-3.16%	20/42	3/6	
2		Cancer Care	Percentage of all cancers diagnosed at stage 1 or 2	K&M Cancer Alliance Director	Monthly	Aug-2025	60.00%	A/R	59.50%	22/42	4/6	
3		Primary care	Growth in number of urgent dental appointments provided versus target	Director of Primary and Community (Out of Hospital) Care	Monthly	Sep-2025	89.00%	G	86.00%	16/42	3/6	
4			Percentage of patients to describe booking a general practice appointment as easy	Director of Primary and Community (Out of Hospital) Care	Monthly	Nov-2025	65.70%	R	73.70%	41/42	6/6	
5	Effectiveness and experience of care	Discharges	Acute bed days per 100,000 people	Director System Commissioning and Operational Planning	Monthly	Q1 2025/26	128.67	G	138.04	11/42	3/6	
6		Inpatients (Mental Health)	Change in the number of inpatients who are autistic or have a learning disability	Director System Commissioning and Operational Planning	Monthly	Oct-2025	0.00%	G/A	-0.60%	7/42	2/6	
7		Discharges	Average number of days from discharge ready date and actual discharge date	Director System Commissioning and Operational Planning	Monthly	Oct-2025	1.50	R	0.92	40/42	5/6	
8		Community Health Services	Percentage of continuing healthcare referrals completed in 28 days	Director of Primary and Community (Out of Hospital) Care	Quarterly	Q2 2025/26	60.50%	R	76.00%	35/42	6/6	
9		Inpatients (Mental Health)	Percentage of inappropriate out of area placement adult acute mental health bed days	Director System Commissioning and Operational Planning	Monthly	Oct-2025	12.50%	G/A	19.20%	16/42	1/6	
10		Effectiveness	Percentage of patients who receive all 8 diabetes care processes	Director of Primary and Community (Out of Hospital) Care	Quarterly	Q4 2024/25	51.40%	R	61.50%	38/42	5/6	
11		Prevention	Percentage of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Director of Primary and Community (Out of Hospital) Care	Quarterly	Q1 2025/26	41.50%	R	62.10%	40/42	5/6	
12			Percentage of hypertension patients treated to target	Director of Primary and Community (Out of Hospital) Care	Quarterly	Q1 2025/26	64.40%	R	70.90%	41/42	6/6	
13		Patient experience	Percentage of patients with a preferred general practice professional reporting they were able to get an appointment with that professional	Director of Primary and Community (Out of Hospital) Care	Monthly	Nov-2025	69.70%	G/A	67.10%	15/42	4/6	
14	Patient safety	Patient safety	NHS Staff Survey – raising concerns sub-score	Director of People and Culture	Annually	2024	5.72	R	6.39	39/41	6/6	
15			Number of neonatal deaths and stillbirths per 1,000 total births	Director of Strategic Change and Population Health	Annually	2024	4.20	G	4.90	3/42	1/6	
16		Primary care	Percentage of children (aged 0 – 9) prescribed antibiotics in the last 12 months	Director of Strategic Change and Population Health	Monthly	Oct-2025	26.70%	G/A	28.70%	16/42	3/6	
17	People and workforce	People and workforce	Sickness absence rate	Director of People and Culture	Monthly	Jul-2025	2.9%	G	5.1%	10/42	2/6	
18			NHS staff survey engagement theme sub-score	Director of People and Culture	Annually	2024	6.03	R	6.85	40/41	6/6	
19			NHS staff survey education and training theme score - "we are always learning" section score	Director of People and Culture	Annually	2024	4.90	A/R	5.19	30/42	4/6	
20		Primary care	GP leaver rate	Director of Primary and Community (Out of Hospital) Care	Monthly (12 month rolling)	Sep-2025	6.30%	G/A	6.50%	18/42	3/6	

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Kent and Medway most up-to-date local assessment

(published data, which is not yet reported on Model Health System)

No.	Domain	Domain Sub-Group	Metric	ICB Lead	Data Frequency	Latest Data Period	Performance	SPC Variation Icon	National Quartile	National Average	National Rank	Peer Rank
21	Finance and productivity	Finance	Planned surplus/deficit	Director of Finance	Monthly	Nov-2025	0.70%					
22			Variance year-to-date to financial plan	Director of Finance	Monthly	Nov-2025	2.00%					
23			Combined finance score	Director of Finance	Monthly	Nov-2025	4					
24		Productivity	Implied productivity level (year-to-date compared to previous year)	Director of Finance	Monthly	Jul-2025	2.40%	G/A	2.90%	16/42	3/6	
25	Improving health and reducing inequality	Improving population health	Time spent in good health, before people develop their first significant long term health condition	Director of Strategic Change and Population Health	Annually	2023/24	51.08	G/A	50.75	18/42	5/6	
26a		Primary prevention	Cervical screening coverage for females aged 25-64 within the target period	K&M Cancer Alliance Director	Annually	2023/24	71.70%	G/A	71.66%	18/42	4/6	
26b			Bowel screening coverage in the last 30 months aged 60-74	K&M Cancer Alliance Director	Annually	2023/24	72.96%	A/R	73.02%	23/42	4/6	
26c			Breast screening coverage in the last 36 months for females aged 53-70	K&M Cancer Alliance Director	Annually	2023/24	71.56%	G/A	71.46%	20/42	4/6	
27			Percentage of pregnant women who quit smoking (Banded estimate score)	Director of Strategic Change and Population Health	Monthly	Sep-2024	3	G	2	6/42	1/6	
28			Percentage of patients supported by obesity programmes (Proportion of people taking up lifestyle/behavioural programmes to reduce obesity) -Banded score	Director of Strategic Change and Population Health	Quarterly	Q1 2025/26	3.44	R	3.12	10/42	1/6	
29			MMR2 vaccine uptake rate	Director of Strategic Change and Population Health	Quarterly	Mar-2025	85.10%	A/R	87.89%	32/42	6/6	
30		Inequalities	Deprivation and ethnicity gap in pre-term births score (composite scored band)	Director of Strategic Change and Population Health	Quarterly	Q4 2024/25	3	R	2	33/42	5/6	
31			Deprivation gap in early cancer diagnosis gap	Director of Strategic Change and Population Health	Quarterly	Q4 2024/25	8.18%	A/R	7.24%	28/42	6/6	
32a			Deprivation gap in myocardial infarction admissions	Director of Strategic Change and Population Health	Monthly	Jun-2025	30.21%	A/R	28.34%	25/42	5/6	
32b			Deprivation gap in stroke admissions	Director of Strategic Change and Population Health	Monthly	Jun-2025	14.44%	G	27.29%	5/42	3/6	
33			Percentage of annual health checks completed for patients with a learning disability or who are autistic (banded score)	Director System Commissioning and Operational Planning	Monthly	Oct-2025	1	G	1	N/A	N/A	

Kent and Medway most up-to-date local assessment

(published data, which is not yet reported on Model Health System)

No.	Domain	Domain Sub-Group	Metric	ICB Lead	Data Frequency	Latest Data Period	Performance	SPC Variation Icon	National Quartile	National Average	National Rank	Peer Rank
34	System performance for ICBs	Urgent and emergency care	Has the system been in the lowest quartile for 4 hour UEC performance for each of the last three months?	Director System Commissioning and Operational Planning	Quarterly	Nov-2025	●	●				
35		Elective care	Has the system been in the lowest quartile for 18-week performance for each month of the last quarter?	Director of Elective Care	Quarterly	Oct-2025	●	●				
36		Cancer Care	Has the system been in the lowest quartile for 62-day performance for each month of the last quarter?	K&M Cancer Alliance Director	Quarterly	Oct-2025	●	●				
37		Primary care	Is the system in the lowest quartile for overall primary care patient satisfaction?	Director of Primary and Community (Out of Hospital) Care	Quarterly	Nov-2025	●	●				
38		Mental health	Is the system's proportion of annual physical health checks for those with severe mental illness completed in the last year below 60%?	Director System Commissioning and Operational Planning	Quarterly	Nov-2025	●	●				
39		Finance	Is the system projecting an annual deficit of over 2.5% or a deficit below 2.5% that is over 1% off plan?	Director of Finance	Quarterly	Nov-2025	●	●				

Appendices

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No.	Metric	Domain	Domain Sub-Group	Data Source	Methodology	Ranking/Benchmarking based on National or Model System
1	Annual change in the size of the waiting list	Access	Elective care	https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/	Numerator: Total number of incomplete pathways (Sum of all weekly time bands) at the end of the month within the current year. Denominator: Total number of incomplete pathways (Sum of all weekly time bands) at the end of the same month of the previous year. Filters: Referral to Treatment (RTT) pathways commissioned by non-English commissioners are excluded from the calculation.	National
2	Percentage of all cancers diagnosed at stage 1 or 2	Access	Cancer	Monthly rapid registration early stage proportion data by ICB is published at (nhsd-ndrs.shinyapps.io/rcrd/) Staging completeness is published at (nhsd-ndrs.shinyapps.io/staging_dashboard/)	Numerator: Number of cases of cancer with a known stage at diagnosis which were of stage 1 or 2. Denominator: Number of cases of cancer with a known stage at diagnosis. Filters: Only cancers (in residents of England) with a known stage within the Rapid Cancer Registration Dataset (RCRD) are included in the early diagnosis computation. Stage completeness is based on stageable cancers, diagnosed and discussed at multi-disciplinary team (MDT) meetings at NHS trusts in England.	National
3	Growth in number of urgent dental appointments provided versus target	Access	Primary care	https://future.nhs.uk/DENTISTRY/view?objectId=263835269	Numerator: Total units of urgent dental activity delivered Denominator: Planned units of urgent dental activity delivered	National
4	Percentage of patients to describe booking a general practice appointment as easy	Access	Primary care	Published: Health Insight Survey. The Health Insight Survey is being conducted by the Office for National Statistics (ONS) and funded by NHS England. The data collected cover adults' experiences of NHS healthcare services including GP practices, hospital waiting lists, dentistry and pharmacy services. For more information, please see: https://www.ons.gov.uk/surveys/informationforhouseholdsandindividuals/householdandindividualsurveys/healthinsightsurvey/aboutthehealthinsightsurvey Published Link: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datasets/experiencesofnhshealthcareservicesinengland	Definition: This metric reflects the proportion of people who said it was easy to make contact with their GP practice, for those who were successful in contacting their practice in the last 28 days Method: Question number: 6 Logic: Numerator/ Denominator Denominator: Number who successfully made contact with their GP Numerator: Of the denominator, the number who responded 'Easy' or 'Very easy' to question 'How easy or difficult was it to make contact with your GP practice?'	National

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No.	Metric	Domain	Domain Sub-Group	Data Source	Methodology	Ranking/Benchmarking based on National or Model System
5	Acute bed days per 100,000 people	Effectiveness and experience of care	Effectiveness and experience of care	Derived from NHS Hospital Episode Statistics, data is not currently published. https://digital.nhs.uk/services/hospital-episode-statistics	Numerator: Total number of bed days per quarter. Denominator: Standardised population. Computation: Data are restricted to NHS commissioned spells for specific acute treatment functions for stays in NHS acute hospitals. Totals are age-sex standardised by five-year age-sex bands with an upper band of 85 years plus. Bed day totals per month are converted into crude rate using month GP registration estimates at Sub-ICB level. Crude rates by age-sex band are then applied to the England population as of the 1st July 2024 to generate a bed days total had each ICB shared the same population structure as England as a whole. Totals have then been converted into a rate per 100,000 patients using the English population.	TBC
6	Change in the number of inpatients who are autistic or have a learning disability	Effectiveness and experience of care	Effectiveness and experience of care	Published figures from the assuring transformation dataset suppress values due to disclosure risks. This measure uses internal unsuppressed data to allocate each system to a performance band based on the level of change from baseline	Numerator: Total number of adult inpatients with a learning disability or autism Denominator: Baseline number of adult inpatients with a learning disability or autism	National
7	Average number of days from discharge ready date and actual discharge date	Effectiveness and experience of care	Effectiveness and experience of care	Statistics » Discharge ready date (https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-readydate/)	Numerator: The total aggregate number of days from discharge ready date to date of discharge for all patients discharged in the period. Denominator: The total number of patients that have been discharged in the period. Calculation: Numerator divided by denominator presented as a number of days. Please note: Where the provider reports that all their discharges are on discharge ready date, i.e. the denominator is zero, the denominator is set to the total count of discharges to allow a metric value to be calculated.	National
8	Percentage of continuing healthcare referrals completed in 28 days	Effectiveness and experience of care	Effectiveness and experience of care	https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-chc-fnc/	Numerator: The total number of standard NHS CHC referrals in the period that were completed within 28 days. Denominator: The total number of standard NHS CHC referrals completed in the period. Computation: Numerator as a percentage of denominator.	National

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No.	Metric	Domain	Domain Sub-Group	Data Source	Methodology	Ranking/Benchmarking based on National or Model System
9	Percentage of inappropriate out of area placement adult acute mental health bed days	Effectiveness and experience of care	Effectiveness and experience of care	Published: Mental Health Services Monthly Statistics Published Link: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics/	**Definition: ** Percentage of total adult acute inpatient bed days that were occupied by patients placed in Out of Area Placements (OAPs) deemed inappropriate during a specified reporting period. An OAP is considered inappropriate when the placement occurs outside the patient's local area due to lack of available beds, rather than clinical need or patient choice. Logic: MEASURE_ID = 'OAP09a' or MEASURE_NAME: 'Proportion of Inappropriate OAPs bed days in Adult Acute beds in the period' For each Provider, ICB, Region or National, use the appropriate breakdown. For National figures, use filter [Breakdown] = 'England', for region, use 'Commissioning Region', for ICB, use "ICB of GP Practice or Residence" and for provider use "Provider"	Model System
10	Percentage of patients who receive all 8 diabetes care processes	Effectiveness and experience of care	Primary care	National Diabetes Audit - NHS England Digital	Numerator: of the denominator, the number to receive the 8 care processes in the audit period. Denominator: the number of patients with either type 1 or 2 diabetes at the end of the audit period.	National
11	Percentage of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Effectiveness and experience of care	Primary care	CVDPREVENT	Indicator CVDP012CHOL Numerator: Of the denominator, the count where the most recent blood cholesterol level (measured in the preceding 12 months) is within the treatment target levels low density lipoprotein (LDL) cholesterol less than or equal to 2.0 mmol/l or non-high density lipoprotein (non-HDL) cholesterol less than or equal to 2.6 mmol/l Denominator: Patients aged 18 and over with GP recorded CVD (narrow definition which includes coronary heart disease (CHD), non-haemorrhagic stroke and stroke cause not specified, transient ischaemic attack (TIA), and peripheral arterial disease (PAD))	National
12	Percentage of hypertension patients treated to target	Effectiveness and experience of care	Primary care	CVDPREVENT	Indicator CVDP007HYP Numerator: The percentage of patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (recorded in the last 12 months) is below the age appropriate treatment threshold (140/90 mmHg or less in patients 79 and under and 150/90mmHg or less in patients aged 80 and over). Denominator: The percentage of patients aged 18 and over with GP recorded hypertension	National

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No.	Metric	Domain	Domain Sub-Group	Data Source	Methodology	Ranking/Benchmarking based on National or Model System
13	Percentage of patients with a preferred general practice professional reporting they were able to get an appointment with that professional	Effectiveness and experience of care	Primary care	Experiences of NHS healthcare services in England - Office for National Statistics https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datasets/experiencesofnhshealthcareservicesinengland Indicator: GPP044	Numerator: Number of respondents who have a preferred health professional and were given a face-to-face appointment, a video call appointment or a call-back appointment with that professional. Denominator: Number of respondents who have a preferred health professional and were given a face-to-face appointment, a video call appointment or a call-back. Computation: Numerator as a percentage of denominator.	National
14	NHS Staff Survey – raising concerns sub-score	Patient safety	Patient safety	(https://www.nhsstaffsurveys.com/results/localresults/) Local results for every organisation NHS Staff Survey (https://www.nhsstaffsurveys.com/results/localresults/)	NHS staff survey sub score for the following measures: Q20a – I would feel secure raising concerns about unsafe clinical practice Q20b – I am confident that my organisation would address my concern Q25e – I feel safe to speak up about anything that concerns me in this organisation Q25f – If I spoke up about something that concerned me I am confident my organisation would address my concern For further details see Section 3.1 of NHS Staff Survey Technical Guide	Model System
15	Number of neonatal deaths and stillbirths per 1,000 total births	Patient safety	Patient safety	Perinatal mortality data viewer MBRRACE-UK	Numerator: Of the denominator, the number of stillbirth and neonatal deaths (who died before 28 completed days after birth) during a calendar year. Denominator: The number of total births occurring during a calendar year. Filters: Terminations of pregnancy are excluded from the indicator (including late terminations after 24 weeks gestational age) Births less than 24 weeks gestational age are excluded from the indicator (and any neonatal deaths associated with these births) Computation: Rates are stabilised and adjusted as per the MBRRACE methodology Because the rate is indirectly standardised, it is presented in comparison to the comparator group rate as a category.	National
16	Percentage of children (aged 0 – 9) prescribed antibiotics in the last 12 months	Patient safety	Primary care	https://www.nhsbsa.nhs.uk/access-our-data-products/epact2/dashboards-and-specifications/antimicrobial-stewardship-children-dashboard	Numerator: The number of children (aged 0-9) prescribed at least one antibacterial drug in the last 12 months. Denominator: The number of children (aged 0-9) on the registered list.	National

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No.	Metric	Domain	Domain Sub-Group	Data Source	Methodology	Ranking/Benchmarking based on National or Model System
17	Sickness absence rate	People and workforce	People and workforce	NHS Sickness Absence Rates – NHS EnglandDigital (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sicknessabsence-rates)	Definition: The sickness absence rates of NHS Hospital and Community Health Services staff. This covers staff working in NHS trusts, NHS support organisations and central bodies. Sickness absence rate is calculated by dividing the total number of sickness absence days (including non-working days) by the total number of days available per month for all staff. Method: Logic: Numerator/ Denominator Denominator: The number of days available per month for all staff Numerator: The number of sickness absence days (including non-working days)	National
18	NHS staff survey engagement theme sub-score	People and workforce	People and workforce	Local results for every organisation NHS StaffSurvey (https://www.nhsstaffsurveys.com/results/localresults/)	Composition: This score is comprised of 3 individual sub-scores covering motivation, involvement and advocacy, aggregated to an overall score. Each sub-score is comprised of a number of questions which are scored on a 0-10 scale and reported as a mean score. A higher score indicates a more favourable result. Specific variable ID: theme_engagement_2024	Model System
19	NHS staff survey education and training theme score - "we are always learning" section score	People and workforce	People and workforce	https://www.nhsstaffsurveys.com/Survey_I.D._PP5_2025	Combined score for staff survey questions 23a (Appraisals), 24a, 24b, 24c, 24d and 24e (Development) presented as a single section score out of 10.	National
20	GP leaver rate	People and workforce	Primary care	https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services#latest-statistics	Numerator: The number of fully qualified permanent GPs leaving the general practice workforce entirely (FTE) (rolling 12 months) Denominator: The number of fully qualified permanent GPs (FTE)	National
21	Planned surplus/deficit	Finance and productivity	Finance	This information is not currently published and is based on annual financial plan returns	Numerator: Planned Surplus / Deficit excluding deficit support funding Denominator: Turnover (trusts) or Allocation (ICBs) minus deficit support funding	N/A
22	Variance year-to-date to financial plan	Finance and productivity	Finance	This information is not currently published and is based on annual financial plan returns	Numerator: Year to date (YTD) variance – YTD actual surplus/deficit less YTD planned surplus/deficit Denominator: YTD Turnover (trusts) or YTD Allocation (ICBs)	N/A
23	Combined finance score	Finance and productivity	Finance	This information is not currently published and is based on monthly financial returns	Measure one: Planned surplus deficit score (OF0076 / 0079) Measure two: Variance year-to-date score (OF0078 / 0081) Computation: The two measure scores are plotted on a sixteen box grid to give an overall score, see scoring methodology section for details	N/A
24	Implied productivity level (year-to-date compared to previous year)	Finance and productivity	Productivity	Not currently published, will be published as an experimental statistic from September	Numerator: Estimated growth in cost-weighted activity between the periods Denominator: Real terms spending growth between the periods Computation: Numerator divided by denominator presented as a % of the same calculation for the same period in the previous year	Model System

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No.	Metric	Domain	Domain Sub-Group	Data Source	Methodology	Ranking/Benchmarking based on National or Model System
25	Average number of years people live in healthy life - ICB	Improving health and reducing inequality	Improving population health	https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/between2011to2013and2021to2023	The healthy life expectancy for males and females aged <1 based on the number of deaths registered, mid-year population estimates, and health state prevalence aggregated over three consecutive years.	National
26a	Cervical screening coverage for females aged 25 - 49 within the target period	Improving health and reducing inequality	Primary prevention	https://fingertips.phe.org.uk/search/cervical%20screening	Numerator: The number of eligible women aged 25-49 years, registered at the practice on the last day of the review period, who had an adequate cervical screening test recorded in the previous 42 months (3.5 years). Denominator: The number of eligible women aged 25-49 years registered at the practice on the last day of the review period.	National
26b	Bowel screening coverage in the last 30 months aged 60-74	Improving health and reducing inequality	Primary prevention	https://fingertips.phe.org.uk/search/bowel%20screening	Numerator: The number of eligible people aged 60 to 74, registered to the practice on the last day of the review period, who have had an adequate faecal immunochemical test (FIT) screening result in the past 30 months (2.5 years). Denominator: The number of eligible people aged 60 to 74 registered to the practice on the last day of the review period.	National
26c	Breast screening coverage in the last 36 months for females aged 53 - 70	Improving health and reducing inequality	Primary prevention	https://fingertips.phe.org.uk/search/breast%20screening	Numerator: The number of eligible women aged between 53 and 70, registered to the practice on the last day of the review period, who have had a breast screening test result recorded in the past 36 months Denominator: The number of eligible women aged between 53 and 70 registered to the practice on the last day of the review period	National
27	Percentage of pregnant women who quit smoking	Improving health and reducing inequality	Primary prevention	https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics/	Numerator: The number of women smoking at the time of booking minus the number smoking at delivery Denominator: The number of women smoking at the time of booking	National

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No.	Metric	Domain	Domain Sub-Group	Data Source	Methodology	Ranking/Benchmarking based on National or Model System
29	MMR vaccine uptake rate - Percentage of children to health and receive two doses of MMR vaccine before their 5th birthday	Improving health and reducing inequality	Primary prevention	Published: UKHSA quarterly vaccination coverage statistics (COVER programme) https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2025-to-2026-quarterly-data/quarterly-vaccination-coverage-statistics-for-children-aged-up-to-5-years-in-the-uk-cover-programme-april-to-june-2025	<p>Definition: The percentage of eligible children who received the two doses of the Measles, Mumps, and Rubella (MMR) vaccine by their fifth birthday.</p> <p>Method: Logic: Numerator/ Denominator</p> <p>Denominator: Number of 5 year old children eligible to receive the second dose of the MMR vaccine. Column [Metric] = '5y_MMR2_Boo_Denom'</p> <p>Numerator: Of the denominator, the number who have received the second dose of the MMR vaccination by their fifth birthday. Column [Metric] = '5y_MMR2_Boo_Num'</p>	National
30	Deprivation and ethnicity gap in pre-term births	Improving health and reducing inequality	Inequalities	Maternity Services Dataset (MSDS)	<p>Definition: A ratio comparing the preterm birth rate of Black and Asian women to White women. The preterm birth rate is calculated for White women and then for Black and Asian women. The rate for Black and Asian women is divided by the rate for White women to create a ratio.</p> <p>Method: Logic: numerator/denominator</p> <p>Numerator: The total number of births at between 24+0 weeks and 37+0 weeks gestation.</p> <p>Denominator: The total number of births (live and still) at 24+0 weeks gestation and over.</p>	National
31	Deprivation gap in early cancer diagnosis gap	Improving health and reducing inequality	Inequalities	<p>Unpublished: Rapid Cancer Registration Data (RCRD).</p> <p>Early diagnosis data from the RCRD is published at a higher aggregate level, for example by ICB, or for England by deprivation quintile. Link here: https://digital.nhs.uk/nhrs/data/data-outputs/cancer-data-hub/rapid-cancer-registration-data-dashboards</p>	<p>Definition: The percentage point gap in early cancer diagnosis proportion between the most and least deprived areas, as calculated using the Slope Index of Inequality (SII). Early cancer diagnosis proportion is defined as the number of cancer cases at stages 1 or 2 divided by those at stages 1, 2, 3 or 4. All data is based on a 12-month period represented by the latest month of that period e.g. 'July 2024' represents the period August 2023 to July 2024.</p> <p>Method: The difference between the most and least deprived areas is calculated using the Slope Index of Inequality where the early cancer diagnosis proportion is plotted for each deprivation quintile (least to most deprived). A regression line of best fit is then applied across all data points. The measure is the percentage point difference between the top and bottom of the regression line. An outline of the methodology for calculating the SII is available via FutureNHS: https://future.nhs.uk/canc/view?objectId=61978917</p> <p>Logic: For early cancer diagnosis proportion: numerator/denominator</p> <p>Numerator: The total number of cancer diagnoses diagnosed at stage 1 or 2 in the previous 12 months.</p> <p>Denominator: The total number of cancer diagnoses in the previous 12 months.</p>	National

Appendix 1 - Glossary

No.	Metric	Domain	Domain Sub-Group	Data Source	Methodology	Ranking/Benchmarking based on National or Model System
32b	Deprivation gap in stroke admissions	Improving health and reducing inequality	Inequalities	SUS admissions data, ONS populations data (https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/clinicalcommissioninggroupmidyearpopulationestimates)	<p>Definition: the difference in age-standardised rates of non-elective hospital admissions for stroke between populations living in the most deprived areas and those in the least deprived areas.</p> <p>Method: The difference between the most and least deprived areas is calculated using the Slope Index of Inequality where the early cancer diagnosis proportion is plotted for each deprivation quintile (least to most deprived). A regression line of best fit is then applied across all data points. The measure is the percentage point difference between the top and bottom of the regression line. An outline of the methodology for calculating the SII is available via FutureNHS: https://future.nhs.uk/canc/view?objectId=61978917</p> <p>For stroke admission logic: numerator/denominator</p> <p>**Numerator:** Admissions counted using spells rather than first finished consultant episodes for strokes.</p> <p>Denominator: GP registered populations.</p>	National
33	Percentage of annual health checks completed for patients with a learning disability or who are autistic (cumulative financial year)	Improving health and reducing inequality	Inequalities	Published: Learning Disabilities Health Check Scheme Published Link: https://digital.nhs.uk/data-and-information/publications/statistical/learning-disabilities-health-check-scheme	<p>Definition: The proportion of eligible individuals aged 14 and over with a diagnosed learning disability or autism who receive a comprehensive annual health check from their GP practice, across the financial year.</p> <p>Logic: numerator/denominator</p> <p>Denominator: individuals aged 14 and over with a diagnosed learning disability or autism, who are eligible for an annual health check from their GP practice</p> <p>Numerator: of the denominator, those who received a Learning Disability Annual Health Check by the GP practice</p> <p>For each Provider, ICB, Region or National, use the appropriate breakdown in the column [Breakdown]. For National figures, use [Breakdown] = 'England' For region, use [Breakdown] = 'Commissioning Region' For ICB, use [Breakdown] = "ICB of GP Practice or Residence"</p>	National

Appendix 1 - Glossary

No.	Metric	Domain	Domain Sub-Group	Data Source	Methodology	Ranking/Benchmarking based on National or Model System
34	Has the system been in the lowest quartile for 4 hour UEC performance for each of the last three months?	System performance for ICBs	Urgent and emergency care			
35	Has the system been in the lowest quartile for 18-week performance for each month of the last quarter?	System performance for ICBs	Elective care			
36	Has the system been in the lowest quartile for 62-day performance for each month of the last quarter?	System performance for ICBs	Cancer care			
37	Is the system in the lowest quartile for overall primary care patient satisfaction?	System performance for ICBs	Primary care			
38	Is the system's proportion of annual physical health checks for those with severe mental illness completed in the last year below 60%?	System performance for ICBs	Mental health			
39	Is the system projecting an annual deficit of over 2.5% or a deficit below 2.5% that is over 1% off plan?	System performance for ICBs	Finance			

Appendix 2 - NHS Oversight Framework 2025/26 Quarter 2 Provider Segmentation

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2025/26 Quarter 2 Provider Segmentation

The following slides have been sourced from the Oversight Framework Provider components available on the Model Health System and from the public facing dashboards found on the links below:

- [acute trusts](#)
- [non-acute hospital trusts](#)

Delivery Score:

The delivery score is derived from its performance against the metrics listed in [Annex A](#). To calculate the overall organisational delivery score, the individual metric scores are averaged according to the number of metrics the organisation will be measured against.

Segmentation Score:

An override relating to organisational financial performance where those trusts in deficit or in receipt of deficit support will be limited to an organisational delivery score of no greater than 3. This financial override is applied to form the overall segmentation score.

(For those organisations **currently in the Recovery Support Programme** (RSP), there is an **automatic entry to segment 5 (Provider Improvement Programme)** until any proposed exit is agreed through NHSE governance).

Provider Capability Rating:

The 'Capability Rating' assesses provider capability to deliver its priorities which will be used alongside the NOF segmentation score to determine what actions or support are appropriate at each Trust. Providers are asked to complete a self-assessment against a set of 6 domains which will then be used alongside a range of considerations, including the historical track record of the Trust, its recent regulatory history and any relevant third-party information. NHSE Oversight teams will decide the Trust's capability rating.

Segmentation and Domain Scoring Key:

The following provides a key to the colour coding of segment and domain scores detailed in the next slides.

1 - High Performing
2 – Above Average
3 – Below Average
4 – Low Performing
5 – Recovery Support Programme

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Provider NHS Oversight Framework Segmentation Summary

1 - High Performing
2 – Above Average
3 – Below Average
4 – Low Performing
5 – Recovery Support Programme



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Kent and Medway

Dartford and Gravesham NHS Trust

Domain	Score
Access to services	3
Effectiveness and experience of care	3
Patient safety	4
People and workforce	2
Finance and productivity	3

Delivery Score
3**
Segmentation Score
3
Capability*

Provider League Table 92 / 134

TBC

East Kent Hospitals University Foundation Trust

Domain	Score
Access to services	3
Effectiveness and experience of care	4
Patient safety	4
People and workforce	4
Finance and productivity	2

Delivery Score
3**
Segmentation Score
3
Capability*

Provider League Table 96 / 134

TBC

Kent Community Health NHS Foundation Trust

Domain	Score	Delivery Score
Access to services	4	1
Effectiveness and experience of care	2	Segmentation Score
Patient safety	1	1
People and workforce	1	Capability*
Finance and productivity	1	TBC

Kent and Medway Mental Health NHS Trust

Domain	Score
Access to services	1
Effectiveness and experience of care	1
Patient safety	3
People and workforce	3
Finance and productivity	1

Delivery Score
1
Segmentation Score
1
Capability*

Provider League Table 11 / 61

TBC

Maidstone and Tunbridge Wells NHS Trust

Domain	Score	Delivery Score
Access to services	1	1
Effectiveness and experience of care	2	Segmentation Score
Patient safety	2	1
People and workforce	1	Capability*
Finance and productivity	2	TBC

Provider League Table 16 / 134

TBC

Medway NHS Foundation Trust

Domain	Score	Delivery Score
Access to services	4	4**
Effectiveness and experience of care	4	Segmentation Score
Patient safety	4	5
People and workforce	3	Capability*
Finance and productivity	4	TBC

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Note: *Capability Rating subject to National Executive Approval / Delivery Score ** = Trust in financial deficit / financial override applied



Segmentation Summary – Q2 2025/26	Q2	Q1	Delivery Score	Q2	Q1
Segmentation Score	3	4		3	4
Average metric score	2.57	2.78	Financial Override applied (Y/N)?	Y	Y
Provider league table (acute)	92 / 134	114 / 134	Capability Rating		TBC

Domain Summary – Q2 2025/26

Access to services		Effectiveness and experience of care		Patient safety		People and Workforce		Finance and productivity	
3 – Below Average	(Q1: 4)	3 – Below Average	(Q1: 3)	4 – Low Performing	(Q1: 4)	2 – Above Average	(Q1: 2)	3 – Below Average	(Q1: 3)
% of patients treated for cancer within 62 days of referral	3.51 (2.92) ▼	CQC inpatient survey satisfaction rate	2.00 (2.00) -	NHS Staff Survey - raising concerns sub-score	2.98 (2.98) -	Sickness absence rate	1.62 (1.26) ▲	Combined finance	2.00 (2.00) -
% of urgent referrals to receive a definitive diagnosis within 4 weeks	3.13 (3.57) ▲	Summary Hospital-level Mortality Indicator	2.00 (2.00) -	Number of MRSA infections	3.21 (3.36) -	NHS staff survey engagement theme sub-score	2.87 (2.87) -	Planned surplus/deficit score	4.00 (4.00) -
Difference between planned and actual 18 week performance	2.86 (3.74) ▲	Average days from discharge ready date to actual discharge date	3.06 (2.92) ▼	Rate of C-Difficile infections	3.46 (3.82) ▲			Variance year-to-date to financial plan	1.00 (1.00) ▼
% of cases where a patient is waiting <18 weeks for elective treatment	2.34 (2.89) ▲			Rate of E-Coli infections	3.48 (3.78) ▲			Implied productivity level	2.83 (3.08) ▼
% of patients waiting over 52 weeks for elective treatment	3.51 (3.19) ▼			CQC safe inspection*	NA				
% of ED attendances admitted, transferred or discharged within 4hrs	1.00 (2.77) ▲								
% of ED attendances spending over 12 hours in the department	2.04 (2.67) ▲								

Nb: Previous quarter metric score included against each metric and domain within brackets (). The triangle = actual direction of performance travel between periods

Note: Capability rating subject to National Executive approval.

*CQC safe inspection score - To ensure organisational scores are not impacted by historic ratings this measure is only applied where it is less than two years old.

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Segmentation Summary – Q2 2025/26	Q2	Q1		Q2	Q1
Segmentation Score	3	3	Delivery Score	3	3
Average metric score	2.60	2.60	Financial Override applied (Y/N)?	Y	Y
Provider league table (acute)	96 / 134	101 / 134	Capability Rating	TBC	

Domain Summary – Q2 2025/26

Access to services		Effectiveness and experience of care		Patient safety		People and Workforce		Finance and productivity	
3 – Below Average	(Q1: 2)	4 – Low Performing	(Q1: 4)	4 – Low Performing	(Q1: 4)	4 – Low Performing	(Q1: 4)	2 – Above Average	(Q1: 3)
% of patients treated for cancer within 62 days of referral	1.00 (2.09)	▲ CQC inpatient survey satisfaction rate	2.00 (3.00)	- NHS Staff Survey - raising concerns sub-score	3.93 (3.93)	- Sickness absence rate	2.18 (2.22)	▲ Combined finance	2.00 (2.00)
% of urgent referrals to receive a definitive diagnosis within 4 weeks	2.92 (3.03)	▼ Summary Hospital-level Mortality Indicator	2.00 (2.00)	- Number of MRSA infections	2.89 (3.01)	- NHS staff survey engagement theme sub-score	3.95 (3.95)	- Planned surplus/deficit score	4.00 (4.00)
Difference between planned and actual 18 week performance	2.83 (1.00)	▼ Average days from discharge ready date to actual discharge date	3.66 (3.52)	▼ Rate of C-Difficile infections	2.76 (2.70)	▲		Variance year-to-date to financial plan	1.00 (1.00)
% of cases where a patient is waiting <18 weeks for elective treatment	3.70 (3.56)	▼		Rate of E-Coli infections	2.07 (2.32)	▲		Implied productivity level	1.81 (2.71)
% of patients waiting over 52 weeks for community services **	1.00 (1.00)	-		CQC safe inspection*	3.00	-			
% of patients waiting over 52 weeks for elective treatment	3.33 (2.99)	▼							
Annual change in the number of CYP accessing MH services **	2.65 (1.72)	▼							
% of ED attendances admitted, transferred or discharged within 4hrs	1.00 (1.00)	-							
% of ED attendances spending over 12 hours in the department	3.90 (3.90)	▼							

Nb: Previous quarter metric score included against each metric and domain within brackets (). The triangle = actual direction of performance travel between periods

Note: Capability rating subject to National Executive approval.

*CQC safe inspection score - To ensure organisational scores are not impacted by historic ratings this measure is only applied where it is less than two years old.





Segmentation Summary – Q2 2025/26	Q2	Q1		Q2	Q1
Segmentation Score	1	1	Delivery Score	1	1
Average metric score	1.87	1.87	Financial Override applied (Y/N)?	N	N
Provider league table (acute)	16 / 134	12 / 134	Capability Rating		TBC

Domain Summary – Q2 2025/26

Access to services		Effectiveness and experience of care		Patient safety		People and Workforce		Finance and productivity	
1 – High Performing	(Q1: 1)	2 – Above Average	(Q1: 2)	2 – Above Average	(Q1: 2)	1 – High Performing	(Q1: 1)	2 – Above Average	(Q1: 3)
% of patients treated for cancer within 62 days of referral	1.00 (1.00) ▼	CQC inpatient survey satisfaction rate	2.00 (2.00) -	NHS Staff Survey - raising concerns sub-score	1.56 (1.56) -	Sickness absence rate	1.47 (1.32) ▲	Combined finance	1.00 (1.00) -
% of urgent referrals to receive a definitive diagnosis within 4 weeks	2.59 (2.81) ▼	Summary Hospital-level Mortality Indicator	2.00 (2.00) -	Number of MRSA infections	2.60 (2.37) ▼	NHS staff survey engagement theme sub-score	1.43 (1.43) -	Planned surplus/deficit score	1.00 (1.00) -
Difference between planned and actual 18 week performance	3.60 (2.70) ▼			Rate of C-Difficile infections	2.78 (2.54) ▼			Variance year-to-date to financial plan	1.00 (1.00) -
% of cases where a patient is waiting <18 weeks for elective treatment	1.39 (1.18) ▼			Rate of E-Coli infections	3.83 (3.80) ▼			Implied productivity level	2.80 (3.80) ▲
% of patients waiting over 52 weeks for elective treatment	1.00 (1.00) -			CQC safe inspection*	NA				
% of ED attendances admitted, transferred or discharged within 4hrs	1.00 (1.00) ▼								
% of ED attendances spending over 12 hours in the department	2.12 (2.28) ▲	<p><i>Nb: Previous quarter metric score included against each metric and domain within brackets (). The triangle = actual direction of performance travel between periods</i></p> <p>Note: Capability rating subject to National Executive approval.</p>							

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*CQC safe inspection score - To ensure organisational scores are not impacted by historic ratings this measure is only applied where it is less than two years old.





Segmentation Summary – Q2 2025/26	Q2	Q1		Q2	Q1
Segmentation Score	5	5	Delivery Score	4	4
Average metric score	3.19	2.99	Financial Override applied (Y/N)?	Y	Y
Provider league table (acute)	133 / 134	130 / 134	Capability Rating		TBC

Domain Summary – Q2 2025/26

Access to services		Effectiveness and experience of care		Patient safety		People and Workforce		Finance and productivity	
4 – Low Performing	(Q1: 4)	4 – Low Performing	(Q1: 4)	4 – Low Performing	(Q1: 4)	3 – Below Average	(Q1: 3)	4 – Low Performing	(Q1: 3)
% of patients treated for cancer within 62 days of referral	2.74 (3.39) ▲	CQC inpatient survey satisfaction rate	4.00 (4.00) -	NHS Staff Survey - raising concerns sub-score	3.50 (3.50) -	Sickness absence rate	2.15 (2.25) ▲	Combined finance	4.00 (2.00)
% of urgent referrals to receive a definitive diagnosis within 4 weeks	2.89 (3.96) ▲	Summary Hospital-level Mortality Indicator	3.00 (3.00) -	Number of MRSA infections	3.40 (3.01) ▼	NHS staff survey engagement theme sub-score	3.17 (3.17) -	Planned surplus/deficit score	4.00 (4.00)
Difference between planned and actual 18 week performance	3.02 (1.00) ▼	Average days from discharge ready date to actual discharge date	3.83 (3.71) ▼	Rate of C-Difficile infections	2.36 (3.08) ▲			Variance year-to-date to financial plan	4.00 (1.00) ▼
% of cases where a patient is waiting <18 weeks for elective treatment	3.79 (3.63) ▼			Rate of E-Coli infections	2.31 (2.40) ▼			Implied productivity level	3.26 (2.49) ▼
% of patients waiting over 52 weeks for community services **	3.85 (3.83) ▼			CQC safe inspection*	NA				
% of patients waiting over 52 weeks for elective treatment	3.90 (3.72) ▼								
Annual change in the number of CYP accessing MH services **	3.39 (3.51) ▼	<i>Nb: Previous quarter metric score included against each metric and domain within brackets (). The triangle = actual direction of performance travel between periods</i>							
% of ED attendances admitted, transferred or discharged within 4hrs	1.00 (1.00) ▼	Note: Capability rating subject to National Executive approval.							
% of ED attendances spending over 12 hours in the department	3.16 (2.84) ▼	<i>*CQC safe inspection score - To ensure organisational scores are not impacted by historic ratings this measure is only applied where it is less than two years old.</i>							





Segmentation Summary – Q2 2025/26	Q2	Q1		Q2	Q1
Segmentation Score	1	1	Delivery Score	1	1
Average metric score	1.91	1.87	Financial Override applied (Y/N)?	N	N
Provider league table (acute)	8 / 61	7 / 61	Capability Rating		TBC

Domain Summary – Q2 2025/26

Access to services		Effectiveness and experience of care		Patient safety		People and Workforce		Finance and productivity	
4 – Low Performing	(Q1: 4)	2 – Above Average	(Q1: 1)	1 – High Performing	(Q1: 1)	1 – High Performing	(Q1: 1)	1 – High Performing	(Q1: 1)
% of patients waiting over 52 weeks for community services	2.29 (2.43) ▲	Urgent Community Response 2-hour performance	1.95 (1.71) ▼	NHS Staff Survey - raising concerns sub-score	1.10 (1.10)	Sickness absence rate	2.00 (1.85) ▲	Combined finance	1.00 (1.00)
Annual change in the number of CYP accessing MH services	3.87 (3.87) ▼			CQC safe inspection*	NA	NHS staff survey engagement theme sub-score	1.65 (1.65) -	Planned surplus/deficit score	1.00 (1.00)

Nb: Previous quarter metric score included against each metric and domain within brackets (). The triangle = actual direction of performance travel between periods

Note: Capability rating subject to National Executive approval.

*CQC safe inspection score - To ensure organisational scores are not impacted by historic ratings this measure is only applied where it is less than two years old.



Segmentation Summary – Q2 2025/26	Q2	Q1		Q2	Q1
Segmentation Score	1	1	Delivery Score	1	1
Average metric score	1.94	1.91	Financial Override applied (Y/N)?	N	N
Provider league table (acute)	11 / 61	9 / 61	Capability Rating		TBC

Domain Summary – Q2 2025/26

Access to services		Effectiveness and experience of care		Patient safety		People and Workforce		Finance and productivity	
1 – High Performing	(Q1: 1)	1 – High Performing	(Q1: 1)	3 – Below Average	(Q1: 2)	3 – Below Average	(Q1: 3)	1 – High Performing	(Q1: 1)
Annual change in the number of CYP accessing MH services	1.13 (1.04) ▼	Percentage of inpatients (18-65) with >60 day length of stay	1.26 (1.38) ▲	NHS Staff Survey - raising concerns sub-score	3.55 (3.55) -	Sickness absence rate	2.03 (2.03) ▲	Combined finance	1.00 (1.00)
		CQC community health survey satisfaction rate	2.00 (2.00) -	% of patients in mental health crisis to receive F2F contact within 24hrs	1.61 (1.47) ▼	NHS staff survey engagement theme sub-score	3.65 (3.65) -	Planned surplus/deficit score	1.00 (1.00) -
				CQC safe inspection*	NA			Variance year-to-date to financial plan	1.00 (1.00) -
								Relative difference in costs	1.26 (1.09) ▼

Nb: Previous quarter metric score included against each metric and domain within brackets (). The triangle = actual direction of performance travel between periods

Note: Capability rating subject to National Executive approval.

*CQC safe inspection score - To ensure organisational scores are not impacted by historic ratings this measure is only applied where it is less than two years old.

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Segmentation Descriptions

Segment	Description	How NHS England supports
1	The organisation is consistently high-performing across all domains, delivering against plans.	No specific support or intervention needs are identified. All organisations will have access to NHS IMPACT, the universal NHS improvement approach.
2	The organisation has good performance across most domains. Specific issues exist.	The organisation can diagnose and clearly explain its support needs, which are predominantly met locally. Our support on specific issues is provided where appropriate.
3	The organisation and/or wider system are off-track in a range of domains or are in financial deficit.	NHS England agrees the support needs of the organisation involving the provider's relevant ICB in the decision. To do this we take account of segmentation and capability. Support is delivered through local support offers, defined national support programmes and bespoke regional interventions.
4	The organisation is significantly off-track in a range of domains.	NHS England will consider the organisation's challenges and support needs, taking account of segmentation and capability to inform the appropriate support or intervention. As with segment 3, support needs are prioritised through local support offers, defined national support programmes and bespoke regional interventions.
5	<p>The organisation is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve</p> <p>Or</p> <p>The organisation is a challenged provider where NHS England has identified significant concerns.</p>	The organisation will be subject to NHS England's most intensive support – the Provider Improvement Programme (PIP) – to ensure it meets improvement goals.

Our purpose

NHS Kent and Medway exists to improve health and healthcare for the people of Kent and Medway.

We do this using influence and partnership to lead the NHS to find ambitious, collaborative solutions to long-standing issues and inequalities, driving innovation and transformation. We represent the NHS in Kent and Medway in the national NHS.

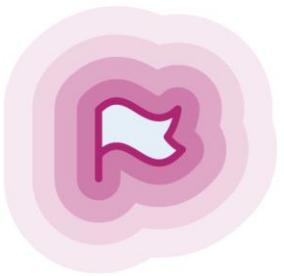


Our values



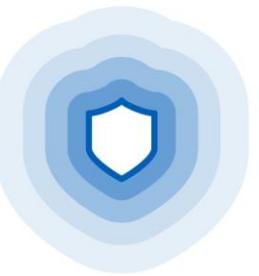
Caring for all

We look after each other and our communities.



Including everyone

We celebrate who we are and our diversity.



Building trust

We are empowered to do our roles and respect each other.



Doing what's right

We are open, honest and welcome challenge.



Being courageous

We are bold and always want to improve.

Title of meeting:	NHS Kent and Medway Integrated Care Board (Part 1)	Date: 3 February 2026
Title of report:	Transition Update Report	
Reporting officer:	Natalie Davies, Executive Director of System Improvement and Transition Director	
Lead Executive:	Natalie Davies, Executive Director of System Improvement and Transition Director	
Freedom of information (FOI) status:	This paper is disclosable under the FOI Act	

Report summary:

NHS Kent and Medway ICB is progressing through a major organisational transition to meet national requirements on running-cost reduction and to reshape the organisation around a strategic commissioning model. The restructure consultation launched on 26 January has engaged staff across the ICB, with voluntary exits already reducing headcount and further changes expected following the close of consultation in March. Alongside this, significant work continues to ensure business continuity, align plans regionally, and manage the safe transfer of services and staff to provider organisations where operational delivery is most appropriate.

Across the wider South East, ICBs are working collectively to establish a set of shared regional functions aimed at reducing duplication, improving consistency and strengthening digital, estates, procurement and policy capabilities. Key transfers—to Kent Community Health NHS Foundation Trust, Maidstone & Tunbridge Wells NHS Trust and Kent & Medway NHS and Social Care Partnership Trust—are progressing well, reinforcing this shift toward system-led delivery. Although risks remain around workforce capacity, affordability, CSU timelines and the complexity of provider transfers, mitigations are in place and further assurance will be provided to the Board following the close of consultation.

Proposal and/or recommendation:

The Board is asked to:

- **Note** the launch of the re-structure consultation.
- **Endorse** progress and next steps on provider transfers.
- **Support** continued participation in the SE shared services programme.
- **Receive** a further update following consultation close in March.

Our ICB objectives:			
1. We will work with the NHS system to improve healthcare for our population	✓	2. We will deliver sustainable services within our 2025/26 spending targets.	✓
3. We will develop a workforce where colleagues feel valued, we celebrate diversity and are fair and inclusive	✓	4. We will reduce healthcare inequalities for the people of Kent and Medway	

Identified risks, issues and mitigations:

- Workforce and Wellbeing Risk**
 - High levels of staff anxiety linked to the restructure and service transfers.
 - Significant capacity constraints as colleagues balance business-as-usual with transition demands.
 - Support measures are in place, but pressure remains elevated.
- Affordability and Sequencing Risk**
 - Regional alignment of transition timelines
 - Significantly reduced running cost envelope will impact on the ICBs ability to operate at the levels it has previously
- CSU Transition Dependencies**
 - Tight national and regional timelines for CSU wind-down place pressure on delivery.
 - Risk of a service “cliff edge” emerging in autumn if shared function hosting, staffing, or design decisions are delayed.
- Provider Transfer Complexity**
 - Transfers require detailed TUPE processes, financial due diligence and organisational readiness.
 - Dependencies include digital access, estates planning, data migration and ensuring business continuity throughout the move.

Resource implications and finance approval:

Significant impact on our running costs and requirement to meet national targets

Sustainability considerations:

Statutory duty becomes responsibilities of all teams

Public and patient engagement considerations

Staff groups and unions have been consulted. Patient and Public engagement has not been undertaken outside of HASC and HOSC

Quality and Equality Impact Assessments

Has a **quality** impact assessment been undertaken?

Yes (please attach the action plan to this paper)

Not applicable (please indicate why an equality assessment was not required)

Has an **equality** assessment been undertaken?

Yes (please attach the action plan to this paper)

Not applicable (*please indicate why an equality assessment was not required*)
Both will be undertaken as part of the plan development

Legal implications

Legal advice has been sought and reflected

Report history / committees reviewed

N/A

Next steps:

Action in accordance with ExCo discussion.

Appendices:

None

List staff contributing to the paper and any conflicts of interest (COI) identified:

Natalie Davies
No Conflicts of Interest

For further information or for any enquiries relating to this report please contact:

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Transition Update

1. Executive Summary

- 1.1 NHS Kent and Medway ICB is progressing through a significant organisational transition to meet national requirements on running-cost reduction and to transform into a strategic commissioner and system conveyor within Kent and Medway and in the South East system. A major milestone was reached on 26 January with the launch of a 45-day restructure consultation, supported by extensive staff engagement led by the Chief Executive, Adam Doyle. Early voluntary exit schemes have already reduced the workforce baseline, and further decisions will follow the close of consultation on 12 March. The scale and pace of change reflect the need to operate within the £19 per head allowance from April 2026.
- 1.2 Alongside internal restructuring, the ICB continues to make progress on the broader transition programme. Business continuity planning is underway to mitigate short-term workforce and capability risks, and the organisation is actively aligning timelines and processes with the other Southeast ICBs. This includes coordinated consultation activity and joint planning for shared risks, dependencies and statutory functions. Provider discussions are also ongoing to support the safe transfer of services where operational delivery is better placed within provider trusts.
- 1.3 Regional collaboration remains a defining feature of this transition. Following the Southeast ICB CEOs' session in December, a set of shared regional functions has been agreed to reduce duplication, consolidate digital and corporate expertise, and improve consistency across the region. These include procurement and strategic estates (potentially hosted by Kent & Medway), shared digital, IG and data models, regional EPRR arrangements and jointly delivered GP IT services. Work continues to confirm hosting arrangements and develop the operating model that will underpin joint commissioning across all six ICBs.
- 1.4 Significant service transfers to provider organisations also form a key element of the transition. All Age Continuing Care and Medicines Optimisation (Primary Care facing) functions are moving to Kent Community Health NHS Foundation Trust, while Cancer Alliance and Diagnostics services are transferring to Maidstone & Tunbridge Wells NHS Trust. In addition, all ICB-employed Health and Care Partnership staff will transfer to Kent & Medway Mental Health NHS Trust, creating a single, coherent transformation resource aligned to operational delivery. These transfers collectively support the ICB's future strategic role and strengthen system delivery arrangements.
- 1.5 Across all areas, the ICB continues to manage a set of significant risks, including workforce pressures, affordability constraints, tight CSU transition timelines and the operational complexity of TUPE and due-diligence processes. Work is underway internally and regionally to mitigate these risks, and the Board will be further updated following the close of consultation in March, alongside responding to the national assurance request now being issued to all ICBs

2. Purpose

2.1 This paper provides the Board with an update on the ongoing transition work across NHS Kent and Medway ICB and the wider South East region, including:

- Launch of the organisation-wide restructure consultation
- Progress on the development of shared services across the South East
- Transfers of services and staff out of the ICB to provider organisations
- Key risks, dependencies and next steps

3. Launch of the Restructure Consultation

3.1 Overview

NHS Kent and Medway ICB formally launched its 45-day restructure consultation on the 26 January, designed to run until 12 March 2026.

The launch was undertaken with an all-staff briefing delivered by the Chief Executive, Adam Doyle and followed up by divisional team meetings. Visible executive presence was spread across our sites with well publicised support routes and consultation response options.

3.2 Key points communicated in the briefings

- The root of the restructure through the requirement to reduce running costs by 50% and operate at £19/head from 1 April 2026.
- Our intent to become a strategic commissioner and system conveyor.
- 129 colleagues have already agreed exit dates in place through MARS and our first voluntary redundancy (VR) scheme.
- A second VR window was opened on 26 January and would run for 2 weeks. New application for VR would be considered against the published structures with an expectation that this would limit the number of accepted applications.
- 194 staff were out of scope of consultation; many of these would be transferring to Provider Trusts.
- Due to the significant change in the operating model and purpose of the ICB, it was likely that more than a hundred staff would be likely to be designated redeployees.
- Regrettably, it was expected that there would be a number of compulsory redundancies.

3.3 Consultation timeline

The timeline for the consultation is as follows:

Milestone	Date
Consultation opens	26 January
VR window	26 January – 6 February
Line manager training	2–12 February
Individual meetings	Mid-February
Consultation closes	12 March
VR decisions finalised	13 March
Outcome report	End March
Final meetings & earliest redundancies	From 1 April

4. Wider Transition Programme

4.1 As the consultation progresses, the wider transition programme continues to move at pace, with parallel workstreams focused on maintaining service and workforce resilience, ensuring regional synchronisation, and progressing the major provider transfers already underway. This includes ongoing business continuity planning to mitigate staffing and operational gaps arising from MARS, voluntary redundancy and the restructure; close alignment with South East ICBs on consultation timing and approach; and continued engagement with provider partners on the transfer of key functions including All Age Continuing Care, Medicines Optimisation, the Cancer Alliance, Diagnostics and Health and Care Partnership teams. These areas are summarised below.

Shared Services Programme

4.2 Following the SE ICB CEOs Development Session held at the end of December 2025, the ICB CEOs confirmed a set of shared functions which they agreed to actively pursue in order work up some proposals for potential shared services. These areas have been identified as it is believed they present the greatest opportunity for shared work to deliver a quality service at a consolidated costs and where the reduction of duplication and increase of standardisation across the region could deliver efficiency and quality benefits.

Proposed Shared Functions

4.2.1 The initial proposals are not final decisions but agreed for development. Once reviewed and developed further, the services models will be brought back through the appropriate governance groups and to the Chief Executives for consideration and review.

Function	Description	Host / Model (potential)
Procurement	Region-wide service	Hosted by K&M
Strategic Estates	Small estates function	Hosted by K&M
Corporate IT & Cyber	Part of digital consolidation	Shared model
Info Governance & Data Management	Combined IG & data	Shared model
Digital leadership & transformation	SE leadership role	End-state one-host
DSCRO	In scope for digital review	TBC
GP IT & GP IG	Consolidated GP support	Shared
Clinical policies/ Individual Funding Reviews	Policy/Effectiveness	Hosted by HIOW

EPRR	Regional model or East/West ICB hosted	Hosted by HIOW if region wide
HR & Legal (future)	Under review (26/27)	TBC

Data and Digital Review: Kent and Medway with Surrey and Sussex

4.2.2 The recent independent digital, data and analytics review undertaken by Health Innovation Network (HIN) Kent Surrey Sussex concluded, providing a clear set of findings and a proposed future operating model for Kent, Surrey and Sussex. The review, commissioned jointly by NHS Kent and Medway ICB and the Surrey and Sussex ICBs, highlights significant fragmentation, variation in digital maturity, inconsistent data standards, and duplicated analytical effort across the three systems. However, clear strengths were also identified throughout the review; pockets of strong digital maturity and well-established analytical capability including some Kent and Medway providers demonstrating high performance on several core data sets. Several successful examples of digital transformation and data driven improvement were also cited as showing significant opportunity to be extended and embedded.

4.2.3 Central to the HIN's recommendation is the establishment of a shared leadership model across Kent, Surrey and Sussex, anchored in a single Central Strategic Digital, Data and Technology (DDaT) Office serving all three ICBs. This proposed office has been included as part of our consultation proposals. If confirmed through consultation, the new leadership team, once appointed, will develop the structures below them.

4.2.4 The HIN has also offered to continue to provide expert advisory support to the office as it is established.

4.2.5 Looking ahead, the review recommends a structured programme of work to identify which functions should be delivered centrally, which should remain local, and which could transition over time. While the initial proposal is across the three ICBs to the east of the south east region, we remain open to joint work in areas across the southeast.

Commissioning Support Unit

4.3 The Board will be aware that Commissioning Support Units (CSUs) were established to provide a wide range of business-critical functions on behalf of ICBs, including GP IT, digital and corporate support services, procurement, clinical policy, and a number of specialist enabling functions. Kent and Medway ICB currently spends significant sums on these services, most notably GP IT support, Procurement and Individual Funding requests. With NHS England now requiring the dissolution of CSUs as part of the 2025–2027 national optimisation and cost-reduction programme, these services must be either brought in-house, redesigned, or delivered through new regional shared arrangements. This aligns with the wider South East planning

process described above, where all six (to be four) ICBs are working collectively to develop consistent, affordable end-state models for CSU delivered functions.

4.4 In line with this, Kent and Medway has written formally to both SCW and AGEM to request revised, lower-cost proposals, fair-share allocations, and transition options. We are actively progressing our local transition programme while contributing to regional design work where a single South East approach provides the most value.

Transfers to External Provider Organisations

4.5 As part of aligning to the future strategic commissioning model, several services and their associated workforces will move from the ICB to external provider organisations. This ensures that operational delivery sits with providers while the ICB focuses on strategy, assurance and outcomes.

4.6 The summary table for staff transfers is shown below.

Summary Table – Staff Transfers

Service	Destination	Staff affected
AACC	KCHFT	127
Medicines Optimisation (Primary Care facing)	KCHFT	49
Cancer Alliance	MTW	8
Diagnostics	MTW	3
HaCP Teams	KMMH	16

4.7 The ICB is taking a structured, programme-managed and partnership-based approach to all staff transfers, ensuring that statutory responsibilities are met, service continuity is protected, and colleague welfare remains central throughout.

4.8 Each transfer programme is being delivered jointly with the receiving provider organisations through a multidisciplinary programme structure, including HR, finance, digital, information governance, contracting, communications and clinical leadership. This ensures that all technical, operational and workforce considerations are addressed in an integrated way, with clear accountability and coordinated decision-making.

4.9 For the larger and complex transfers, a dedicated programme plan and critical path are maintained, supported by weekly or twice-weekly team meetings to track progress, resolve issues early and maintain alignment between organisations.

4.10 Staff welfare and experience remain core to the design and delivery of all transfers. Colleagues are being supported through clear and sequenced communication, including all-staff briefings, written updates, FAQs, and opportunities for individual discussion. HR teams from both the ICB and receiving organisations work together to provide consistent information, respond promptly to queries, and ensure staff have access to wellbeing support throughout the transition period.

4.11 The overall approach is grounded in partnership working, disciplined programme management and a strong commitment to staff wellbeing, ensuring that colleagues move into their new organisations feeling respected, informed and supported, and that services remain safe and resilient throughout the transition.

National Board Assurance Request

4.12 The Board should note that a national Board assurance request will be requested by NHSE. This request will require each ICB to provide a formal assurance statement confirming that the Board:

- **Understands its statutory and delegated functions**
The Board must confirm it has considered and understood:
 - All functions for which it is accountable under legislation
 - Functions formally delegated from NHSE
 - Functions described within the Model ICB Blueprint
 - The national position regarding functions currently marked as “*review for transfer*”
 - The good practice guides for Continuing Healthcare, Infection Prevention and Control, Safeguarding, Special Educational Needs, and Medicines Optimisation
- **Is confident the proposed ‘To Be’ structure is fit for purpose**
The Board must be assured that the future structure enables the ICB to discharge its functions effectively and efficiently within the £19 per head running cost allowance.
- **Has assessed risks arising from running-cost reductions**
The Board must confirm that it has fully assessed all risks associated with meeting the mandated cost envelope and has identified clear and tangible mitigations for changes to how functions will be delivered.

4.13 Our assessment of the structures proposed is that they meet the requirements under the assurance statement. However, a further detailed report will be brought back to Board for review following the confirmation of the final structures.

5 Key Risks and Issues

Business Continuity Planning

- 5.1 As we enter this period of significant organisational change, we are facing a number of potential risks and issues linked to a number of factors. This restructure will see the workforce reduce from 740 to around 320 staff by mid-2026, including 116 colleagues already approved for voluntary redundancy and our consultation document sets out the proposal to remove a significant number of further posts or specialisms. The rapid scale of change and the gaps between staff leaving and the new structures being in place presents a risk to the continuity of statutory and business-critical functions, particularly where specialist skills and institutional knowledge may be lost. To manage this risk, the ICB will activate its formal Business Continuity arrangements to ensure essential services remain safe, resilient and legally compliant throughout the transition.
- 5.2 A dedicated management group, chaired by an Executive will be established to provide real-time oversight of organisational risks and coordinate mitigation across all Divisions. The group will develop a single organisational picture of emerging vulnerabilities by assessing workforce changes against Business Impact Assessments, statutory obligations and Maximum Tolerable Periods of Disruption. This will inform a prioritised set of actions, including short-term redeployment, internal training, targeted cross-ICB support, and sourcing external expertise where essential technical capabilities cannot be maintained internally.
- 5.3 Through this structured approach, the ICB will ensure that risks are identified early, mitigations are applied consistently, and service resilience is strengthened during the restructuring period.

Staff Wellbeing

- 5.4 The programme continues to carry significant workforce and wellbeing risks, with high levels of staff anxiety and limited capacity across teams despite the support measures already in place. Alongside this, our ability to sequence the transition effectively remains dependent on a number of factors over which we have limited influence including national policy. The Chief Executive and Executives, together with the leadership of the organisation are continuing to support staff and have increased visibility, publishing access routes and other opportunities for staff to engage, express themselves and gain support. The different support mechanisms have been consistently published in events and on our intranet.

Other risks and Issues

- 5.5 The CSU transition itself brings further dependencies, as national and regional timelines remain tight and create a risk of a “cliff edge” in service provision by the autumn if decision-making or mobilisation slips.

- 5.6 In parallel, provider transfers introduce considerable operational complexity, requiring detailed TUPE planning, thorough due diligence, and coordinated system readiness across digital access, estates, data environments and wider infrastructure.
- 5.7 Together, these factors underscore the need for careful phasing, clear regional coordination, and proactive risk management to maintain continuity and staff confidence as we progress through the transition.

6 Next Steps

- 6.1 Looking ahead, our immediate priority is to deliver the remaining consultation milestones through to 12 March while finalising the business continuity arrangements that will underpin safe service delivery during the transition. In parallel, we are completing the necessary preparations for provider transfers, including TUPE processes, financial modelling and due-diligence activity, to ensure services can move seamlessly and with minimal operational disruption.
- 6.2 At a regional level, work continues to clarify the future hosting arrangements for the South East shared functions, enabling all ICBs to plan against a stable and consistent end-state model. The South East Directors of Transition are also working to identify where further transformation programmes should be taken forward on a regional basis, ensuring that scale, expertise and shared priorities are reflected in how future services are designed and implemented.

7 Recommendation

The Board is asked to:

- **Note** the launch of the re-structure consultation.
- **Endorse** progress and next steps on provider transfers.
- **Support** continued participation in the SE shared services programme.
- **Receive** a further update following consultation close in March.

Natalie Davies
Executive Director of System Improvement and Transition Director
January 2026

Title of meeting:	NHS Kent and Medway Integrated Care Board (Part 1)	Date: 3 February 2026
Title of report:	Board Charter	
Reporting officer:	Cedi Frederick, Chair Adam Doyle, Chief Executive	
Lead member:	Cedi Frederick, Chair	
Freedom of information (FOI) status:	This paper is disclosable under the FOI Act	

Purpose: This paper is for (please tick)

Assurance	Decision	✓	Information	Discussion	
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Report summary:

Purpose

This paper seeks Board approval to formally sign off the Kent and Medway Integrated Care Board Charter, to note the individual Board member pledges supporting our cultural goals, and to acknowledge the internal communications issued to the organisation regarding these commitments.

Background

The Board has undertaken a facilitated workshop focused on culture and leadership, resulting in the creation of a Board Charter. This Charter sets out our shared commitment to building a positive, inclusive, and ambitious culture, with equality, diversity, and inclusion (EDI) at its core. It outlines our values, guiding principles, and behavioural standards, and describes how we will work together to improve outcomes for our population.

Board Charter

The Charter commits the Board to:

- Placing EDI at the centre of our work
- Creating a safe environment for all voices
- Prioritising safety and wellbeing
- Supporting informed, evidence-based decisions
- Valuing every contribution and encouraging constructive challenge
- Welcoming challenge and sharing responsibility for long-term planning
- Maintaining transparency, collaboration, and accountability in all Board activities

The Charter (appendix 1) will be reviewed annually and updated to reflect organisational priorities and legislative changes.



Board Member Pledges

Alongside the Charter, each Board member has made a personal pledge to role model a positive culture. These pledges include commitments such as:

- Increasing visibility and engagement with staff
- Seeking feedback and continuous learning
- Championing wellbeing, inclusion, and quality
- Fostering open communication and collaboration
- Supporting equity and belonging for all

These individual commitments demonstrate leadership in action and reinforce our collective responsibility for culture and holding each other to account to deliver on these.

Communications

A communications piece has been issued to the organisation (appendix 2), outlining the Board's cultural commitments and individual pledges. This aims to build transparency, encourage staff engagement, and reinforce the Board's role in shaping organisational culture.

Proposal and/or recommendation:

1. APPROVE the Kent and Medway Integrated Care Board Charter.
2. NOTE the individual Board member pledges.
3. NOTE the internal communications issued regarding these pledges.

Our objectives: Tick the objectives the report aims to support.

1. We will work with the NHS system to improve healthcare for our population.	✓	3. We will develop a workforce where colleagues feel valued, we celebrate diversity and are fair and inclusive.	✓
2. We will deliver sustainable services within our 2025/26 spending targets.	✓	4. We will reduce healthcare inequalities for the people of Kent and Medway.	✓

Identified risks, issues and mitigations:

Risk/Issue impact areas

Financial Patient Staff Services Reputational

Risk: Board members do not consistently role model the behaviours outlined in their pledges.

Mitigation: Schedule regular Board "check-in" sessions, use 360-degree feedback. Monitoring of performance will be via annual appraisals in line with the Charter. The Chair's office will oversee this for NEDs and the CEO for Executive roles.

Risk: Charter and pledges become static and do not evolve with organisational needs.

Mitigation: Commit to annual reviews of the Charter and pledges, incorporating staff and stakeholder feedback.

Risk: Failure to embed Equality, Diversity, and Inclusion (EDI) in decision-making.

Mitigation: Monitor EDI outcome and complete the EDI MOT process.

Resource implications and finance approval:

None

Sustainability considerations:

N/A

Public and patient engagement considerations

N/A

Equality, health inequalities and quality impact assessment

Please tick the correct box and provide required information. [When to complete an equality, health inequalities and quality impact assessment \(EHQIA\) - kam](#)

Has an equality assessment been undertaken?

Yes (please attach the action plan to this paper)

Not applicable (please indicate why an assessment was not required)

Legal implications

None

Report history / committees reviewed

Board Workshop took place on 2 December 2025.

Next steps:

The Board Charter will be published on our external website and shared internally with colleagues via the intranet.

Appendices:

Appendix 1 – Board Charter

Appendix 2 – Board Pledges

List staff contributing to the paper and any conflicts of interest (COI) identified:

None

For further information or for any enquiries relating to this report please contact:

Cedi Frederick, Chair

Adam Doyle, Chief Executive

Kent and Medway Integrated Care Board – Board Charter

1.0 Introduction

- 1.1 At the heart of the Kent and Medway Integrated Care Board (ICB) is a shared commitment to building a positive, inclusive, and ambitious culture, one that places equality, diversity, and inclusion (EDI) at the forefront of everything we do. Our work is grounded in the safety and wellbeing of the patients, staff and communities we serve, and we strive to lead with both heart and ambition.
- 1.2 This Charter sets out how we, as a unitary Board, commit to working together through supporting each other to make informed, evidence-based decisions that improve outcomes for our population. We recognise that our effectiveness depends on how we interact with each other and connect within the organisation, and with our partners, staff, patients, and the wider community.
- 1.3 We are ambitious for our system and for the people we serve. We welcome challenge, embrace learning, and are open about our doubts, seeking assurance and sharing responsibility for long-term planning and improvement.

2.0 Our Values and Cultural Commitments

- 2.1 We are guided by the ICB's published values:

- Caring for all
- Including everyone
- Building trust
- Doing what is right
- Being courageous

2.2 We commit to:

- Placing EDI at the centre of our work, ensuring our decisions reflect and respect the diversity of our organisation and the communities we serve.
- Creating a safe environment where all voices are heard, and staff feel empowered to speak up.
- Prioritising the safety and wellbeing of patients, staff, and the public.
- Supporting each other to make informed, data-driven, and evidence-based decisions.
- Valuing every contribution and encouraging constructive challenge.
- Being open to discomfort and difference, recognising that disagreement can lead to better outcomes.
- Welcoming challenge and expecting that Board discussions may result in amendments to proposals as this is effective and appropriate governance.
- Sharing doubts and seeking assurance, with a duty of candour in all our dealings.
- Committing to long-term planning and sustainability for Kent and Medway.

3.0 Purpose and Scope

3.1 This Charter describes how the Board commits to working together, rather than detailing individual or committee responsibilities. For specific governance arrangements, including schemes of delegation and terms of reference (TOR), please refer to the relevant documents.

3.2 In future, this Charter will continue to evolve to reflect our learning and the changing needs of our system.

4.0 Guiding Principles

- **Accountability:** We are collectively and individually responsible for our decisions and actions, ensuring clarity of roles and adherence to statutory duties. We expect visibility and transparency, including colleagues joining Board meetings.
- **Transparency:** Our decision-making is open, well-documented, and clearly communicated to all stakeholders.
- **Collaboration:** We act as a unified leadership team, working across organisational boundaries and supporting each other to achieve system-wide outcomes.
- **Inclusivity and respect:** We value every contribution, encourage constructive challenge, and ensure all voices are heard in a respectful manner.
- **Agility:** We respond quickly to emerging risks and opportunities, adapting our governance as needed.
- **Data-driven and evidence-based:** Our decisions are grounded in robust data and evidence, and we seek input from stakeholders wherever appropriate.
- **Valuing contributions:** We recognise and celebrate the unique perspectives and expertise each member brings.

5.0 Roles and Responsibilities

- **The Board (as a unitary body):** Acts collectively, with all members sharing responsibility for decisions. The Board is accountable for the overall direction, strategy, and performance of the ICB, and for upholding the highest standards of governance and culture.
- **Chair:** Leads the Board, ensures effective governance, and champions a culture of openness, candour, and accountability.
- **Chief Executive:** Provides strategic leadership, ensures delivery of statutory duties, and fosters organisational improvement.
- **Executives:** Lead and assure both their individual and collective areas of responsibility, supporting the Board's work and modelling expected behaviours.
- **Non-Executive Directors:** Offer independent scrutiny, challenge, and assurance on performance and risk.
- **Partner Members:** Provide a view of their sector, supporting the transition to the ICS model and ensuring integration and alignment across health and care services.

- **All Members:** Commit to collective responsibility, uphold the principles of this Charter, and support each other to make informed decisions.

6.0 Behavioural Standards

6.1 Board members agree to:

- Commit to a shared purpose and system leadership, supporting each other to make the best possible decisions.
- Engage in constructive challenge, welcoming different perspectives and being comfortable with discomfort.
- Maintain professional integrity, confidentiality, and a duty of candour.
- Support collective decision-making, even when individual views differ.
- Demonstrate behaviours that reflect our organisational values in all interactions.
- Share doubts and seek assurance, recognising that challenge and amendment of proposals is a sign of effective governance.

6.2 Examples of Expected Behaviours:

- Listening actively and respecting diverse perspectives.
- Avoiding siloed thinking and prioritising system-wide impact.
- Being prepared for meetings and contributing fully to discussions.
- Welcoming ICB staff and partners to Board meetings.

7.0 Decision-Making and Governance

- Decisions will align with the Triple Aim: improving population health, enhancing quality of services, and ensuring sustainability.
- The Board will maintain compliance with statutory duties, including financial stewardship, safeguarding, and equality obligations.
- Conflicts of interest will be declared and managed transparently.
- The Board will use evidence-based approaches, seek input from stakeholders, and provide real options in a timely manner so that meaningful decisions can be taken.
- The Board will refer to schemes of delegation, terms of reference, and other governance documents for detailed arrangements.

8.0 Engagement and Accountability

- The Board will maintain open communication with system partners, patients, staff, and the public.
- Decisions will be informed by engagement and co-production wherever possible.
- We will publish key decisions and rationales to maintain trust and transparency.

- The Board will interact and connect across the organisation, including through informal discussions and work, to ensure the right decisions are made and accountability is clear.
- We expect visibility, including relevant colleagues joining Board meetings to participate in discussions.

9.0 Review and Continuous Improvement

9.1 The Charter will be reviewed annually and updated to reflect legislative changes and organisational priorities.

9.2 Compliance will be monitored through a range of approaches, including:

- Regular Board effectiveness (well led domain) reviews.
- Assessment of the quality of Board discussions, with a focus on evidence of healthy challenge and the extent to which Board papers are amended because of constructive debate.
- 360-degree feedback on the Board's collective performance.
- Annual individual appraisals for all Board members.
- Scheduled "check-in" sessions to honestly reflect on how the Board is adhering to the Charter, with this included in the Board's forward planner.
- Effective use of the Board Assurance Framework (BAF) to support ongoing evaluation.

Board Development Session: Culture & Commitments

Individual Commitments

Alongside the Charter, each Board member has made a personal pledge to support our cultural goals. These commitments reflect individual accountability and leadership in action.

Board Member	I will commit to the following action to role model a positive culture.....
Cedi Frederick, Chair	“...by being more present within and across the organisation. I will attend more staff meetings in person and online, share what I know and listen with a quiet mind. I will work harder to get to know our staff and make it easier for the staff to know me”
Angela McNab, Vice Chair	“...by engaging with staff and teams outside of formal committees to hear about their roles and work and the important contribution they make. I will seek feedback on my style and behaviours to enable continuous learning about personal impact.”
Hugh McIntyre, Non-Executive Director	“...by putting people first by leading committees that scrutinise the people impact of decisions, uphold wellbeing, and hold the organisation to compassionate, transparent standards during change.”
Peter Harrison, Non-Executive Director	“...by being actively inquisitive about how staff are coping with pressures and changes, demonstrating genuine interest and empathy. I also welcome any feedback regarding my own behaviours and adherence to our values.”
Liz Butler, Non-Executive Director	“...by aiming to spend at least 2 days a month in one of our offices, to increase visibility and hopefully encourage colleagues to feel that I am available.”
Gurvinder Sandher, Non-Executive Director	“...I commit to role-modelling a positive culture by leading with kindness, communicating openly, and fostering an inclusive, collaborative environment.”
Adam Doyle, Chief Executive Officer	“... by supporting executives being comfortable being asked difficult questions and giving well thought through answers.”
Dr Kate Langford, Chief Medical and Outcomes Officer	“...by championing reducing healthcare inequalities by raising the need for actions to be built into every commissioning decision.”
Ed Waller, Chief Commissioning Officer	“...by making sure we are embedding insight and patient voice into our commissioning decisions.”

Natalie Davies, Executive Director of System Improvement	“...by fostering a workplace where respect and inclusion thrive. I will actively listen to understand, acknowledge and learn from mistakes with transparency, and demonstrate visible allyship to support equity and belonging for all.”
Ivor Duffy, Chief Finance Officer	“...to actively listen with full attention, provide honest and constructive feedback that is kind not nice and take meaningful action on what I hear.”
Paul Lumsdon, Chief Nursing, Experience and Quality Officer	“...by championing quality and safety to be at the heart of every decision.”
Lee-Anne Farach, Medway Council Partner member	To be received as on annual leave.
David Whittle, Kent County Council Partner Member	“...by making time for more informal interactions to build personal connections and trust between the ICB and across all public service partners in Kent and Medway,”
Jonathan Bryant, GP Partner Member	“...by using the increased psychological safety provided by the cultural review to empower myself and my colleagues to do our best work, demonstrating courage and integrity in my duties as a board member.”
Sheila Stenson, Community and Mental Health Partner Member	“by calling out behaviours that are not aligned to our Board Charter.”
Bali Rodgers, People and Communities Champion	“...by committing to embrace change.”

Title of meeting:	NHS Kent and Medway Integrated Care Board (Part 1)	Date: 3 February 2026
Title of report:	Annual Emergency Preparedness Resilience and Response (EPRR) Assurance Ratings	
Reporting officer:	Ed Waller, Deputy Chief Executive and Chief Strategic Commissioning Officer	
Lead member:	Ed Waller, Deputy Chief Executive and Chief Strategic Commissioning Officer	
Freedom of information (FOI) status:	This paper is disclosable under the FOI Act	

Purpose: This paper is for (please tick)

Assurance	✓	Decision		Information		Discussion	
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Report summary:

The NHS Kent and Medway ICB EPRR Team has completed the annual NHS England EPRR assurance process for both the ICB and the NHS organisations that form the Kent and Medway Local Health Resilience Partnership (LHRP).

The results, reviewed and confirmed by NHS England South East, show that the ICB continues to meet all requirements as a Category One Responder under the Civil Contingencies Act 2004, as well as its duties under the Health and Care Act 2022 and the NHS England EPRR Framework 2022.

NHS Kent and Medway ICB has been rated **Fully Compliant**.

Across the system, the LHRP has been rated **Substantially Compliant**.

With the exception of IC24 which is partially compliant, all NHS LHRP organisations are either Fully or Substantially Compliant.

Two Acute Trusts moved from Fully to Substantially Compliant this year due to changes to the DSPT standard.

NHS England will update the Core Standards that underpin the EPRR Assurance Process for 2026.

Proposal and/or recommendation:

The Board is asked to note that:

- NHS Kent and Medway ICB remains Fully Assured against NHS England's EPRR Assurance Standards.



- Except for IC24, who have an action plan to return to substantial or full compliance, the NHS members of the Kent and Medway LHRP have all achieved Full or Substantial Assurance.
- Two organisations DGT and NELFT moved from a Full compliance position to that of Substantial compliance. In both cases this was due to a partial compliance assessment relating to Core standard 49 DPST. It has been recognised that compliance for this standard sits outside of the direct control of EPRR staff and noted that it was changes to the DPST standard that resulting in this outcome. Both organisations have detailed action plans to rectify this position already in train.
- The current NHS England Annual EPRR process will end this year. It will be replaced in 2026 with an updated set of criteria.

Attention is brought to the good practice identified locally and the areas where regional or national guidance has been sought.

Good Practice

- **EPRR networks and collaborative working continue to thrive** across the LHRP and wider multi-agency partners. Long-standing relationships and a strong culture of sharing across organisational boundaries ensure efficient and effective use of EPRR specialist expertise.
- **Integrated training and exercising activity has expanded**, with increasing numbers of programmes developed and delivered by LHRP member organisations. A provider-led approach has strengthened skills development and shared learning. Recent examples include the Melville 1 (tabletop) and Melville 2 (command post) hospital evacuation exercises, Logist training, and the establishment of a Logist forum.
- **The Kent and Medway LHRP CBRN Standard for Acute Trusts has been updated and approved** by the LHRP Executive Group. This refreshed standard embeds consistent CBRN training for acute staff countywide, supporting a unified response and enabling easy transfer of staff competencies between organisations.
- **Learning from two chemical-contamination fatalities in 2024 led to the development of the KMRF Individual Chemical Exposure (ICE) Protocol.** This work was chaired by Hayley Lingham, Head of EPRR at EKHUFT, through a Kent and Medway Resilience Forum task-and-finish group. The protocol was recognised at the NHS England South East Regional EPRR Conference in September 2025, where Hayley received the Significant Achievement in EPRR award.
- **The NHS continues to play a leading role within the Kent and Medway Resilience Forum**, co-chairing several key Delivery Groups. Strong, well-established relationships support effective planning and response—for example, preparations for the EU Entry/Exit System (EES), oversight of phased implementation, and ongoing multi-agency work supporting migrants arriving via small boats.
- **The ICB has launched a postgraduate-level EPRR in Healthcare qualification** in partnership with the University of Kent. The pilot cohort completed in 2025 with excellent feedback, and applications are now being reviewed for the 2026 intake.
- **Pan-regional EPRR collaboration strengthened further in 2025**, with joint ICB assurance reviews for ambulance trusts expanded from the Kent–Surrey–Sussex footprint to the full South East region. This enabled deeper discussions, greater sharing of good practice, and more efficient use of resources across all participating organisations.

Issues to raise regionally or nationally

- A review of national NHS England EPRR guidance to confirm it is up to date, along with a timeline for circulating national guidance to support the development of local plans (e.g., Pandemic Disease and Radiation Monitoring Units).
- A request for national guidance establishing minimum standards for the number and grading of NHS EPRR staff across different types and sizes of NHS-funded organisations.

- Clarification on whether responsibility for implementing the new Martyn's Law requirements will sit with Estates teams or EPRR teams.
- Further detail on the division of EPRR responsibilities between ICBs and the new regional tier of the NHS.

Our objectives: Tick the objectives the report aims to support.

1. We will work with the NHS system to improve healthcare for our population.	✓	3. We will develop a workforce where colleagues feel valued, we celebrate diversity and are fair and inclusive.	
2. We will deliver sustainable services within our 2025/26 spending targets.		4. We will reduce healthcare inequalities for the people of Kent and Medway.	

Identified risks, issues and mitigations:

Risk/Issue impact areas

Financial Patient Staff Services Reputational

N/A

Resource implications and finance approval:

N/A

Sustainability considerations:

Climate Change Adaptation may be included in the updated NHS England EPRR Assurance Standards for 2006/27.

Public and patient engagement considerations

There has not been any media interest in previous Annual EPRR Assurance Reporting.

This has been an internal Assurance Exercise. The NHS England EPRR Assurance Process requires each participant to present the results of the process at a Public Board meeting.

Equality, health inequalities and quality impact assessment

Has an equality assessment been undertaken?

Yes (please attach the action plan to this paper)

Not applicable - The assurance process is a review of existing systems noting that its results may be used to inform future change that could be subject to an EIA.

Legal implications

The report demonstrates that NHS Kent and Medway ICB's duties as a Category One Responder under the Civil Contingencies Act 2004 and EPRR duties set out in the Health and Care Act 2022 and NHS England EPRR Framework 2022 have been met.

Report history / committees reviewed

The results of the EPRR Assurance Process are reviewed by the LHRP Delivery Group, Executive Group, NHS Provider Boards and NHS England.

Next steps:

The high level of preparedness in Kent and Medway will be noted. Good practice will be shared and the process will be repeated in 2026/27 with the new NHS England EPRR Assurance Standards.

Appendices:

Supporting information to the report should be listed here.
Any supporting documents are to be provided as standalone documents and not embedded.

List staff contributing to the paper and any conflicts of interest (COI) identified:

Matthew Drinkwater. No conflicts of interest.

For further information or for any enquiries relating to this report please contact:

Matthew Drinkwater Matthew.drinkwater@nhs.net

1 EPRR assurance 2025-26: ICB return summary – NHS Kent and Medway ICB

Overall Compliance Statement

The LHRP has agreed their overall assessment of compliance is: Substantially Compliant

The overall assessment of the NHS in the LHRP is:

Substantially Compliant

The overall assessment of CBRNe/Hazmat readiness is:

Fully Compliant for the Acute Sector

Substantially Compliant for SECAmb

Date of approval by Local Health Resilience Partnership: LHRP Executive group meeting 18th November 2025

Describe the process used to gain confidence with organisational ratings:



2025 K+M EPRR
Assurance Process Ag

Top Three Most Common Health Risks Raised in the LHRP:

1	Increased likelihood of Cyber-attack.
2	Challenges with preparing local plans in key areas including Pandemic Disease and Radiation Monitoring Units whilst national guidance is updated.
3	Uncertainty around future EPRR arrangements following the merging of DHSC and NHS England and the 50% reduction in running costs of ICBs.

Issues identified and plans to rectify (including organisations identified as partially compliant or non-compliant)

- IC24 have been assessed as partially compliant in 2025; a reduction from substantial.
- Following a Cyber/IT system outage exercise in the Summer of 2025 IC24 undertook a deep dive review of their EPRR mechanisms with the support of LHRP members. This resulted in their assessment of partial compliance. A detailed action plan to address the gaps has been discussed with the ICB and details of IC24's plans to share EPRR provision with KCHFT were presented to the LHRP Executive Group. The ICB is assured that if these actions are taken IC24 will be on track to move quickly to substantial compliance.
- All other organisations achieved either substantial or full levels of compliance.

Annual EPRR Assurance Results for the Kent and Medway LHRP

Organisation	2017	2018	2019	2020	2021	2022	2023	2024	2025 (NOTE: unrated)	CHANGE
NHS KM ICB										↔
Organisation	2017	2018	2019	2020	2021	2022	2023	2024	2025 (NOTE: unrated)	CHANGE
MTW										↔
EKHUFT										↔
MFT										↔
DGT										↓
	2017	2018	2019	2020	2021	2022	2023	2024	2025 (NOTE: unrated)	CHANGE
KCHFT										↔
MCH [inc Meddoc]										↔
HCRG Care Group										↔
	2017	2018	2019	2020	2021	2022	2023	2024	2025 (NOTE: unrated)	CHANGE
KMPT										↑
NELFT *										↓
G4S										↑
KMSS NHS 111 **										↔
SECAMB 999 ***										↔
IC24 [NHS 111 and GP OOH]										↓

* assessed by NHSE London Region

** 2025 – SECAMB 111 assessed by NHS Surrey Heartlands ICB

*** assessed by NHS Surrey Heartlands ICB in conjunction with wider regional ICB partners

- It was noted that two organisations DGT and NELFT moved from a Full compliance position to that of Substantial compliance. In both cases this was due to a partial compliance assessment relating to Core standard 49 DPST. It has been recognised that compliance for this standard sits outside of the direct control of EPRR staff and noted that it was changes to the DPST standard that resulted in this outcome. Both organisations have detailed action plans to rectify this position already in train.

Good practice identified

- EPRR Networks and collaborative working continuing to flourish across LHRP and wider multi agency partners. Relationships developed and embedded over years and a culture of sharing and collaborative working across organisational boundaries have led to efficient and effective use of available EPRR subject matter experts.
- Increasing amounts of training and exercises are being developed and delivered by LHRP member organisations and delivered across LHRP members. A provider led approach that utilising skills of all LHRP members to best effect has been encouraged and shown to enable skills development and sharing of learning. Examples include the provider led Hospital Evacuations Exercises Melville 1(tabletop) and 2 (Command post), Logist training and a Logist forum
- An updated Kent and Medway LHRP CBRN Standard for Acute Trusts has been approved by the LHRP Executive Group following a detailed review. The common standard has embedded consistent training of acute trust staff across the county. This ensures that there is a consistent approach to responding to a CBRN incident and allows for transfer of staff qualifications when they move between organisations within the county.
- Following learning from two incidents which involved a chemically contaminated fatality in 2024, Hayley Lingham Head of EPRR, EKHUFT, chaired a Kent and Medway Resilience Forum task and finish group which developed and delivered a KMRF Individual Chemical Exposure (ICE) Protocol. This piece of work was recognised at the NHS England South East Regional EPRR Conference in September 2025 with Hayley receiving the award for Significant Achievement in EPRR.
- The NHS is a key member of the Kent and Medway Resilience Forum and provides co-chairs to several key Delivery Groups. Relationships developed over years continue to support efficient and effective planning for and responding to events and incidents. For example – preparations for the EU Entry Exit System (EES) and ongoing monitoring of the current phased implementation and continued work with partners to support the arrival of migrants via small boats and their ongoing care needs.

- Use of Resilience Direct in the annual assurance process. This has been in place for many years and has built over time a vast repository of specialist documents and resources which can be drawn upon and shared across LHRP members. It also allows for efficient and effective use of EPRR resource to deliver the assurance process, with each year building upon the last.
- The ICB has established and started delivering a post graduate level EPRR in Healthcare qualification in collaboration with the University of Kent. A pilot course was successfully delivered in 2025 with excellent feedback received from students. Applications are being considered for the 2026 intake.
- Pan region EPRR collaboration. 2025 saw an expansion of the joint ICB assurance reviews for ambulance trusts. Historically delivered across Kent, Surrey and Sussex, with SECAMB, this year saw this expanded across the whole region to include all ICB and ambulance trust partners. This was very successful and enabled detailed conversations and sharing of good practice between trusts and was an efficient use of resources.

Issues to raise regionally or nationally (including EPRR Assurance process feedback)

- A review of national NHS England EPRR guidance to ensure that it is in date and the sharing of timeline for the circulation national guidance to support the preparation of local plans e.g. Pandemic Disease and Radiation Monitoring Units.
- A request for a national guidance setting a minimum standard for numbers and grading of NHS EPRR staff in different types and size of NHS funded organisations.
- Guidance as to whether the implementation of the new Martyn's Law requirements will be led by Estates or the EPRR teams.
- Further details of the responsibilities for EPRR that will lie with ICB and with the new regional tier of the NHS.

Summary position for the LHRP	Status	2024/25		2025/26	
		Number of Organisations	%	Number of Organisations	%
	Fully Compliant	10	71%	8	57%
	Substantially Compliant	4	28%	5	35.8%
	Partially Compliant	0	0	1	7.2%
	Non-Compliant	0	0	0	0

2 Organisational Assurance Summary

Organisation	ODS code	Acute providers	Specialist providers	Services provided or organisational type (X those which apply)								Compliance achieved:					
				NHS Ambulance Services	Core standards	Interoperable Capability Standards	Patient Transport Providers	NHS 111	Community services providers	Mental health providers	ICB	Primary care (GP, community pharmacy)	Other NHS funded organisations	NHS England	2024/2025	2025/2026	Change
NHS England Regional Office													X	TBC	TBC		
NHS Kent and Medway ICB													X		Full	Full	↔
NHS Provider Name																	↑
EKHUFT		X												Full	Full	↔	

MTW		X											Full	Full	↔
DGT		X											Full	Substantial	↓
MFT		X											Full	Full	↔
KCHFT							X						Full	Full	↔
MCH							X						Full	Full	↔
HCRG							X						Full	Substantial	↓
KMPT [wef Nov 2025 now KMMHT]								X					Substantial	Full	↑
NELFT								X					Full	Substantial	↓
G4S						X							Full	Full	↔
KMSS NHS 111						X							Substantial	Substantial	↔
SECAMB				X	X								Substantial	Substantial	↔
IC24											X		Substantial	Partial	↓

[Please list provider organisations by lead ICB]



Kent and Medway

Kent and Medway LHRP Annual EPRR Assurance Framework Process 2025

Agreed version

Introduction

It is anticipated that NHS England will publish its 2025 Assurance toolkit and accompanying Guidance letter in early July. Initial verbal update from NHS England have advised that the Assurance toolkit will be largely the same as used in 2024. It is anticipated that the ICB will continue to have wider freedoms as to how they manage and deliver the process to gather suitable levels of assurance to satisfy the ICB AEO and Commissioners, LHRP Executive members and onward reporting to regional colleagues.

In line with our current understanding the following process is proposed for use by the Kent and Medway LHRP Executive Chair and LHRP Membership for usage in 2025. Please note: this was considered and agreed by the Kent and Medway LHRP Executive Group meeting held 17th March 2025, and received final agreement at the meeting held 8th July 2025.

Please note: At the Kent and Medway LHRP Executive Group meeting held 17th March 2025 it was discussed and agreed that there would be no additional Kent and Medway Locally Agreed EPRR Assurance standards developed and completed in 2025.

Process for 2025

Each of the provider organisations [listed in appendix 1] to complete the NHS England self-assessment tool and submit a copy of this to Samantha Proctor samantha.proctor@nhs.net by **Friday 12th September** along with the following supporting evidence items:

- A copy of the completed self-assessment tool
- A copy of the report taken to a public board or governing body meeting for agreement.
- a 2025 EPRR Assurance Improvement Plan to address all standards assessed as partial or non-compliant
- a copy of the 2024 EPRR Assurance Improvement Plan to address all standards assessed as partial or non-compliant detailing progress to address these
- a copy of the completed NHS England Statement of Compliance for 2025
- copies or access to copies via use of RD, to documents which are being relied upon as evidence to support self-assessed levels of compliance
- A completed Overview position statement template.

- ICB EPRR team will review materials submitted and if required individual face to face review meetings will be held with organisations found to have significant gaps in assurance. These meetings will provide opportunity for supportive learning and development.

- LHRP Delivery Group meeting set for **Tuesday 21st October** will be used as the EPRR Assurance peer review meeting – each provider organisation to present an overview position statement on the standard template provided, for peer review and discussion. This will have particular focus on items of best practice, areas for improvement and allow for shared learning. Key items identified will be incorporated into the LHRP DG Workplan for 2025/26.
- LHRP Executive Group meeting **Tuesday 11th November** – meeting will consider the collated findings of the Assurance Process for wider system consideration prior to onward submission to NHS England Region colleagues. The meeting will have particular focus on items of best practice, areas for improvement to allow for shared learning. Key items identified will be incorporated into the LHRP Executive Workplan for 2025/26.
- The NHS Kent and Medway Accountable Emergency Officer will make submission of the NHS England Region EPRR Assurance Outcomes reporting template by **Wednesday 26th November**.

Confirmation and reporting of Assurance Compliance levels

It is anticipated that NHS England SE Region EPRR Lead will confirm, and report in writing the EPRR Assurance Compliance levels achieved by the NHS Kent and Medway system to the NHS Kent and Medway ICB in quarter 1 of 2026. Please note that this may be subject to current reorganisation changes within NHS England.

Upon receipt the NHS Kent and Medway ICB Accountable Emergency Officer will write to each organisation Accountable Emergency Officer to confirm and report EPRR Assurance Compliance levels.

Appendix 1

Organisation	Notes
EKHUFT	
DGT	
MFT	
MTW	
KCHFT	
MCH [inc. Meddoc]	
HCRG	
KMPT	
NELFT	Process to be completed by NHS England London and outcome reported by NELFT to the Kent and Medway LHRP
IC24	
G4S	

NHS 111 SECAMB	Process to be completed by NHS Surrey Heartlands ICB and outcome reported by SECAMB to the Kent and Medway LHRP
SECAMB 999	

ICB Board Committee Update

Committee:	Inequalities, Prevention and Population Health Committee
Date of meeting:	13 January 2026
Chair of Committee:	Gurvinder Sandher

Escalation – items to escalate to the Board

No items to escalate to the Board.

Assurance – items to provide assurance to the Board

Update provided on the Integrated Care Strategy. Recognised that events had overtaken current arrangements and that NHS now mandated to produce a 5 Year Strategic Plan which would replace the previous strategy. Recognised that a system-wide conversation would be needed to determine what the future integrated care strategy should look like and how partners would work together going forward.

Update provided on the Joy platform; a digital social prescribing tool providing a single point of access and directory for healthcare professionals, patients, and users to navigate the voluntary sector and social prescribing landscape. Funding for 2026/27 had been successfully secured. It was explained that Joy was intended to be a channel shift, enabling digitally capable users to access services efficiently while maintaining traditional routes (face-to-face, phone) for those who needed them.

The Committee was given an update on the work of the Integrated Care Partnership Sub Committees; Strategic Partnership for Health and Economy which included a presentation on the Get Britain Working Project which is being delivered by the East Kent and Medway and Swale Health Care Partnerships. Update also provided on ICP Prevention Sub Committee where guiding principles have been agreed and over coming months short-term and medium/long-term aspirations for each priority would be agreed.

The Committee also received a detailed presentation around Mental Health Inequalities and an action plan to counter this. This work had been developed collaboratively with ICB health



inequalities and population health teams and local authorities, using increasingly robust population health data. The Committee particularly sought assurance around the emerging mental health needs among children and young people. It was understood that there was limited direct health commissioning, with most provision sitting within local authority services. While activity existed through family hubs and related offers, there was a recognised gap around coordination and early intervention, supported by growing evidence on the importance of addressing trauma and wellbeing early in life. Work was underway to better understand need and consider how the ICB might contribute.

Information – *items for the Board to note*

No items for information.

ICB Board Committee Update

Committee:	Integrated Care Partnership
Date of meeting:	11 December
Chair of Committee:	Vince Maple

Escalation – items to escalate to the Board

No items to escalate to the Board.

Assurance – items to provide assurance to the Board

Summary

The committee received updates from the lead partners, focused on discharge as the topic for Outcome 5 of the Integrated Care Strategy and received the Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 – 2030. It was the first time public questions had been received by the committee, although none were pertaining to items on the agenda and were therefore addressed outside the meeting.

Statutory Partners Update

The committee received verbal updates from NHS Kent and Medway, Kent County Council and Medway Council leaders. For NHS Kent and Medway this covered the financial pressures, the Reset, Recovery and Transformation plan and the 50% reduction in running costs for the organisation. KCC highlighted the Adult Social Care Prevention Framework (2025–2035), Dementia Friendly Kent Awards, the Marmot Coastal programme and the Learning Disability and Autism (LDA) Strategy which had been a previous focus at a committee workshop. Medway Council focused on the neighbourhood health pilot, a national resilience exercise (Exercise Pegasus), local government reorganisation and the Medway Local Plan.



Integrated Care Strategy Update – Shared Outcome 5

The Integrated Care Strategy update was centred on shared outcomes five, and a review of the Shared Delivery Plan and data from the logframe matrix identified hospital discharge as the focus area.

The committee received updates on:

- the Medway Intensive Support Team (MIST) which had supported 63 adults and achieved significant cost savings/avoidance in a short timeframe.
- Joint Brokerage teams supporting discharge with a more integrated approach. Work was continuing to develop and scale the approach.
- Home First, a multi-agency model focused on supporting people at home wherever possible. Early findings had indicated significant improvements in patient outcomes and the focus was now on scaling capacity and the approach across Kent and Medway.

Committee members emphasised the value of integrated, multi-agency working and the need for strong communication and strategic alignment between partner organisations. Also the need to share these positive news stories with residents.

Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 – 2030

The committee noted the strategy. It is based on the mental health needs assessment and highlights areas for localised, tailored interventions, for example coastal communities and culturally competent support. There was recognition of the multi-agency and evidence-based approach to developing the strategy. The committee discussion focused on support for children and young people, resilience and working with schools.

Information – items for the Board to note

Forward Plan

The next meeting of the ICP is 31 March. The main focus of the meeting will be mental health, with the exact area to be confirmed following review of the Mental Health Needs Assessment and information from the logframe and Shared Delivery Plan. Other items on the forward plan, with exact meeting dates to be confirmed, include support for carers and NHS five year plans.

ICB Board Committee Escalation and Assurance Report

Committee:	Improving Outcomes and Experience Committee
Date of meeting:	18 November 2025
Chair of Committee:	Hugh McIntyre

Escalation – items to escalate to the Board

The Committee requested that their concerns regarding adult mental health services be escalated to the Board. In addition, and given these wider concerns, the Committee asked that the Board consider enhanced support for the transition of children's mental health services to Kent and Medway Mental Health NHS Trust (KMMH).

Addendum – from the meeting on 20 January:

The IOEC was assured that the transfer of children's Mental Health services is now supported by a Transition Committee chaired by a member of the Executive. Both data interoperability and Safeguarding services are under direct oversight.

Services for adults with Mental Health remains a concern. The Committee was partially assured pending a further report to the March meeting outlining the individual oversight and assurance mechanisms and their respective ambitions and time frames.

Assurance – items to provide assurance to the Board

Board Assurance Framework / Risk Register

The corporate risks remain:

- The long-term sustainability of the financial plan,
- The delivery of operational plans (notably 65w and 12h waits)
- Medway Foundation Trust (MFT) with weekly tier one meetings.

Gaps in assurance relating to BAF 2 (Delivery of the Operational Plan) were challenged. The high number of 'No Criteria to Reside' (NCTR) patients at MFT was being addressed with a more coordinated following the inclusion of Medway community services within KCHFT.

With regard to BAF 5 (Medway NHS Foundation Trust), under-delivery of provider Indicative Activity Plans (IAPs) is affecting waiting times with Activity Query Notices (AQN) issued to four Trusts and corresponding meetings had been held with two.



Gaps in leadership (BAF 5) are currently being addressed through joint leadership appointments.

The Committee was partially assured noting the focus of the ongoing governance review on a more robust approach to risk management.

Integrated Quality and Performance Report (Month 7)

- Delays continue in audiology, EEG and some cardiac diagnostic tests.
- 65w waits are being driven by contracting issues (IAPs)
- ENT delays were affecting top line reporting numbers
- The ICB Chief Executive (in attendance) emphasised the need for the ICB to examine the system's wider demand profile given that waiting lists numbers and delays were large by national standards.
- The ICB Chief Executive highlighted three areas of concern: Trauma and Orthopaedics, Cardiac and ENT. He emphasised the need for an urgent demand strategy and the importance of close quality monitoring.
- The Committee was assured by the Report and asked that ENT data be disaggregated from future reports to allow evaluation of underlying trends.

Addendum – from the meeting on 20 January:

The IQPR is under revision and was therefore not presented to the Committee. The Committee was therefore not in a position to offer assurance with regard to delivery of services in certain areas notably Elective and Urgent and Emergency Care.

System Quality and Safety Standing Report

The report highlighted ongoing enhanced oversight of EKHUFT and MFT with the need for enhanced surveillance of KMMH under review. KMMH was inspected by the CQC in April, and again in the summer. During and after the inspection phase, inpatient deaths had been reported as well as a cluster of community deaths.

A provisional report outlined serious concerns in adult mental health services in several areas with a Section 29a issued. The full report is awaited. Enhanced oversight is now being implemented.

The committee was also apprised of the emerging complexity of the process involved in transferring Children's MH services, which encompasses the transfer of safeguarding resources as well as information database systems which currently differ; with the associated need to establish Transition Oversight Groups.

The committee reflected on the fact that hitherto the committee had been assured regarding adult mental services but that sufficient concerns existed in April to warrant CQC review at that time.

The committee was thus not fully assured and asked for a full report to come to the next IOEC that would outline KMMH's response (including timelines and outcomes) to the CQC findings regarding Adult MH services.

The Committee also requested that their concerns regarding Adult MH services be escalated to the Board. In addition, and given these wider concerns, the Committee asked that the Board consider enhanced support for the transition of children's MH services to KMMH.

In response to a rising SHMI (Summary Hospital Mortality Indicator - now included in the Report), the Chief Medical Officer explained that this was already being examined by the regional Medical Director. Although several factors are involved, issues centred around UTI and Pneumonia an MFT.

With regard to PSIRF implementation, the committee heard that there are concerns about data completeness and labelling both of which are being addressed in particular with clarification of external data sources and internal understanding of the process.

The Committee expressed ongoing concern regarding the pace, uniformity and completeness of the PSIRF roll out. Further information will be brought to the January meeting including peer benchmark data if possible.

The Committee was partially assured by the report noting the pending detail on PSIRF and mental health.

Maternity Services Update

Stillbirth rates continue to improve but with some local variation.

Enhanced oversight remains in place for all 4 four providers with specific concerns at each Trust (including a Section 29a at MTW following a CQC inspection).

The Committee was concerned to hear that compliance with the CNST Maternity scheme remains incomplete for some providers with issues over the contracting of the Maternity Neonatal Voices Partnerships (MNVP). (CRR 1564).

A new maternity service specification is in discussion to address these issues – the Committee noted that incomplete compliance with CNST exposes the Trusts to significant financial liability and asked that this be addressed as a priority.

The Committee was assured by the Report.

Infection Prevention and Control (IPC) and Vaccination (Interim Report)

Although rates of infection continue to rise this reflects, for the most part, a national trend. Previous system work in this area has been used as National exemplar.

The Committee noted variation between individual Trusts and asked that this be an area of focus for the system IPC leadership forum.

Variable vaccination rates between providers is being addressed through a focus on MFT and KMMH. Improvement targets are in place (with executive escalation where needed) with early evidence of increased uptake.

Vaccination champions and peer vaccination schemes are in place. A focus on school uptake was being introduced at the time of the meeting. The team were also urged to focus on care homes.

The committee were assured by the IPC and Vaccination Report.

Patient Experience Team (Interim Report)

The majority of the backlog from the transfer back of the previously outsourced contract has now been addressed. A system leadership forum for Patient Experience is in discussion with the aim of coordinating a hitherto fragmented approach. The use of AI systems to support case processing is under consideration.

The Committee was assured by the report and commended the team on their excellent work in addressing the historical issues with the service.

Winter Reporting (For information)

The central issue remains flow in the Acute Sector, not least with the challenge of an early rise in 'flu cases. The Committee was concerned that the already escalated numbers of 'No Criteria to Reside' (NCTR) patients would result in a rise in 12hr and 'corridor' waits.

The Executive Committee meet weekly with additional steps to reduce demand and increase discharge being considered.

The Committee asked for an update to be brought to the next meeting providing more clarity reading patient flow and the proposed evaluation of harms if waits increased.

Paediatric Recall and Paediatric Audiology (For information)

A review, following a 2023 investigation in to auditory brainstem response (ABR) in neonates had identified systemic issues and harm in over 300 babies.

Kent and Medway (notably KCHFT, MFT and EKHUFT) are following the national framework to assess these issues. Progress will be overseen by a programme board, reporting to the Quality Improvement Group.

The Committee noted the report and requested an update on progress and harm reviews at the next meeting.

Kent and Medway Suicide and Self Harm Prevention Strategy (For information and assurance)

The Committee was assured by the Draft Strategy albeit noting the overlap with community MH services reported above

Medicines Quality and Safety (Annual Report)

The Committee commended the team and were assured by the annual report.

Child Death Review (CDR) (Interim Report)

The statutory function of Kent and Medway ICB is being reviewed following the reestablishment of the CDR process under the ICB (note other ICBs have partnership arrangements).

A gap analysis is underway regarding CDR functions to ensure completeness. The National Child Death Mortality database was supporting a greater level of detail around emerging risk from incidents.

The Committee was assured by the Child Death Review report.

Safeguarding (Interim Report)

Internal training continues.

Mapping of providers against the NHS Safeguarding and Accountability Assurance Framework (SAAF) is underway:

- as part of the EKHUFT recovery support plan exit requirements
- in MFT following a recent safeguarding maternity incident
- as a requirement of the KMMH enhanced/intensive oversight requirement.

Statutory system Partnerships and boards are supporting recommendations and legislative requirements from statutory reviews including the Children's Wellbeing and Family First framework.

The Kent and Medway Safeguarding Adult Board self-assessment had been submitted.

Work was underway to clarify provider roles and responsibilities. In particular the Committee asked that mental health Safeguarding concerns would be incorporated in the forthcoming paper regarding KMMH.

The Committee was assured by the interim Safeguarding report.

Information – items for the Board to note

No items for information.

ICB Board Committee Escalation and Assurance Report

Committee:	Productivity and Investment Committee (PIC)
Date of meeting:	19 December 2026
Chair of Committee:	Peter Harrison

Escalation – items to escalate to the Board

As previously advised, the Committee had previously raised concerns regarding the Commissioning Plan and its proposed consolidation of contracts, and has yet to receive any update regarding mitigation of these concerns. Acknowledging the new CEO and the welcome Procurement and Contracting review, it is hoped this issue will now be addressed.

As similarly previously escalated, the Kent County Council (KCC) dispute similarly remains unresolved and presents both financial risk, and compromises a sustainable system approach to delayed discharges. It is acknowledged that this issue is being addressed with high focus, albeit the Board will be aware it is not yet resolved.

Assurance – items to provide assurance to the Board

The Committee meets on a monthly basis, and as at the time of writing this summary, has met three times since the last Board. The Committee meeting was joined by the Chair and new CEO in October, and also by the CEO in November.

Following Q2 close, it was confirmed that eligibility for Deficit Support Funding (DSF) has ceased. At the October PIC, this cessation of DSF together with the performance to date, (including compromised CIP delivery), prompted challenge regarding the viability of delivering to plan, and the proposal to request a reforecast. The Finance Team acknowledge the nature of non-recurrent and over ambitious measures and CIPS do not represent a sustainable position, and the risk associated with the KCC dispute. Adam Doyle observed that our spend on the Acute sector is the highest in the South East, and focus is being applied on this during the planning round.

Productivity and IQPR reports were discussed at the October PIC and both will be revised to provide the assurance required; (which is currently lacking).

The October meeting received an Estates and Infrastructure presentation which provided assurance, demonstrating good grip of estate management and control of void costs.

The November meeting received positive assurance regarding management of the Bed Brokerage Programme. Positive assurance was also received regarding management of the Talking Therapies contract. This follows the issuance of an Activity Query Notice (AQN) in April 2025 relating to under-performance. The provider has responded positively, the AQN closed, and an improvement plan is to be incorporated into the contract.



The November meeting included a report on Legal Costs. Adam Doyle advised that he had observed that some former requests had loose scope and there is a need to provide a set approach for seeking legal comment. This work is in-hand.

The Right to Choose pathway for ADHD assessment exposes the ICB to variable costs. Following a request by the PIC, Marie Hackshall presented a proposed approach to the November meeting detailing a lower cost model (as adopted by Surrey Heartlands ICB) to reduce costs to 30% below the current RTC market average. A further update following NHSE dialogue will be provided to the January PIC.

The December meeting received a Procurement Situation Report, and was not assured by the reports received. This remains a focus of the committee.

Adrian Roberts provided a verbal report to the December committee meeting, sharing his observations regarding system finances. This highlighted sustainability concerns, historic approaches (noting accumulation of system finance issues over the last few financial years), and the need for two or three big impact system programmes of change (e.g. patient flow, discharge and urgent and emergency care).

Information – items for the Board to note

The move to ISFE2 as mandated by NHSE was not without significant teething problems, some of which are still being addressed. This impacted staff training, engagement, and some payment runs.

ICB Board Committee Escalation and Assurance Report

Committee:	Audit and Risk Committee
Date of meeting:	4 December, 2025
Chair of Committee:	Elizabeth Butler, Non-Executive Member

Escalation – items to escalate to the Board

Three matters to escalate to the Board:

- Board Assurance Framework (BAF) is only useful if it is kept up to date and focused on the risks in hand. This is being reviewed, but my plea to all colleagues is that this is a powerful tool that saves time and effort, if updated and challenged.
- We remain concerned that the ICB has not learned lessons from the pandemic. There is a sense that no thought is needed until the inquiry reports and the national plan is produced. The committee made the point that the absence of national guidance may have hampered our immediate response. Therefore, we request that thought is given to what our response would be in the absence of national guidance, particularly as we lose vital corporate memory over the next few months.
- The internal auditors expressed concern at the slow response to their reports and recommendations, even those marked urgent. Plus, a reluctance to engage with audit planning. This is a concern because, at the moment, we have not completed enough audits this year for the head of internal audit to form an opinion. We acknowledge the intense pressure on colleagues, but a lack of an opinion will only lead to further scrutiny.

Assurance – items to provide assurance to the Board

Following the introduction of the offence “Failure to prevent fraud”, we commissioned a review of our policies and procedures. We are in a good position, systems are rigorous and the policies of the ICB have been updated to ensure compliance. The Board can take assurance that we are not unduly exposed to this new legislation.

Information – items for the Board to note

An external review of contracting is underway and will be reporting shortly. The external audit is due to start in the next few weeks.



People Committee Update

1.0 Assurance

1.1 Director of People & Culture Report

The Committee received the Director of People & Culture report for assurance. Key points noted:

- Gail House closure withdrawn following colleague feedback; work continues with Trade Unions.
- Mutually Agreed Resignation Scheme (MARS) completed with 13 leavers at the end of October.
- Voluntary Redundancy Scheme (VR) reopened to reflect national changes; now closed again.
- Executive Management restructure now complete, with implementation effective 5 January 2026.
- Sickness absence increased to 4.3%, above target.
 - Increase driven by seasonal illness and mental health pressures.
 - Targeted actions underway with support from Mental Health Trust, Occupational Health and the Employee Assistance Programme.
 - Committee requested further detail on sickness breakdown (seasonal vs mental health) in the next report.
- **ASSURED:** The Committee gained assurance that statutory people obligations continue to be met.

1.2 ICB Reconfiguration Highlight Report (Change 25)

The Committee received the October 2025 report. Key points:

- Information previously circulated and well understood across leadership forums.
- Emphasis on managing communications sensitively with staff whose VR applications were unsuccessful.
- Some staff regarded an unsuccessful VR application as a positive indication of their value to the future structure.
- **ASSURED:** The Committee was assured on programme progress and workforce implications.



1.3 Culture & OD Plan Update

The Committee received an update from the Director of People and Culture and Senior OD Business Partner. Key highlights:

- Six high-impact actions identified by the Culture Implementation Group, including:
 - Behavioural framework;
 - Mandatory leadership and management training;
 - Leadership circles transitioning to mandated learning sets;
 - Increased response to the Pulse survey;
 - Focus on workplace kindness and embedding values.
- Pulse survey results expected to dip due to organisational change; EMT has developed a structured methodology for teams to act on results.
- Committee emphasised the importance of resilience and transparency.
- **ASSURED:** The Committee was assured by the update and progress against cultural review recommendations.

1.4 Freedom to Speak Up (FTSU) – Quarterly Report

The Freedom to Speak Up Guardian presented the Q3 report:

- 12 concerns raised since April 2025, including five during Q3, with two additional cases raised after the report.
- Themes: inappropriate behaviours, attitudes, HR process issues, and breakdowns in line-manager/colleague relationships.
- Increased cases reflect wider workforce pressures.
- Continued work on promoting FTSU, updated Contact Form, and growing visibility of ambassadors.
- **Action:** Work with Communications to encourage teams to invite FTSU Guardian to meetings and issue a supportive blog from a Board/Executive member.
- **NOTED:** Committee noted the report.

Committee Risk Register

- Updated risk register now reflects the split between transition and cultural review risks.
- Pulse survey results more positive than anticipated.

- Committee welcomed the improved clarity and format.
- **ASSURED:** The Committee was assured by the risk register and BAF update