NHS
Kent and Medway

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

Tuesday, 22nd September 2026 at **9:30 am**

Agenda

Notice on meeting etiquette 09:30

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 09:30 (5m)

For Noting

2.0 Apologies for absence 09:35

For Noting

3.0 Quorum 09:35

For Noting

4.0 Declarations of members' interests 09:35

For Noting

5.0 Minutes of the meeting on Tuesday, 21 July 2026 — 09:35 (2m)

For Approval

Attachment: 5.0 Minutes (Part 1) ICB Board 21 July 2026 - DRAFT v4.pdf ***Page 4***

6.0 Actions and matters arising — 09:37 (3m)

For Discussion

Attachment: 6.0 Action Log Board (Part 1) September 26.pdf ***Page 25***

7.0 Chair's Report — 09:40 (10m)

For Information

Lead: Angela McNab, Integrated Care Board Chair - NHS Kent and Medway

Attachment: 7.0 20260922 Chairs Report.pdf ***Page 27***

8.0 Chief Executive Officer's Report — 09:50 (15m)

For Information

Lead: Adam Doyle, Chief Executive Officer - NHS Kent and Medway

Attachment: 8.0 20260922 CEO Report v2.pdf ***Page 33***

Attachment: 8.1 Kent and Medway ICB.pdf ***Page 43***

Commission the right services each year

9.0 Update report on stroke services for Kent and Medway — 10:05 (20m)

For Assurance

Lead: Kate Langford, Chief Medical and Outcomes Officer - NHS Kent and Medway

Attendees: Des Holden, Acting Chief Executive Officer - East Kent Hospitals University Foundation Trust

Attachment: 9.0 Stroke update for Sept Board DRAFT pending ExCo AB.pdf ***Page 47***

10.0 Transfer of Children and Young People's Mental Health Services and All-Age Eating Disorder Service to Kent and Medway Mental Health NHS Trust - Q1 Update — 10:25 (10m)

For Assurance

Lead: Chris Neill, Chief Commissioning Officer - NHS Kent and Medway

Attachment: 10.0 20270922__Board P1_Q1 CYPMHS & AAEDS transfer to ***Page 55***

11.0 ***KMMH.pdf Kent and Medway Maternity Service Review Phase 1 Outputs: Co-Designed TOR Elements and Tabletop Exercise*** ***10:35 (10m)***

For Approval

Leads: Jennie Hall, Chief Nursing, Experience and Quality Officer - NHS Kent and Medway

Supplementary reading

Attachment: 11.0 20260922_KM_Mat_Review_Board .pdf ***Page 66***

Attachment: 11.1 Maternity Programme Board ToR_vDraft_CR.pdf ***Page 82***

12.0 Kent and Medway Urgent and Emergency Care Review (Including Urgent Treatment Centre Review) 10:45 (10m)

For Approval

Leads: Chris Neill, Chief Commissioning Officer and Kate Langford, Chief Medical and Outcomes Officer - NHS Kent and Medway

Attachment: 12.0 UEC_clinical_pathway_29 September 26 (1).pdf ***Page 89***

13.0 Autism and ADHD Assessment Pathways – 2026/27 in-year financial position, forecast outturn and future transition to a sustainable all age clinical model and financial position. 10:55 (10m)

For Assurance

Lead: Chris Neill, Chief Commissioning Officer and Jonathan Wilson, Chief Finance Officer - NHS Kent and Medway

Attachment: 13.0 Autism and ADHD Assessments Pathway Board Paper 220926.pdf ***Page 105***

To ensure financial sustainability over 3 years

14.0 ICB Finance Report Month 4 11:05 (10m)

For Information

Lead: Jonathan Wilson, Chief Finance Officer - NHS Kent and Medway

Attachment: 14.0 FINAL BOARD version - ICB Finance Position Month 4 Board.pdf ***Page 119***

Break 11:15 (10m)

Lead strategy and ensure commissioning levers deliver impact

15.0 Commissioning Intentions 2027/28 — 11:25 (15m)

For Approval

Lead: Chris Neill, Chief Commissioning Officer - NHS Kent and Medway

Supplementary reading

Attachment: 15.0 Board_Commissioning Intentions_Frontsheet_Sept26.pdf ***Page 132***

Attachment: 15.1 Commissioning Intentions 2027_28.pdf ***Page 145***

Attachment: 15.2 Commissioning intentions engagement findings paper ex com.pdf ***Page 229***

Attachment: 15.3 KMICB The Four Layers of Care.pdf ***Page 246***

Develop into a High-Performing Commissioning Organisation

16.0 Kent and Medway Strategic Commissioning Performance Report (SCPR) – NHS Oversight Framework 2026/27 — 11:40 (20m)

For Assurance

Lead: Chris Neill, Interim Chief Commissioning Officer - NHS Kent and Medway

Attachment: 16.0 SCPR Board Report 220926.pdf ***Page 255***

Attachment: 16.1 Appendix 1 SCPR Board Report 220926.pdf ***Page 272***

17.0 Cyber Security Update — 12:00 (10m)

For Assurance

Lead: Mayur Vibhuti, Joint Chief Data, Digital and Information Officer - NHS Kent and Medway

Attachment: 17.0 Kent and Medway Cyber Assurance Report revised.pdf ***Page 333***

Attachment: 17.1 Kent and Medway ExCo Cyber Assurance Report v 2.0.pdf ***Page 342***

18.0 Data Tools and Governance Board Assurance — 12:10 (10m)

For Assurance

Lead: Mayur Vibhuti, Joint Chief Data, Digital and Information Officer - NHS Kent and Medway

Governance

19.0 Corporate Risk Register and Board Assurance Framework — 12:20 (20m)

For Assurance

Lead: Claire Robson, Company Secretary - NHS Kent and Medway

Attachment: 19.0 20260922 CRR and BAF.pdf ***Page 358***

Attachment: 19.1 ICB BAF 26-27-v5-Sep26-Clean Version.pdf ***Page 368***

Attachment: 19.2 Risk,_Controls_and_Actions_Report_2026_09_11_16_51.pdf ***Page 395***

20.0 Briefing note from the following Committees — 12:40 (15m)

For Noting

20.1 Executive Committee — 12:55

For Assurance

Lead: Adam Doyle, Chief Executive Officer - NHS Kent and Medway

Attachment: 20.1 Report from ExCo.pdf ***Page 405***

20.2 Quality, Safeguarding and Patient Experience Committee — 12:55

For Assurance

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

Attachment: 20.2 QSPE Committee report template.pdf ***Page 413***

20.3 Finance and Performance Committee — 12:55

For Assurance

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

Attachment: 20.3 F&P Committee September report v2.pdf ***Page 419***

20.4 Remuneration and People Committee — 12:55

For Assurance

Lead: Gurvinder Sandher, Non-executive member - NHS Kent and Medway

Attachment: 20.4 RPC Board Report September 2026.pdf ***Page 424***

20.5 Transition Committee **12:55**

For Assurance

Lead: Angela McNab, Integrated Care Board Chair - NHS Kent and Medway

Attachment: 20.5 NHSKM ICB Sep Board Committee Update - Transition Committee.pdf ***Page 429***

20.6 South East (SE) Integrated Care Boards' (ICBs) Chief Executive Officers Joint Committee **12:55**

For Assurance

Lead: Adam Doyle, Chief Executive Officer - NHS Kent and Medway

Attachment: 20.6.0 20260922 SE ICB Joint Committee Front Sheet.pdf ***Page 439***

Attachment: 20.6.1 SE ICB JC Report 14 July 2026 v1.pdf ***Page 444***

Attachment: 20.6.2 SE ICB JC Report 11 August DRAFT v0.2.pdf ***Page 452***

21.0 Governance Handbook and Updates to Committee Terms of Reference 12:55 (5m)

For Approval

Lead: Claire Robson, Company Secretary - NHS Kent and Medway

Attachment: 21.0 Governance Handbook and Updates to ToR-Cover Paper.pdf ***Page 456***

Attachment: 21.1 Gov Handbook - Appendix 1 Draft August 2026.pdf ***Page 466***

Attachment: 21.2 Gov Handbook - Appendix 2 QSPE - Terms of Reference v1.2 Sept 26.pdf ***Page 489***

Attachment: 21.3 Gov Handbook - Appendix 3 RPC - Terms of Reference v1.1 July 26.pdf ***Page 501***

Attachment: 21.4 Gov handbook - Appendix 4 FPC - Terms of Reference v1.1 July 26.pdf ***Page 511***

22.0 Questions from members of the public pertaining to the agenda 13:00 (5m)

For Noting

Close 13:05

For Noting

KENT AND MEDWAY ICB BOARD
DECLARATIONS OF INTEREST REGISTER
September 2026

NHS Kent and Medway

Name	Position	Role	Declaration of Interest	Type of Interest	Direct or Indirect	Date From	Date To	Mitigating Actions Taken
Members								
Angela McNab	Member of Kent and Medway ICB Board	Interim Chair, ICB Board Non-Executive Member	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 Rapidhealth (digital developer) Member of the Independent Reconfiguration Panel which advises Sec of State on service reconfiguration/change Interim Chair of Queen Victoria NHS hospital	Financial Financial Financial Professional Professional	Direct Direct Direct Direct Direct	Sep 2020 Jan 2021 Apr 2021 Aug 2023 Jan 2026	Ongoing Ongoing Ongoing Ongoing Ongoing	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	Nil	N/A	N/A	N/A	N/A	N/A
Elizabeth Butler	Member of Kent and Medway ICB Board	Non-Executive Member	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 Chair of a housing association "Look Ahead".	Financial Professional Financial Professional Non-Financial Professional Financial Professional Financial Professional Financial Professional Non-Financial Personal Non-Financial Personal Non-Financial Personal Financia Professional	Direct Direct Direct Direct Direct Direct Indirect Indirect Indirect Direct	 July 2026	All Ongoing	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	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 Medical Examiner at East Sussex Hospitals Trust Occasional Advisory Roles to Independent Healthcare and Pharmaceutical Companies	Financial Financial Non Financial Financial Professional Financial Professional	Direct Direct Direct Direct Direct	Oct 1996 Jan 2017 Jan 2015 2020	All Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Gurvinder Sandher	Member of Kent and Medway ICB Board	Non-Executive Member	Director and CEO of Kent Equality Cohesion Council Artistic Director of Cohesion Plus Board Member of Active Kent and Medway Partnership Chair of Kent and Police Crime Panel Board Member Aletheia Academy Trust Director of Outdoor Arts UK	Financial Financial Non-Financial Professional Non-Financial Non-Financial Non-Financial Professional	Direct Direct Indirect Indirect Indirect Indirect	April 2010 April 2010 April 2022 July 2025 January 2023 June 2023	All Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Peter Harrison	Member of Kent and Medway ICB Board	Non-Executive Member	Nil	N//A	N/A	N/A	N/A	N/A
Jennie Hall	Member of Kent and Medway ICB Board	Chief Nursing, Patient Experience and Quality Officer	Nil	N//A	N/A	N/A	N/A	N/A
Kate Langford	Member of Kent and Medway ICB Board	Chief Medical and Outcomes Officer	Non-Executive Director NHS Professionals NHS Professionals is a n organisation wholly-owned by the Department of Health and Social Care (DHSC)	Financial Professional	Direct	Apr 2019	Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Jonathan Wilson	Member of Kent and Medway ICB Board	Chief Finance Officer	Nil	N//A	N/A	N/A	N/A	N/A
Sheila Stenson	Member of Kent and Medway ICB Board	ICB Board Partner Member Community / Mental Health Services	Chief Executive, Kent and Medway NHS and Social Care Partnership Trust (KMPT) Chair, NHS South East Finance Academy SRO, Kent and Medway MHLDA Provider Collaborative	Non Financial Professional Non Financial Professional Non Financial Professional	Direct Direct Direct	N/A	Ongoing	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
David Whittle	Member of Kent and Medway ICB Board	Local Authority Partner Member, Kent County Council	Companies listed below have 100% ownership by Kent County Council and operate under the Commercial Services Group umbrella. Some of the companies trade with individual NHS trusts and organisations both inside and outside the Kent and Medway ICB area: Director of Lifecycle Management Group (Company No. 06390313) Director of CSG Global Education Ltd (Company No. 01702231) Director and Chairman of Bowerhouse II Solar Limited (Company No. 12128147) Director of Invicta Law Limited (Company No. 10079679) Director of Gen2 Property Limited (Company No. 09834851) Director of Commercial Services Kent Limited (Company No. 05858177) Director of Commercial Services Trading Ltd (Company No. 05858178) Director of Cantium Business Solutions Limited (Company No 11242115) Director of Edseco Ltd (Company No 10970974) Director of Global Commercial Services Group Ltd (Company No 11735631) Director of WF Education Group Holdings Limited (Co No: 05177177) from 14 February 2024 Director of WF Education Group Limited (Co No: 02285483) from 14 February 2025	Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional Non-Financial Professional	Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct Direct	Jan 2023	Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Lee-Anne Farach	Member of Kent and Medway ICB Board	Local Authority Partner Member, Medway Council	Deputy Chief Executive and Director of People, Medway Council Director - Housing Residents Association of Redyear Court Management Company Local authority representative, SECAMB Non-Executive Director, Medway Norse Ltd Non-Executive Director, Norse Transport Ltd	Financial Professional Non-Financial Personal Non-Financial Professional Non-Financial Professional Non-Financial Professional	Direct Direct Direct Direct Direct	 2004 Jun 2025 Oct 2025 Oct 2025	Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Dr Jonathan Bryant	Member of Kent and Medway ICB Board	GP Partner Member	1. GP Partner at White House Surgery, Cheriton. Primary Care Contract (GMS) holder and advocate for patients within the practice boundary. 2. GP Partner at New Lyminge Surgery, Lyminge. Primary Care Contract (GMS) holder and advocate for patients within the practice boundary. 3. Member Practice of Folkestone, Hythe and Rural Primary Care Network. Holds service delivery contracts with ICB. 4. Spouse: Salaried GP (employed) at Canterbury Medical Practice, Lecturer at KMMS Medical School, Patient of East Kent Hospitals, Patient of King's College Hospital, Patient of Kent Oncology Centre (MTW), Patient of Faversham Medical Group (All organisations that have contracting relationships with KMICB). Charity (fundraising) work for Shine Cancer Support (registered charity) and Brainstrust (registered charity). 5. Service user: East Kent Hospitals University NHS Foundation Trust (EKHUFT) and GP Surgery in Canterbury. Receive dental and optometry care in Canterbury. Organisations have a contracting relationship with KMICB. 6. Resident of Faversham. Area sits within KMICB. 7. Shareholder: Channel Health Alliance (GP Federation), but <5% (Not a significant shareholder). 8. Shareholder: Invicta Health Community Interest Company (GP Federation), but <5% (Not a significant shareholder). 9. Family: Children and parents both live within KM and receive healthcare from organisations who have a contractual relationship with KMICB. 10. Employed: EKHUFT, Clinical Director of Programme, National lung cancer screening programme. 11. Employed: Invicta Health CIC (GP Federation), Clinical Director. 12. Kent Local Medical Committee (LMC) Representative, East Kent Contract Holders. 13. Primary Care Medical Director, East Kent Health and Care Partnership. 14. Personal friendships with a number of GPs, Hospital Consultants and other Health Care Professionals who mainly work in East Kent.	1. Financial 2. Financial 3. Financial 4. Non-Financial Personal 5. Non-Financial Personal 6. Non-Financial Personal 7. Financial 8. Financial 9. Non-Financial Personal 10. Non-Financial Professional 11. Non-Financial Professional 12. Financial 13. Non-Financial 14. Non-Financial Professional	1. Direct 2. Direct 3. Indirect 4. Indirect 5. Direct 6. Indirect 7. Direct 8. Direct 9. Indirect 10. Indirect 11. Indirect 12. Indirect 13. Indirect 14. Indirect	1. Dec 2017 2. Aug 2013 3. Jul 2019 4. Mar 2006 5. Nov 2005 6. Oct 2024 7. Apr 2017 8. Apr 2011 9. Ongoing 10. Mar 2024 11. Apr 2024 12. Nov 2023 13. Oct 2023 14. Ongoing	All Ongoing	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
Caroline Rivett	Member of Kent and Medway ICB Board	Non-Executive Member, Chair	1. I was a partner at KPMG until 31/12/2024 2. I am a trustee for Islington Law Centre 3. I am a trustee for Royal College of Psychiatrists 4. I am a trustee and audit chair at The Children's Trust 5. I am the Group Audit Chair for the Royal College of Nursing. I am not on their council. 6. I contract to Beyond Blue cyber security 7. I contract to PaxIdentity cyber security 8. I was previously Audit Chair at NHS Sussex	1. Financial Professional 2. Non-Financial Professional 3. Non-Financial Professional 4. Non-Financial Professional 5. Financial Professional 6. Financial Professional 7. Financial Professional 8. Non-Financial Professional	1. Indirect 2. Indirect 3. Indirect 4. Direct 5. Indirect 6. Indirect 7. Indirect 8. Indirect	1. Jan 2025 2. Jan 2025 3. July 2025 4. Jan 2026 5. Nov 2025 6. May 2026 7. Aug 2025 8. July 2025	1. 31 Dec 2026 2-8. Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Chris Neill	Member of Kent and Medway ICB Board	Deputy Chief Commissioning Officer	Equity Partner at EY UK – now retired	Financial Professional	Direct	September 2024	August 2026	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 2026	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.
Claire Robson	Permanent Participant of Kent and Medway ICB Board	Company Secretary	Sister-in-Law works for East Kent Hospitals Trust Trustee/Deputy Chair - Chartered Secretaries Charitable Trust External Advisor - RCN Foundation, Governance & Nominations Committee SME, Tutor, Trainer, and Chief Examiner (Sector Qualifications) - Chartered Governance Institute	Non-Financial Personal Non-Financial Professional Non-Financial Professional Non-Financial Professional	Indirect Indirect Indirect Indirect	Feb 2026 Feb 2026 Feb 2026 Feb 2026	Ongoing Ongoing Ongoing Ongoing	Interests declared at all committee meetings, reviewed and managed in accordance with the Standards of Business Conduct Policy.
Hollie Snelson	Regular attendee	Head of strategic communications and engagement projects	Nil	N/A	N/A	N/A	N/A	N/A
Sumona Chatterjee	Regular attendee	Deputy Chief Commissioning Officer	Nil	N/A	N/A	N/A	N/A	N/A

DRAFT Minutes of the Part 1 Kent and Medway Integrated Care Board

Date: Tuesday, 21 July 2026 at 10.00 am

Location: Board Room, Gail House

Chair: Angela McNab

Present:

Name	Job title	Initial
Angela McNab	Interim Chair	AMc
Dr Jonathan Bryant	GP Partner Member	JB
Adam Doyle	Chief Executive	AD
Jennie Hall	Chief Nursing and Outcomes Officer	JH
Peter Harrison	Non-Executive Member	PH
Dr Lee-Anne Farach	Local Authority ICS Partner Member (Medway)	LF
Kate Langford	Chief Medical and Outcomes Officer	KL
Dr Hugh McIntyre	Non-Executive Member	HMc
Caroline Rivett	Interim Non-Executive Member	CRi
Gurvinder Sandher	Non-Executive Member	GS
Sheila Stenson	Community and Mental Health ICS Provider Partner Member	SS
Ed Waller	Deputy Chief Executive and Chief Commissioning Officer	EW
Jonathan Wilson	Chief Finance Officer	JW

Other attendees:

Name	Job title	Initial
Dominic Cox	Deputy Chief Commissioning Officer (agenda item 14 only)	DC
Joy Fuller	Freedom to Speak Up Guardian (agenda item 17 only)	JF
Jackie Huddleston	System Coordination Director, NHS England	JHu
Bali Rodgers	People and Communities Champion	BR
Francesca Guy	Head of Corporate Governance	FG
Claire Robson	Company Secretary	CRo
Pauline Smith	Community and Voluntary Sector Representative	PS
Julia Tybura	Board Coach (Observer)	JT
Duncan Lewin	Board Coach (Observer)	DL

Apologies:

Name	Job title	Inital
Elizabeth Butler	Non-Executive Member *(via MS Teams)*	EB
David Whittle	Local Authority ICS Partner Member (Kent)	DW

Minutes:

Item	Minute	Action owner
1.0	**Welcome, introductions and appreciation** 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. The Chair welcomed Pauline Smith back to the Board following a period of absence and welcomed Jackie Huddleston, who was attending in her capacity as System Co-ordination Director of NHS England, together with the Board Coaches who were attending as observers.	
2.0	**Apologies for absence** Apologies for absence were **NOTED**.	
3.0	**Quorum** The Chair confirmed that the meeting was quorate.	
4.0	**Declarations of members' interests** 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. The Chair reminded Board members that, if a conflict of interest should arise during the course of the meeting, they should declare it as soon as possible.	
5.0	**Minutes of the previous meeting** The minutes of the previous meeting held on Tuesday, 19 May were **APPROVED,** subject to Ed Waller's job title being corrected.	
6.0 **6.1**	**Actions and matters arising** <u>Actions</u> **05/25: 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.** A more detailed digital, data and technology plan would be presented at a future meeting of the Board. **05/26: EW to consider whether a reference to local authority health scrutiny guidance should be included in the strategic commissioning policy.** Action complete. **06/26: CRo to provide Board with a paper setting out progress in establishing system governance.** Paper attached to the Kent and Medway Joint Committee agenda item which described system governance. Action complete.	

	07/26: AD to draft a paper for the Board to provide assurance on all the data tools currently utilised, compliance with information governance legislation and assurance that patient identifiable data was secure. Paper scheduled for September's Board.	
6.2	Matters Arising: The Board **NOTED** that there were no matters arising.	
7.0	**Chair's Report** The Chair took the paper as read and drew attention to the following points: • Recent activity had focused on ensuring that the strategy and four layers of care were clearly understood across the organisation and wider system. This had included engagement with provider Trust Chairs and non-executive members. • There had been increased focused on the effectiveness of the Joint Committee, particularly its role in reviewing progress against the strategy, the resources aligned to it, and maintaining the system's collective commitment to delivery. • Jonathan Montgomery, NHSE Regional Chair, had recently visited Kent and Medway. During the visit, he met with a range of system leaders and provider organisations to discuss system challenges and priorities. He reflected that the system strategy was clear and was being articulated consistently across provider organisations, particularly in relation to the four layers of care. The Board **NOTED** the update presented for **INFORMATION**.	
8.0	**Chief Executive's Report** AD took the report as read and drew the Board's attention to a number of key matters. AD noted the publication of the National Maternity and Neonatal Investigation on 30 June and emphasised the importance of reflecting on the lived experience of people in Kent and Medway, ensuring that services were commissioned appropriately and that providers responded effectively to the findings. It was noted that the commissioning intentions, which would be considered later in the agenda, represented significant progress for the organisation. Provider organisations were supportive of the four layers of care and were engaging with the developing provider alliance model. AD welcomed Jennie Hall to her first Board meeting and noted that she had commenced a 60-day review. He thanked Paul Lumsdon for his contribution to the organisation as Chief Nursing Officer, particularly his work over the preceding two months in relation to SEND arrangements. AD also noted this was Ed Waller's final Board meeting and formally thanked him for his significant contribution to the organisation.	

The Board was advised that interviews were taking place that week for the new Chief Commissioning Officer and Chief Medical Officer roles, with the intention of making strong appointments to stabilise the Executive Team. The permanent Chair appointment was expected to be made in early September.

AD reflected positively on the staff conference held two weeks earlier and thanked the People team and colleagues across the organisation for delivering a successful event. He noted the thoughtful and constructive engagement from staff in response to the feedback received.

Looking ahead, AD reported that the next few months would focus on embedding the operating model, responding to the commissioning intentions, commencing dialogue with providers and communities, stabilising the Executive Team, and progressing the 2027/28 plan.

He recognised the hard work of the Executive Team and the wider organisation in delivering significant progress.

In response to a question regarding the importance of multidisciplinary teams (MDTs) to successful delivery, AD advised that the MDTs were already operational and the work presented to the Board reflected the early output of those teams. AD acknowledged that multidisciplinary working represented a significant cultural change for the organisation and that ongoing support would be required to ensure staff felt empowered to make decisions. Progress would be kept under review through staff and pulse surveys.

With reference to the letter from NHSE regarding cyber security risks, assurance was sought that the matter was being actively considered and would be subject to appropriate oversight. AD confirmed that the organisation was responding to the letter and that he was working with the Company Secretary to determine the appropriate governance route, including oversight through the Audit and Risk Committee.

The Board discussed the implications of local government reorganisation and the need to consider strategic alignment carefully. AD advised that the ICB would avoid being overly prescriptive at this stage but would need to consider how it engaged with the four emerging unitary authorities. Neighbourhood health was identified as a clear future direction, with further consideration required regarding the multi-neighbourhood layer and its alignment with the four authorities as they developed.

In relation to SEND, the Board recognised the work undertaken by Paul Lumsdon and noted national concerns arising from SEND inspections, particularly in relation to health. AD provided assurance that the team was clear on the key issues and that a recovery plan was in place. The three principal areas of concern were waiting times for neurodevelopmental assessments, speech and language services, and strengthening user and carer voice through NHS providers. The Board also noted the need to consider how these areas would be supported as the four authorities emerged and in the context of the ICB becoming a smaller organisation.

	The Board **NOTED** the Chief Executive's report.	
9.0	**Kent and Medway General Practice Improvement Plan: Response to the National Association of Primary Care Independent Review of Under-Doctoring** EW introduced the item and explained that Kent and Medway had faced longstanding challenges in primary care capacity. An independent diagnostic review had been commissioned from the National Association of Primary Care (NAPC) to identify the causes of primary care fragility and recommend actions the ICB could take as commissioner. The full NAPC report had been included within the Board pack. EW reported that the review had identified a complex set of factors, including deprivation, ageing populations, GP capacity and the fragility of individual organisations. Particular concerns had been identified in parts of Kent and Medway, including Medway, Swale and East Kent, where general practice fragility was most significant. In response, a 24-month improvement plan was proposed, comprising both Kent and Medway-wide interventions and targeted support for individual practices. The plan would commence with a phase of detailed analysis to identify the areas requiring targeted intervention and would align with the commissioning intentions, including the single neighbourhood contract, and the four layers of care. JB advised that the report had been well received by Local Medical Committee (LMC) colleagues, particularly the report's shift away from simple workforce headcount measures and its recognition that increasing staffing could have unintended consequences, such as additional supervision requirements that might initially reduce productivity. JB welcomed the segmentation of general practice according to areas of greatest need and emphasised the importance of tailoring support packages accordingly. He also highlighted the need to address information technology and remove challenges at the interface between primary and secondary care. KL echoed the importance of tailored support and asked that the Board recognise the positive work already undertaken by peer ambassador GPs within Kent and Medway to practices experiencing difficulties. HMc welcomed the report and asked what oversight and assurance mechanisms would be in place within the ICB to monitor delivery of the improvement plan. EW advised that the plan would be owned by the Primary Care MDT, with oversight provided through the Strategic Commissioning Subgroup, and onward reporting to the Executive Committee. He noted that further consideration would be given to whether progress should also be reported through other Board assurance routes. SS noted that the improvement plan referred to acute providers and emphasised that mental health and community providers should also be included.	

	PS observed that GPs were a key access point to the NHS and that it was therefore critical to address the issues identified. She emphasised the importance of consistency, noting the current variation in provision. The Chair asked whether there would be a discrete piece of work on primary care estates or whether this would form part of an overarching estates strategy aligned to the four layers of care. EW responded that there were specific challenges relating to the general practice estate and limited resources available. The ICB would therefore need a clear prioritisation approach for determining where estates improvements would be made first. He also highlighted wider estates considerations and the need to align general practice with the wider system. EW advised that, as the four layers of care were developed, the ICB would need to consider the locations from which care would be delivered and how the estates footprint would be planned to support the care models. He emphasised the importance of an integrated service offer for the population, optimising estate utilisation and ensuring that provider partners were involved. EW suggested that the estates strategy be presented to a future Board meeting as a discrete piece of work. **DECISION:** The Board **APPROVED** the 24-month improvement plan as the ICB's formal response to the National Association of Primary Care (NAPC) independent review and endorsed the proposed programme of improvement activity. **ACTION(S):** • **EW to present the developing estates strategy, including alignment with the four layers of care, to a future Board meeting.**	**EW**
10.0	**Stroke Services in East Kent: Update Report** Caroline Rivett declared that she was on the board of a children's charity that provided neurorehabilitation services. Lee-Anne Farach declared an interest as the local authority representative on the Board of South East Coast Ambulance Service NHS Foundation Trust (SECAmb). The Chair noted the declarations, confirming that they did not represent a conflict of interest for today's discussion and that therefore no action needed to be taken. KL introduced the item and provided an update on the Kent and Medway-wide stroke reconfiguration programme, which was in its final stages with the development of the third and final Hyper Acute Stroke Unit (HASU). She advised that concerns had been raised regarding travel times to William Harvey Hospital (WHH), and that the ICB had commissioned (SECAmb) to undertake further travel time analysis. The paper also set out plans for stroke rehabilitation services, which formed part of the commissioning intentions. In light of the further travel time analysis being undertaken, and the development of future commissioning arrangements for stroke rehabilitation, the Board was being asked to reaffirm its support for the overall direction of travel of the stroke services reconfiguration.	

KL advised that the analysis undertaken to date indicated very limited change in travel times for people living in the Margate postcode area when compared with the original business case. Improvements had been identified for the Romney Marsh and Dungeness areas, with a slight deterioration identified for people in the Broadstairs postcode area. She explained that this would be the focus of the further work being undertaken by SECAmb, which was expected to take approximately two months, with findings to be reported to a future Board meeting.

PH confirmed his support for the recommendations and acknowledged the sensitivities associated with travel times. He noted that, any future assessment of travel times would be strengthened by also considering the impact on patient outcomes, rather than travel times alone.

PH also noted that Kent and Medway did not currently have a 24-hour mechanical thrombectomy service and asked how the system compared nationally in relation to the percentage of patients receiving thrombolysis and the percentage undergoing mechanical thrombectomy.

In response to the first question, KL advised that the temporary unit at Kent and Canterbury had delivered good patient outcomes and that staff had developed an effective programme for patients. Whilst performance at the new WHH unit could not be confirmed until it was operational, given that the same team would be moving into a purpose-built unit, it was anticipated that performance would be maintained and potentially improved. KL also noted that neurorehabilitation had an impact on patient outcomes and that it was therefore important that neurorehabilitation was included within the commissioning intentions.

In response to the question regarding mechanical thrombectomy, KL advised that mechanical thrombectomy services fell within NHS specialised commissioning arrangements and were therefore outside the scope of the current reconfiguration programme. She noted that a mechanical thrombectomy unit in Kent and Medway would be welcomed, as patients currently had to travel to London to access the service. KL also noted that a mechanical thrombectomy unit did not need to be attached to a HASU and that consideration would need to be given to its location and staffing model.

LF asked whether the travel time analysis would include the use of air ambulance services. KL advised that suspected stroke was nationally categorised as a category 2 response and would typically be road based. It was therefore unlikely that helicopter response would routinely apply to these calls.

The Chair summarised the discussion and welcomed the inclusion of neurorehabilitation within the commissioning intentions.

DECISION: The Board **APPROVED** the proposed approach to the future commissioning and transformation of community stroke rehabilitation services, including development of an integrated Neurorehabilitation Framework included in commissioning intentions for 2027/28.

11.0	**Kent and Medway Urgent Treatment Centres Review: Case for Change** EW introduced the paper, noting that it represented the case for change stage of the review and that no decisions had yet been taken regarding the future configuration of Urgent Treatment Centres (UTC) services. The Board was asked to endorse the work undertaken to date and approve progression to the next stage. EW outlined the case for change, noting that Kent and Medway had more UTCs than comparable systems and higher UTC attendance rates. Analysis suggested that a substantial proportion of patients attending UTCs may be able to have their needs met through primary care and other community-based services. KL stated that, where clinically appropriate, the ICB was committed to commissioning within layer one of the models of care, reflecting the population's desire for timely care closer to home. A significant proportion of activity currently delivered by UTCs could be delivered in layer one. Further work was needed to understand whether activity was occurring outside primary care due to capacity, opening hours or access issues, and to identify whether there was any value added, from a clinical perspective, of delivering activity in layer two. JB welcomed the paper, noting the current variation in the offer across Kent and Medway and the opportunity to establish a more consistent model. JB also highlighted the potential role of GPs in supporting the future model. Board members emphasised the importance of meaningful public engagement and communications as the review progressed, noting public confidence would be critical to the success of any future proposals. The Chair suggested that additional insight work may be required to support the review. JH noted the importance of avoiding a single, standardised approach that did not reflect local circumstances, while AD emphasised that credibility would be critical in securing public confidence in any future changes. SS emphasised that the review should not focus solely on physical health and that the mental health dimension should also be considered, including services such as safe havens. AD advised that the review would need to establish and communicate clearly whether mental health services formed part of its scope and, if not, how related services such as safe havens and crisis cafes would be considered within the wider urgent and emergency care model. **DECISION:** The Board **ENDORSED** the case for change for UTC reconfiguration as part of the wider clinically led UEC pathway redesign and four-layer model of care. **ACTION(S):**	

	• **EW to confirm, as part of the next stage of the review, what information was available on mental health services to take into account for the UTC review and how this aligned with wider mental health urgent care provisions.**	**EW**
12.0	**Kent and Medway Maternity Services Review: Terms of Reference and Co-Design Approach** JH introduced the item and explained that the Board was asked to approve the initial Terms of Reference and endorse the proposed co-design methodology for the Kent and Medway Maternity Services Review. The review was being undertaken in the context of the current position of maternity services in Kent and Medway and in response to issues highlighted through the Amos Review, published on 30 June, which had included East Kent as one of the 12 sites visited by Baroness Amos. JH advised that an engagement event was planned for 5 August which would focus on acute hospitals but would also need to include community and mental health services. She emphasised the importance of incorporating the voice of women through the Maternity Voices Partnership. The intended outcomes of the event were to confirm the scope of the review and to reach a consensus on the approach to managing differing views. JH advised that an independent chair would be appointed, with appropriate consideration of conflicts of interest, and that both obstetric and midwifery leadership would be included in the review. The outcomes of the review would feed into the ICB's quality governance arrangements. CRi welcomed the paper but queried whether the proposed timetable was longer than necessary. JH advised that the timetable was indicative and that the work would be progressed as quickly as possible, while ensuring that an appropriate process was followed, given the potential for significant service change. CRi noted that one of the key findings of the Amos Review was that women did not always feel listened to, and asked how the review would address this issue. JH confirmed that the voices and experiences of women would be central to the review and that engagement would need to include harder-to-reach communities through established routes such as trusted community leaders. The Chair asked when the Board could expect to see emerging outcomes from the work. JH advised that the outputs of phase one would be presented to the Board in September, at which point a more detailed timetable may be available. She noted that a regional maternity services review was due to commence shortly and that alignment with this work would be important, particularly given that women accessed maternity services across organisational and geographical boundaries. **DECISION:** The Board: • **APPROVED** the elements of the Terms of Reference set out in Section 4 of this paper: governance and accountability, scope, methodology and the indicative timeline.	

	• **APPROVED** delegated authority for the Chair, in consultation with the Chief Executive, to finalise and approve the complete Terms of Reference by Chair's Action, following co-design engagement with all four provider trusts in August 2026.	
13.0	**ICB Finance Report Month 2** JW provided an update on the month 2 finance position and noted the following: • The financial position was on plan, with a year-to-date deficit of £8.5 million and an in-month deficit of £4.2 million. • Emerging pressures included ADHD assessment costs (potential £13 million adverse variance to plan if unmitigated), out-of-sector specialist provider overperformance, and prescribing costs due to geopolitical factors. • Underspends in community, delegated specialised commissioning, and delegated primary care had helped offset pressures, enabling a break-even position at month 2. • Work was underway to identify any underspends and opportunities to offset emerging pressures. Proactive steps were being taken to manage ADHD costs, including activity caps and improved provider market management. In summary, JW confirmed confidence in hitting the plan for the year, with ongoing monitoring and mitigation actions. EW provided further detail in relation to ADHD and autism assessments, noting that increasing demand represented a significant emerging financial and operational pressure, reflecting a wider national trend. The standard contract framework enabled the ICB to develop indicative activity plans (IAPs), setting out the level of activity to be commissioned from each provider. The ICB was systematically putting IAPs in place with providers, which would include clinical prioritisation. However, a longer-term strategy would be required to respond to increasing referral demand, including establishing a referral management system to ensure equitable access. Consideration would also need to be given to support for people who may require assistance following diagnosis. PH asked whether the emerging overspend risk reflected IAPs not operating as intended or not being deployed effectively, and sought an update on the development of the Single Point of Access (SPOA) triage approach. EW explained that IAPs were set at the beginning of the year and noted that future discussions on IAPs would need to take place earlier, with consideration given to multi-year agreements. EW advised that the SPOA was not yet in place and would not be a major part of the in-year solution, as it needed to be designed appropriately. He stated that, in the longer term, it would be an important mechanism for improving equity of access. CRi noted the importance of holding providers to account for the quality, cost and volume of activity delivered, whilst ensuring that commissioning decisions remained clinically led. She cautioned against creating an unsustainable treatment baseline, particularly in relation to children.	

	GS joined the meeting. CRi sought assurance on how the Board would maintain oversight of delivery of the Cost Improvement Plan (CIP). AD stated that the Finance and Performance Committee and the Executive Committee had a role in scrutinising CIP delivery and that progress would be reflected in those Committees' reports to the Board. JW confirmed that further detail would be included in future reporting. The Chair summarised the discussion and confirmed the Board's support for the actions outlined in the paper, including the identification of mitigations for emerging pressures and continued oversight of CIP delivery. AD reflected that future reporting should set out both the in-year actions being taken to manage demand and the longer-term commissioning response for 2027/28. He acknowledged the Board's challenge that quality, access and patient outcomes should be considered alongside financial management and noted the importance of progressing the ADHD SPOA at pace. The Board **NOTED** the financial position of the ICB at the close of Month 2 (May) 2026 and the actions being taken to mitigate emerging financial pressures. **ACTION(S):** • **EW to present a paper to a future Board meeting on actions to manage ADHD demand.**	**EW**
14.0	**Commissioning Intentions and Forward Plan** Dominic Cox joined the meeting for this agenda item. EW introduced the item and explained that the Board had received a suite of documents setting out the future direction for commissioning. These included the five-year strategy, the three-year commissioning plan, the strategic commissioning policy, and the commissioning intentions for 2027/28. EW advised that there would be a period of engagement to test and refine the commissioning intentions. The final commissioning intentions would be brought back for approval in September 2026, after which providers would be given notice of intended changes. He noted that the supporting documents provided context on the four layers of care, the commissioning intentions, the underpinning financial assumptions, the national quality strategy and the proposed engagement approach over the summer. KL outlined the four layers of care: • Layer 1 (Primary Care) would be based on general practice, with every practice expected to deliver its obligations under the General Medical Services contract, alongside a set of additional services through the primary care quality standards work.	

- Layer 2 (Single Neighbourhood Care) would include services that could be better delivered at scale for people with the highest levels of need, with a stronger focus on prevention, long-term conditions and mental health.
- Layer 3 (Multi-Neighbourhood Care) would provide multi-neighbourhood, community-delivered services at scale, including services traditionally delivered in hospital settings, urgent response for frail older people and rehabilitation.
- Layer 4 (Acute Hospital Care) would comprise acute hospital services, recognising that some specialist care would require people to travel to hospital.

KL stated that, when commissioning services, the default position should be to commission in layer 1 unless there was a clear clinical value-add for commissioning in layers 2, 3 or 4. The next stage of work would be to describe the universal offer within each layer.

DC described the development of the commissioning intentions and explained that they set out how the ICB would move from strategy into delivery. The documents described the outcomes expected, the changes providers would be asked to deliver, and the mechanisms that would be used to secure improvement. The commissioning intentions were aligned to the four layers of care, driven by the emerging commissioning multidisciplinary teams, and underpinned by a new approach to population health. DC advised that, from a patient perspective, the intentions should result in more standardised and digitally enabled pathways, improved patient flow, a consistent all-age model for mental health, learning disability and autism, and safer maternity services. DC noted that the approach was intended to shift commissioning towards the improvement of outcomes and to establish a new relationship between commissioners and providers.

JW outlined the financial underpinnings of the approach and noted that a multi-year financial plan had been set in April. He advised that future allocation increases would be allocated in line with the developing commissioning framework.

JH advised that the national quality strategy for the next ten years had been published the previous week. The strategy mirrored the core components of quality and made clear that quality should be central to commissioning and the delivery of care. The document set out a number of aspirations and described the role of ICBs going forward. JH noted that there remained further work to do to embed the approach locally.

IP emphasised that the commissioning intentions were not yet final and that the ICB needed to engage further with communities, partners and staff to test whether the intentions were right. She highlighted the importance of ensuring that lived experience was reflected in the final commissioning intentions.

HS explained that the engagement approach would have three components. Stakeholder engagement would commence immediately with local authorities, NHS provider partners, VCSE partners and wider system partners. This would be supported by statistically robust insight, including 1,000 interviews across Kent and Medway which would be

	demographically and geographically representative of the population. EK360 would also conduct community conversations across the 12 districts to gather views on the commissioning intentions and priorities. In addition, workshops would be held with people who had contributed to the development of the five-year plan to test whether the commissioning intentions reflected their feedback. Board members welcomed the suite of documents and recognised the significant work undertaken to develop a coherent commissioning framework aligned to the ICB's strategic direction. JB advised that the documents had been circulated to GP colleagues and noted that there was a willingness to engage. He highlighted the importance of the aspirations around GP access models, relationship-based healthcare and continuity of care. CRi sought assurance that the commissioning intentions were deliverable within the financial assumptions set out by the ICB. AD advised that the financial framework underpinning the commissioning intentions was in place although delivery would require active prioritisation and management of investment decisions. He noted that provider feedback would be important and that the September Board would need assurance that the commissioning intentions and financial assumptions were appropriately aligned. The Chair noted the importance of ensuring that the role of mental health services within the four-layer model of care was clearly articulated throughout the documentation. **DECISION:** The Board: • **APPROVED** the final 5 Year Strategy post engagement • **APPROVED** the draft Commissioning Intentions for 2027/28 and the proposed engagement approach over the summer, with the final version to be presented for approval at the September 2026 Board • **ENDORSED** the full suite of Commissioning documents for publication:	
15.0	**Kent and Medway Strategic Commissioning Performance Report** EW introduced the item and explained that the latest version of the Strategic Commissioning Performance Report (SCPR) had been included in the Board pack. He advised that each metric had been allocated to one of the commissioning multidisciplinary teams (CMDTs) and the CMDTs had been tasked with developing an action plan and improvement trajectory for their allocated metrics. EW noted that work was underway to develop the governance and assurance approach, including how priority metrics would be identified, monitored and improved. EW stated that the report would need to incorporate actions from the 2026/27 business plan and reflect the actions arising from the commissioning intentions. It would also need to align with the new oversight framework, for which datasets were expected from August.	

EW advised that, although Kent and Medway was improving against a number of metrics, its relative performance compared with other ICBs was deteriorating and therefore the organisation needed to focus on improving at a faster pace. As a number of ICB footprints had changed, Kent and Medway's relative performance compared with other ICBs would also likely change.

The Chair thanked colleagues for their work on the report and acknowledged that it remained a work in progress.

CRi asked whether sufficient focus was being given to mental health given that all mental health and learning disability metrics were rated in the lowest quartile and that the position was deteriorating. EW advised that a dedicated mental health CMDT had been established and that the planned all-age mental health review would provide an opportunity to reassess priorities and improvement actions across the pathway.

Noting that the mental health CMDT had a significant programme of work to deliver, HMc sought assurance that CMDTs would be appropriately resourced to deliver improvement, particularly where they were responsible for a large number of metrics.

AD responded that the commissioning intentions included an all-age mental health review and advised that draft Terms of Reference were being developed and would be shared with the Board and partners. The review would consider how to engage providers and relevant partners and would need to determine the appropriate model for each of the four layers of care. AD advised that only once this work had been completed would it be possible to assess whether the MDT was appropriately sized to meet need. Consideration may also need to be given to how resources could be flexed into teams during periods of high workload.

AD advised that the Board would receive assurance on organisational capacity and capability through the planned six-month post restructure review.

PH sought assurance on how the Board would monitor progress against actions to improve delayed discharge performance. EW advised that MDTs would be tasked with developing action plans and improvement trajectories. He stated that the intention was to bring those action plans through the appropriate governance routes as quickly as possible.

The Chair emphasised the importance of focusing on improvement, particularly in the critical areas identified through the report.

GS asked what learning could be drawn from other ICBs. EW advised the proposed actions and trajectories would need to be supported by an appropriate evidence base. This would include learning from other ICBs and consideration of what had been proven to be successful elsewhere.

KL advised that the Integrated Quality and Performance Group would provide detailed scrutiny of improvement plans and trajectories and would offer assurance on whether proposed actions were credible and sufficient to deliver improvement.

	The Board: 1. **NOTED** the ICB's reported performance position against the NHS Oversight Framework Contextual Metrics at Q4, alongside the updated local assessment based on the most recent published data. 2. **NOTED** the next steps on development of the SCPR.	
16.0	**Involving People and Communities 18 month approach** IP introduced the item and advised that the paper set out the proposed approach to engaging with the Kent and Medway population over the next 18 months. She noted that Board members had been engaged in the development of the approach and that six workstreams had been identified. IP emphasised the importance of ensuring that feedback from people and communities informed commissioning decisions and service changes, and advised that a framework would be developed to support this. HS explained that the paper described a fundamental shift in ways of working, moving from engagement as a discrete activity to involvement being routinely embedded throughout commissioning, service redesign and decision-making processes. She noted that there were strong foundations on which to build, including the insight bank, but acknowledged areas for improvement, including inconsistent feedback, uneven reach into underserved communities and variable levels of engagement. The proposed plan sought to make involvement everybody's business and to embed it into organisational ways of working. HS advised that the future approach would be based on partnership with communities, with the primary delivery model based on Voluntary, Community, Social Enterprise and Faith (VCSEF) organisations and grassroots organisations that already held trusted relationships with local communities. HS outlined the proposed success measures to be achieved by November 2027. These included people's views routinely influencing commissioning decisions; every MDT being able to demonstrate how involvement had shaped commissioning decisions; improved reach into underserved communities; providers being held to account for involvement through contracts and oversight; communities being able to see what had changed as a result of their involvement; and the Board receiving regular assurance on progress. BR welcomed the paper, noting it provided significantly greater assurance than previous arrangements and represented substantial progress. She emphasised the importance of the Board receiving assurance that communities had been involved in the development of commissioning decisions. BR also highlighted the importance of demonstrating to communities how their feedback had influenced decisions and what had changed as a result. The Chair thanked BR for her contribution to the work and noted that progress would be monitored through the Quality, Safeguarding and	

	Patient Experience Committee, which would provide assurance to the Board. PS noted that, while the voluntary sector was diverse, there was a strong VCSE alliance in Kent and Medway which would support the approach. Board members welcomed the paper and highlighted the importance of ensuring that the approach included children and young people, people who may find communication difficult and elected members. SS asked how insights from other organisations across the system would be brought together. HS advised that the insight bank had recently been launched and was intended to operate on a cross-system basis, with providers, Healthwatch, local authorities and partner organisations able to upload insight into one place. She explained that the bank was searchable by theme and geography and should help avoid asking people the same questions more than once. **DECISION:** The Board **APPROVED** the Involving People and Communities 18 month approach. **ACTION(S):** • **IP to consider how the approach can further strengthen involvement of children and young people, people who may find communication difficult and elected members.**	**IP**
17.0	**ICB Freedom to Speak Up (FTSU) Annual Report 2025/26** JF joined the meeting for this item and presented the Freedom to Speak Up Annual Report for 2025/26. She took the report as read and highlighted the following: • Freedom to Speak Up continued to provide an important route for colleagues who may not feel able to raise concerns through normal line management channels. • Twenty concerns had been raised during the year, compared with 37 in the previous year. All cases had been closed from a Freedom to Speak Up perspective through advice and support, local resolution, referral or signposting to other appropriate routes. • The main themes arising from concerns were workplace behaviours, team culture, line management support, organisational change and consultation processes. • Psychological safety remained variable across the organisation and across different teams, reinforcing the need for visible leadership, effective communication, compassionate management and transparent decision-making. • The report demonstrated the value of using Freedom to Speak Up themes as a source of organisational insight. • The report described activity undertaken over the previous year and set out priorities for the next six months, including maintaining visibility of Freedom to Speak Up arrangements,	

	reviewing the ambassador network following organisational change, and improving feedback mechanisms for staff who speak up. • Appendix 1 set out the ICB's response to the NHS England publication on the future of Freedom to Speak Up following the closure of the National Guardian's Office. The Board was advised that the majority of actions had been completed, with only a small number remaining outstanding. The Chair noted the importance of the report, particularly in the context of the outcomes of the cultural review and observed that the findings demonstrated that psychological safety remained variable across the organisation. Whilst acknowledging the progress made, she emphasised that there could be no complacency and that continued focus was required. JH welcomed the report and stated that it was encouraging to see the feedback loop and the actions underway in response to the closure of the National Guardian's Office. GS noted that he was acting as the interim Board Champion for Freedom to Speak Up and would meet quarterly with the Freedom to Speak Up Guardian to provide Board oversight and support. In response to a question on the future of the Freedom to Speak Up Guardian role, IP advised that the intention was to extend JF's current arrangement to the end of the calendar year while opportunities were explored to develop a joint service either across the South East or with providers in Kent and Medway. She noted that a shared arrangement could strengthen independence and resilience whilst maintaining an effective Freedom to Speak Up function. The Chair noted that the Board would receive a further report in the autumn on progress against the identified priorities and future arrangements for the Freedom to Speak Up function. The Board: • **RECEIVED** the Freedom to Speak Up Annual Report for 1 April 2025 to 31 March 2026 for discussion and assurance. • **NOTED** Appendix 1 'The Future of Freedom to Speak Up' for assurance on readiness for the new national requirements. JF left the meeting.	
18.0	**Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD) – Review and Endorsement** CRo introduced the item and explained that the revised Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD) were being presented following a comprehensive review undertaken across the organisation in response to governance changes made earlier in the year. She noted that the documents were fundamental components of the ICB's governance framework and had been updated to provide greater clarity on delegated authority, financial	

	control, accountability and decision-making responsibilities. The updates also supported the organisation's continued development as a strategic commissioner. CRo acknowledged that the documents would ordinarily be considered by the Audit and Risk Committee prior to Board approval; however, the timing of the review had not allowed for this. She advised that the documents had been reviewed and endorsed by the Executive Committee and by senior colleagues across the organisation. The Executive Committee was therefore providing assurance to the Board on the robustness of the proposed framework. Subject to approval, the revised documents would take effect from 1 August 2026 and would sit alongside the updated Governance Handbook. JW added that the SFIs were foundational documents from a financial control perspective. He stated that the review represented an important reset and that an annual refresh would be expected thereafter. AD emphasised that the organisation would be required to comply with the revised SFIs and SoRD once approved. He noted that successful implementation would require cultural change across the organisation, with clearer expectations regarding accountability, decision-making and individual responsibility. AD stated that, as part of the internal audit plan, assurance would be sought on organisational compliance with the revised SFIs and SoRD following implementation. HMc asked whether the financial limits had been benchmarked against national values. CRo noted that the financial limits were broadly similar to those previously in place and that benchmarking had not been undertaken, as limits were often specific to individual organisations. However, she agreed to check this outside of the meeting. AD added that, as part of the planned internal audit review, consideration should be given to whether the delegation limits remained appropriate going forward. **DECISION:** the Board: • **APPROVED** the SFIs and SoRD, effective 1 August 2026. • **AUTHORISED** the Company Secretary to update the Governance Handbook on the website with the updated documents **ACTION(S):** • **CRo to review whether the financial delegation limits are consistent with relevant comparatory organisations and advise the Board accordingly.**	**CRo**
19.0	**Corporate Risk Register and Board Assurance Framework** CRo introduced the item and advised that a significant programme of work had been undertaken to strengthen the Board Assurance Framework (BAF), following feedback from the Audit and Risk Committee to improve the Board's oversight of principal strategic risks.	

	The BAF would remain an iterative framework and would continue to mature over time. CRo advised that a comprehensive review of the risk management framework would be undertaken during the autumn. This review would inform future development of the Corporate Risk Register and support a more mature approach to risk management across the organisation. CRo reported that there had been no material deterioration in the organisation's risk position. The BAF and Corporate Risk Register would continue to be presented to the Audit and Risk Committee for scrutiny and oversight. The Chair provided assurance that she had discussed the work undertaken to strengthen risk management with the Chair of the Audit and Risk Committee. PH drew attention to the escalation within the Audit and Risk Committee report regarding engagement with the risk management process. The Chair agreed that the BAF and Corporate Risk Register needed to operate as live documents. AD acknowledged that risk management processes had not previously operated as effectively as required and outlined the steps being taken to strengthen organisational ownership of risk. It was acknowledged that, as risk identification improved, an increase in the number of risks recorded on the Corporate Risk Register should not necessarily be interpreted as an increased risk position, but rather as evidence of more effective risk identification and escalation. AD noted that this was linked to the earlier discussion on culture and psychological safety, as staff needed to feel safe to raise risks. HMc sought assurance on how gaps in assurance identified within the BAF would be addressed and suggested that target dates be included where appropriate. He also asked for further clarification regarding the increase in the committee risk threshold for quality to 10. The Board **NOTED** the Board Assurance Framework and Corporate Risk Register. The Chair suggested that additional time should be allocated at the next Board meeting to enable further discussion of the BAF and Corporate Risk Register. **ACTION(S):** • **CRo to provide clarification regarding the revised quality risk threshold outside the meeting.** • **CRo to ensure that additional time was scheduled at the next Board meeting for a detailed discussion of the Board Assurance Framework and Corporate Risk Register.**	**CRo** **CRo**
20.0	**Annual General Meeting (AGM) 2025/26 – Notice and Arrangements** CRo introduced the item and explained that the purpose of the paper was to seek Board approval of the Annual General Meeting notice and	

	associated arrangements for the 2025/26 AGM. She advised that, subject to Board approval, the formal notice would be published in August, and the Annual General Meeting would be held immediately following the September Board meeting. **DECISION:** The Board: 1. **APPROVED** the Annual General Meeting Notice attached at Appendix 1 2. **APPROVED** the proposed website notice and registration information attached at Appendix 2 3. **APPROVED** the Annual General Meeting Agenda attached at Appendix 3 4. **DELEGATED AUTHORITY** to the Chair, Chief Executive Officer, and Company Secretary to make any minor amendments required prior to publication, provided these do not materially alter the approved arrangements.	
21.0	**Briefing note from the following Committees** Executive Committee AD took the Executive Committee report as read and highlighted that the patient experience team had moved into the Corporate Affairs directorate. He advised that a significant backlog of complaints had been identified and that work was underway to clear this by the end of September. Quality, Safeguarding and Patient Experience Committee The Board noted the briefing from the Quality, Safeguarding and Patient Experience Committee. Finance and Performance Committee The Board noted the briefing from the Finance and Performance Committee. Audit and Risk Committee The Board noted the briefing from the Audit and Risk Committee. Remuneration and People Committee The Board noted the update from the Remuneration and People Committee. GS advised that he hoped to observe an equivalent committee meeting in Surrey and Sussex ICB to support learning and development. South East (SE) Integrated Care Boards' (ICBs) Chief Executive Officers Joint Committee The Board noted the briefing from the South East Integrated Care Boards' Chief Executive Officers Joint Committee.	

	Kent and Medway Joint Committee AD introduced the Kent and Medway Joint Committee report, noting that it had been presented to all relevant Boards. He advised that the report reflected the matters previously described to the Board and set out the scale of the challenge facing the system. The Joint Committee had discussed the scale of the financial and clinical challenges facing the system and the conclusion that current organisational models were not sustainable in the longer term, requiring significant transformation across Kent and Medway. AD advised that there had also been a significant discussion about how organisations worked together. The Joint Committee had agreed a system-wide organisational development approach intended to strengthen collaborative working across partner organisations. This would initially focus on NHS organisations before being expanded to include wider partners. AD noted that there had been significant leadership change within the provider sector and that the organisational development work was expected to commence in September, enabling new leaders to participate fully from the outset. The Board **NOTED** the reports from the Committees.	
22.0	**Questions from members of the public pertaining to the agenda** There were no questions from members of the public.	
23.0	**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.	

Angela McNab

Interim Chair

NHS Kent and Medway Integrated Care Board (Part 1)
Action log - September 2026

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.	Mayur Vibhuti	Apr-27	03/02/2026: the Board NOTED that a more detailed digital, data and technology plan would be presented at a future meeting of the Board. 14/09/2026: The DDaT strategy will need to be reworked to focus on the ICB's strategic commissioning role, given the new shared Digital, Data and Intelligence function. To be produced by April 2027	Not yet due	
08/26	9.0 Kent and Medway General Practice Improvement Plan: Response to the National Association of Primary Care Independent Review of Under-Doctoring	21/07/2026	EW to present the developing estates strategy, including alignment with the four layers of care, to a future Board meeting.	Chris Neill	Nov-26	Action transferred to Chris Neill	Not yet due	
13/26	19.0 Corporate Risk Register and Board Assurance Framework	21/07/2026	CRo to provide clarification regarding the revised quality risk threshold outside the meeting.	Claire Robson	Sep-26	CRo to follow up outside of the meeting.		
Recommended to close								
07/26	14.0 Questions from members of the public pertaining to the agenda	19/05/2026	AD to draft a paper for the Board to provide assurance on all the data tools currently utilised, compliance with information governance legislation and assurance that patient identifiable data was secure.	Adam Doyle	Sep-26	On agenda for September.	Recommended to close	
09/26	11.0 Kent and Medway Urgent Treatment Centres Review: Case for Change	21/07/2026	EW to confirm, as part of the next stage of the review, what information was available on mental health services to take into account for the UTC review and how this aligned with wider mental health urgent care provisions.	Chris Neill	Sep-26	Mental health will be incorporated into the UEC review as outlined in the paper to the Board.	Recommended to close	
10/26	13.0 ICB Finance Report Month 2	21/07/2026	EW to present a paper to a future Board meeting on actions to manage ADHD demand.	Chris Neill	Sep-26	On agenda for September.	Recommended to close	
11/26	16.0 Involving People and Communities 18 month approach	21/07/2026	IP to consider how the approach can further strengthen involvement of children and young people, people who may find communication difficult and elected members.	Indi Pearce	Sep-26	The work plan is being updated to reflect how recognised elected leaders can support our approach to involving people, alongside strengthening the focus on children and young people and individuals with communication difficulties. As the work plan has already been formally approved, it is not proposed to bring back through the approval process. Future updates can be managed through the QSPE committee as agreed in the plan.	Recommended to close	

12/26	18.0 Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SoRD) – Review and Endorsement	21/07/2026	CRo to review whether the financial delegation limits are consistent with relevant comparatory organisations and advise the Board accordingly.	Claire Robson	Sep-26	There are no nationally mandated financial thresholds for ICBs. The expectation is to set thresholds that are proportionate for the organisations size, risk appetite, and operating model with a clear and consistent framework. The framework has been reviewed against NHS England guidance and published NHS governance arrangements, and no material anomalies have been identified. In addition, a comparator review has been done against published documents for Hampshire and Isle of Wight ICB, Surrey and Sussex ICB, and Thames Valley ICB. Benchmarking against comparator ICB governance frameworks has not identified any material issues requiring immediate amendment to Kent and Medway's Standing Financial Instructions or delegated financial limits. The review indicates that the framework is broadly aligned with comparator NHS organisations and, in some areas, adopts a more conservative approach. A small number of opportunities have been identified to strengthen wording and improve clarity, particularly in relation to procurement, direct awards, legal escalation, and capital approvals. These matters can be considered as part of the planned review and ongoing development of the governance framework rather than requiring immediate change.	Recommend to close	
14/26	19.0 Corporate Risk Register and Board Assurance Framework	21/07/2026	CRo to ensure that additional time was scheduled at the next Board meeting for a detailed discussion of the Board Assurance Framework and Corporate Risk Register.	Claire Robson	Sep-26	20 minutes scheduled for the agenda item.	Recommended to close	

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report Title	Chair's Report
Key question	What assurance can the Board take from recent Chair activity regarding the strength of system leadership, governance arrangements and stakeholder engagement across Kent and Medway?
Executive Lead	Angela McNab, Chair
Author	Angela McNab, Chair

Which of the organisation's strategic objectives does the report support:	
☐ Commission the right services each year	☐ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☒ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the Meeting:

The Board is asked to:

1. **NOTE** the contents of the Chair's report.

Executive summary:

This report provides an update on key activities undertaken by the Chair since the July 2026 Board meeting. The reporting period has included the August holiday period and has therefore been less extensive than usual. Activity has focused on supporting

important recruitment processes, maintaining engagement with NHS England and provider Boards, and continuing to strengthen relationships across the Kent and Medway system.

During the period, I have supported recruitment processes for the Chief Medical and Outcomes Officer and Director of Commissioning roles and have overseen the arrangements for appointing a substantive Chair of the Audit and Risk Committee and an Independent Member. I have also continued to attend NHS England meetings with provider Boards, including the meeting with Medway, and supported the visit by Sir Jonathan Montgomery, Regional Chair of NHS England.

Alongside this, I have continued regular engagement with provider Chairs to strengthen system relationships and consider how partners can support new Chairs and Chief Executives joining the system over the coming months. I have also noted the local government reconfiguration process and the importance of working constructively with local authority partners throughout the transition and as the new structures develop. The Chief Executive's report provides further detail on executive changes. My comments are therefore limited to the Chair's role in supporting robust appointments and maintaining leadership continuity during this period.

Proposed next steps:

Continue to support effective recruitment, leadership continuity and strong system relationships, including working with provider and local authority partners as leadership and structural changes progress across Kent and Medway.

Governance pathway to date:

Meeting name:	Date:	Outcome:
N/A		

Contact for further information	Angela McNab, angela.mcnab@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities, and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

There are no direct equality or health inequalities implications arising from this paper, which focuses on governance and oversight arrangements.

COMPLIANCE NOTES:

Conflicts of Interest

Are there any conflicts associated with authors or reporting officers?

☐ Yes ☒ No

If yes, please confirm how the conflict has been managed.

FOI Status

Is this report disclosable under FOI?

☒ Yes ☐ No

If no, please specify why:

Financial Implications

Are there financial implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Legal Implications

Are there legal implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Quality and Safety Implications

Are there quality or safety implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Patient and Public Engagement

Are there patient and public engagement implications associated with this report?

☐ Yes ☒ No

If yes, please describe. If no, please specify why:

There are no specific patient or public engagement implications arising directly from this report. However, the report highlights ongoing work to strengthen stakeholder, community and partner engagement arrangements to support future service development and system transformation.

CHAIR'S REPORT

1. INTRODUCTION

1.1 This report provides an update on key activities undertaken by the Chair since the July 2026 Board meeting. The reporting period has included the August holiday period and has therefore been less extensive than usual. My focus has been on supporting important recruitment processes, maintaining engagement with NHS England and provider Boards, and continuing to strengthen relationships across the Kent and Medway system.

2. STRATEGIC ALIGNMENT

2.1 The activity described in this report supports delivery of the ICB's strategic objectives by:

- supporting robust recruitment and appointment processes for key Board and executive roles;
- maintaining effective relationships with NHS England, providers and local authority partners;
- supporting leadership continuity during a period of organisational and system change; and
- strengthening collaborative working across Kent and Medway.

2.2 These activities support the ICB's commitment to good governance, collective leadership and effective system working.

3. RECRUITMENT AND LEADERSHIP

3.1 During the period, I have supported a number of important recruitment processes, including those for the Chief Medical and Outcomes Officer and Director of Commissioning. I have also overseen the process for appointing a substantive Chair of the Audit and Risk Committee and an Independent Member, both processes will conclude during September.

3.2 These appointments are important to maintaining effective Board and executive leadership and ensuring that the organisation has the capacity, expertise and independent challenge required to deliver its strategic objectives. The Chief Executive's report provides further detail on changes within the Executive Team, and I have therefore not repeated that information here.

4. NHS ENGLAND AND PROVIDER ENGAGEMENT

4.1 I have continued to participate in NHS England meetings with provider Boards. Since the last Board meeting, this has included engagement with Medway. These meetings provide an opportunity for open discussion about organisational and system priorities, delivery challenges and the contribution of individual providers to the wider strategic direction for Kent and Medway.

4.2 The Board will recall that Sir Jonathan Montgomery, Regional Chair of NHS England, visited Kent and Medway earlier in the summer. My July report covered the initial visit and noted that a further visit to Medway was planned. The subsequent visit provided a further opportunity to engage directly with services and local leaders and to discuss the priorities and challenges affecting Medway within the wider Kent and Medway system.

5. SYSTEM LEADERSHIP AND RELATIONSHIPS

5.1 I have continued to meet with provider Chairs to support the development of strong and effective relationships across the system. These discussions remain important in maintaining constructive dialogue, building shared understanding and supporting collective leadership across organisational boundaries.

5.2 A particular focus has been ensuring that new Chairs and Chief Executives joining organisations across Kent and Medway are welcomed into established system networks and are able to engage quickly and effectively in collective system leadership. Leadership changes provide an opportunity to strengthen system relationships, while also requiring a deliberate approach to induction, relationship-building and shared understanding of the system's strategic direction.

5.3 I was pleased to attend the launch of the London and South East University Group, where I had the opportunity to meet the newly appointed Vice Chancellor and hear more about the ambitions of this innovative collaboration. The "super university", the first of its kind, brings together significant academic expertise and presents exciting opportunities for partnership with health and care organisations across the region. Discussions highlighted the potential contribution that the University Group could make to workforce development, research, innovation and the broader delivery of health and social care priorities. As we develop our new strategy, there may be valuable opportunities to explore how this partnership could support the continued development of the Four Layers of Care model and our wider transformation ambitions.

5.4 I will continue to work with provider Chairs and wider partners to help create the conditions in which incoming leaders can establish effective relationships quickly and contribute fully to collective system leadership.

6. LOCAL GOVERNMENT RECONFIGURATION

6.1 Local government reorganisation will be an important development for Kent and Medway and for the partnerships through which health and care priorities are delivered. As the programme progresses, it will be important to maintain strong relationships with local authority partners and ensure that health remains fully engaged in shaping future arrangements. The Board will continue to receive updates on any implications for system leadership, partnership working and governance.

7. KEY RISKS, MITIGATIONS, AND CONTROLS

7.1 The principal risks relate to maintaining leadership continuity and effective system relationships during a period of change, including executive and non-executive

appointments, the arrival of new provider leaders and the transition to new local government structures.

7.2 These risks are mitigated through robust recruitment and appointment processes, continued engagement between system Chairs and Chief Executives, regular dialogue with NHS England and early engagement with local authority partners. These arrangements support continuity, clear communication and the continued development of effective working relationships across the system.

8. OTHER CONSIDERATIONS

8.1 Although the reporting period has been quieter than usual, the activity undertaken has supported important leadership appointments and maintained the relationships needed to sustain effective system working during a period of continuing change.

8.2 I remain encouraged by the commitment of NHS and local authority partners to working constructively together. Continued attention to leadership relationships, effective induction and shared purpose will be important as new leaders and structures emerge across Kent and Medway.

9. REQUIRED OUTCOMES AND NEXT STEPS

9.1 The Board is asked to:

- **NOTE** the contents of the Chairs report.

10. SUPPORTING DOCUMENTATION

10.1 There are no supporting documents relevant to this report.

Report to	Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Chief Executive Officer Report
Key question	What progress has been made against the ICB's Corporate Objectives, and where should the Board focus its attention to support successful delivery of priorities, transformation, and financial sustainability?
Executive Lead	Adam Doyle, Chief Executive Officer
Author	Adam Doyle, Chief Executive Officer

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☒ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

The Board is asked to:

1. **NOTE** the contents of this report.

Executive summary:

This report provides an update on progress since the July 2026 Board meeting against the ICB's five Corporate Objectives. It highlights continued progress in developing the Four Layers of Care model, neighbourhood health, digital transformation, and strategic

commissioning capability, alongside strengthened executive leadership and system partnership arrangements.

The report also identifies areas requiring sustained Board and executive attention, particularly delivery of the agreed financial plan, oversight of the proposed transfer of services from Medway Community Healthcare to Kent Community Health NHS Foundation Trust, safeguarding reform, and the implications of Local Government Reorganisation. These priorities require continued focus on quality and patient safety, workforce engagement, service continuity, effective governance, and system-wide delivery.

Overall, the report provides assurance that progress is being made, while recognising that continued leadership focus, organisational discipline and partnership working will be essential to maintain momentum and deliver agreed priorities.

Proposed next steps:

The priorities highlighted within this report will continue to be progressed through the ICB's established executive, programme, and governance arrangements. Particular focus will be maintained on financial recovery, delivery of the Four Layers of Care model, neighbourhood health development, oversight of the proposed transfer of services from Medway Community Healthcare to Kent Community Health NHS Foundation Trust, and preparation for Local Government Reorganisation. Progress against these priorities and any emerging issues requiring Board attention will be reported through routine assurance and performance reporting mechanisms.

Governance pathway to date:

Meeting name:	Date:	Outcome:
N/A		

Contact for further information	Adam Doyle, adam.doyle5@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities, and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

No separate equality, health inequalities or quality impact assessment is required, as the report provides an update on progress and activity, with any relevant considerations addressed within the body of the report.

COMPLIANCE NOTES:

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?

☐ Yes ☒ No

If yes, please confirm how the conflict has been managed.

FOI status

Is this report disclosable under FOI?

☒ Yes ☐ No

If no, please specify why:

Financial implications

Are there financial implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Legal implications

Are there legal implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Quality and safety implications

Are there quality or safety implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Patient and public engagement

Are there patient and public engagement implications associated with this report?

☐ Yes ☒ No

If yes, please describe. If no, please specify why:

There are no specific patient or public engagement implications arising directly from this report. However, the report highlights ongoing engagement with patients, communities, VCSE partners, primary care, elected representatives, and other stakeholders in support of commissioning, transformation, and service improvement activities.

CHIEF EXECUTIVE OFFICER REPORT

1. INTRODUCTION

1.1 Overview

This report provides an update on progress across Kent and Medway since the July 2026 Board meeting. During this period, the organisation has continued to focus on delivery against its statutory responsibilities, development of the Four Layers of Care model, strengthening system leadership arrangements and maintaining a clear focus on financial, quality, and operational performance.

1.2 Key Developments

A number of significant developments have occurred during the reporting period. These include the appointment of Michelle Kane as the incoming Chief Commissioning Officer, the arrival of Sumona Chatterjee as Deputy Chief Commissioning Officer, confirmation of Dr Mike Smith as Chief Medical and Outcomes Officer and the establishment of interim arrangements led by Chris Neill pending Michelle's arrival.

Alongside these leadership developments, the organisation has continued to progress transformation priorities including neighbourhood health development, the transfer of Data, Digital and Information services into shared arrangements with NHS Surrey and Sussex ICB, ongoing oversight of the proposed transfer of services from Medway Community Healthcare to Kent Community Health NHS Foundation Trust, and preparations for Local Government Reorganisation across Kent and Medway.

2. STRATEGIC ALIGNMENT

2.1 This report supports delivery of the ICB's five Corporate Objectives for 2026/27 by providing assurance on system grip, recovery, and progress against key commissioning, financial, transformation and organisational priorities. It reflects alignment with NHS England expectations, the refreshed governance framework, and the system strategy, ensuring continued focus on disciplined delivery, partnership working, and effective leadership.

3. CORPORATE OBJECTIVE 1 – COMMISSION THE RIGHT SERVICES EACH YEAR

3.1 Primary care engagement

Engagement with local communities, patients, providers, and elected representatives remains an important part of ensuring that commissioning decisions are informed by the needs of our population.

During the reporting period I met with Lauren Sullivan MP alongside a number of general practices in Gravesham. The discussions provided an opportunity to hear directly from primary care colleagues regarding the challenges and opportunities currently facing practices and the important role that general practice will play in delivering the ambitions contained within the Four Layers of Care model.

The discussions reinforced the importance of supporting access, workforce sustainability, and the continued development of integrated neighbourhood services around primary care.

3.2 Future population growth and health infrastructure

I also met separately with Lauren Edwards MP to discuss the health implications arising from planned housing growth and development within Strood.

As population growth continues across Kent and Medway, it is essential that health infrastructure requirements are considered alongside wider housing and regeneration plans. Discussions focused on ensuring that future commissioning decisions support the development of sustainable services capable of meeting the needs of growing communities.

3.3 Sittingbourne Memorial Hospital

During the reporting period I met with Kevin McKenna MP to discuss future opportunities for Sittingbourne Memorial Hospital and the role the site may play in supporting wider service transformation ambitions.

Discussions considered the contribution that Sittingbourne Memorial Hospital could make to neighbourhood health services, intermediate care provision, and broader community-based models of care as our strategic plans continue to develop.

3.4 MCH to KCHFT transfer

The proposed transfer of services from Medway Community Healthcare to Kent Community Health NHS Foundation Trust remains a significant programme of work.

The programme continues to be monitored closely through established governance arrangements, with a particular focus on quality, patient safety, workforce

engagement, and continuity of service provision. Whilst progress continues to be made, this remains a major strategic priority for the organisation and wider system.

4. CORPORATE OBJECTIVE 2 – DELIVER FINANCIAL SUSTAINABILITY OVER THE MEDIUM-TERM

4.1 Regional accountability meetings

Financial recovery and sustainability continue to represent one of the most important priorities facing the system.

During the reporting period I attended a further round of Regional Accountability Meetings involving provider organisations across Kent and Medway. These meetings provided an opportunity to review progress against agreed financial plans and assess delivery trajectories for the remainder of the financial year.

It was clear from discussions with each organisation that there remains a strong commitment to delivery of the agreed financial plan. Equally, it was recognised that sustained leadership focus and organisational discipline will be required throughout the remainder of the year if agreed objectives are to be achieved.

Actions have been agreed with individual organisations where further intervention or oversight is required, and progress will continue to be monitored through established governance arrangements.

The ICB will continue to maintain close oversight of financial performance through regular monitoring arrangements and through our ongoing engagement with provider organisations and NHS England.

5. CORPORATE OBJECTIVE 3 – DELIVER THE SYSTEM STRATEGY AND TRANSFORMATION PRIORITIES

5.1 Four Layers of Care

The Four Layers of Care model continues to provide the overarching framework for health and care transformation across Kent and Medway.

Work continues across all partners to translate the model into practical delivery plans that support improved outcomes, better patient experience, and more sustainable services. I am pleased that we are discussing later today at our meeting alongside our commissioning intentions for 2027/28.

5.2 Dartford and Gravesham NHS Trust visit

During the reporting period I visited the Hyper Acute Stroke Unit at Dartford and Gravesham NHS Trust.

I was particularly impressed by both the quality of care being delivered and the innovative use of artificial intelligence and digital technologies to support patient rehabilitation and recovery. The visit demonstrated the significant opportunity that technology provides in supporting improved outcomes, reducing variation, and enhancing patient experience. The visit also highlighted the strength of clinical leadership and the benefits that innovation can bring when applied directly to patient care pathways.

5.3 Neighbourhood health development

Neighbourhood health services remain a critical component of our transformation ambitions. During the reporting period we received a visit from Dr Claire Fuller to discuss the continued development of neighbourhood health arrangements across Kent and Medway. Discussions focused on maintaining momentum, strengthening delivery arrangements, and ensuring that the opportunities associated with neighbourhood health are translated into tangible improvements for local communities. We have appended a letter that we have received from national colleagues and a single slide summary.

5.4 Safeguarding reform

I also chaired the Kent and Medway Safeguarding Children Multi-Agency Partnership. There was significant discussion regarding the next phase of safeguarding reform and the implications for organisations across Kent and Medway. It was clear that these developments will require close monitoring over the coming months and there will need to be continued focus on maintaining effective safeguarding arrangements throughout the transition period.

5.5 Data, Digital and Information transition

An important milestone was reached during the reporting period through the successful transfer of the Data, Digital and Information function into the shared arrangements hosted by NHS Surrey and Sussex ICB. This development creates opportunities to strengthen resilience, improve capability and enhance collaboration across a broader geography whilst maintaining a clear focus on supporting the priorities of Kent and Medway. I would like to place on record my thanks to all colleagues involved in supporting the transition and recognise the professionalism demonstrated throughout the process.

I am pleased to report that Dr Mayur Vibhuti joined NHS Kent and Medway ICB and NHS Surrey and Sussex ICB on 1 September 2026 as Joint Chief Data, Digital and Information Officer. This appointment represents an important opportunity to accelerate our ambitions around digital transformation, population health management, advanced analytics, and the appropriate use of artificial intelligence across health and care services.

6. CORPORATE OBJECTIVE 4 – BE A HIGH PERFORMING STRATEGIC COMMISSIONING ORGANISATION

6.1 Chief Commissioning Officer appointment

I am delighted to confirm that Michelle Kane has been appointed as the new Chief Commissioning Officer and will join the organisation in the new year. Michelle brings extensive leadership experience, and her appointment represents an important step in strengthening the long-term strategic commissioning capability of the organisation. I would like to place on record my thanks to Chris Neill who will provide leadership support for the commissioning portfolio from 1 September until Michelle Kane takes up post. Chris's contribution will provide important continuity and stability during this transition period.

I am also pleased to welcome Sumona Chatterjee, who has joined the organisation as Deputy Chief Commissioning Officer. Sumona has already made a significant contribution and will play a key role in supporting delivery of the commissioning agenda and broader organisational development priorities.

6.2 Chief Medical and Outcomes Officer

Further strengthening of the executive team will occur through the arrival of Mike Smith on 19 October as Chief Medical and Outcomes Officer. Mike's appointment reflects our commitment to strengthening clinical leadership and improving outcomes for the population of Kent and Medway.

6.3 National Quality Strategy

The recently published National Quality Strategy sets out an important framework for strengthening quality governance, patient safety, and improvement capability. The organisation has been asked to identify executive and board leadership arrangements in response to the report. I am pleased to confirm that Jennie Hall will undertake the Executive Lead role on behalf of the ICB and will oversee implementation of relevant recommendations.

6.4 Governance appointments

Recruitment activity continues across a number of important governance positions. Interviews for both the ICB Chair position and the East Kent Hospitals University NHS Foundation Trust Chair position took place om 7 September. Recruitment is also progressing to the ICB Audit Committee Chair position and Independent Member vacancies. The Board will be notified as appointments are confirmed.

6.5 Kent County Council leadership

I was pleased to welcome Helen Woodland into her new role as Director of Adult Social Services at Kent County Council. Strong local authority partnerships remain

fundamental to delivery of our shared ambitions, and I look forward to continuing our close working relationship.

6.6 Recognising Kate Langford's contribution

As Kate Langford prepares to leave the organisation, I would like to place on record my sincere thanks for her outstanding contribution to NHS Kent and Medway. Kate has provided exceptional leadership during a period of considerable organisational change and her personal support to me as Chief Executive has been invaluable.

She has played a critical role in helping to stabilise the organisation, strengthen relationships across the system and support delivery through a period of transition and uncertainty. Perhaps most significantly, Kate has been instrumental in developing and shaping the Four Layers of Care model. Her ability to bring together partners around a common vision and articulate a coherent strategic direction has helped create the framework that now underpins our future ambitions.

On behalf of colleagues across the organisation and wider system, I would like to thank Kate for her commitment, professionalism and leadership and wish her every success for the future.

7. CORPORATE OBJECTIVE 5 – PROVIDE EFFECTIVE LEADERSHIP AND A COMPASSIONATE, VALUES-LED ORGANISATION

7.1 Local Government Reorganisation

Local Government Reorganisation is likely to represent one of the most significant strategic developments affecting Kent and Medway over the coming years. There is increasing recognition across the system that the scale of potential change will have implications for governance, partnerships, place-based arrangements, and the future delivery of public services. We will be working closely with Amanda Beer as the Senior Responsible Officer for this programme to ensure that health has a strong and influential voice throughout the development process.

Whilst Local Government Reorganisation presents opportunities to strengthen partnership working and integration, it also introduces a number of risks and uncertainties which will require careful management. These include maintaining effective relationships, preserving successful place-based arrangements, and ensuring continuity of service provision throughout periods of change.

Given the scale of the programme, Local Government Reorganisation is expected to remain a major strategic priority for the foreseeable future and regular updates will be provided to the Board.

7.2 Conclusion

Despite continued operational and financial pressures, there remains strong evidence of progress across Kent and Medway. The strengthening of the executive team, continued development of neighbourhood health services, progress in digital

transformation and increasing maturity of partnership working provide a strong foundation for the next phase of delivery.

The focus for the months ahead will be on maintaining momentum, delivering agreed plans, and continuing to improve outcomes for the people of Kent and Medway.

8. KEY RISKS, MITIGATIONS, AND CONTROLS

8.1 The principal risks relate to delivery of the agreed financial plan; maintaining quality, patient safety, workforce engagement and continuity of services through the proposed transfer from Medway Community Healthcare to Kent Community Health NHS Foundation Trust; translating the Four Layers of Care and neighbourhood health ambitions into practical delivery; managing safeguarding reform; maintaining stability through executive leadership changes; and responding to the governance, partnership and service implications of Local Government Reorganisation.

8.2 These risks are being managed through established governance and oversight arrangements, including regular monitoring of financial performance, engagement with provider organisations and NHS England, and agreed actions where further intervention is required. The proposed service transfer continues to receive focused oversight, interim executive arrangements are in place to maintain leadership continuity, and the ICB is working with system partners to manage safeguarding reform, transformation delivery, and Local Government Reorganisation. The Board will continue to receive updates through the relevant governance and reporting arrangements.

9. OTHER CONSIDERATIONS

9.1 There are no other considerations relevant to this report.

10. REQUIRED OUTCOMES AND NEXT STEPS

10.1 The Board is asked to:

- **NOTE** the contents of this report.

11. SUPPORTING DOCUMENTATION

- NHSE letter and one page summary

ICB Chief Executive
ICB Chair

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

10 September 2026

Dear Angela and Adam

Neighbourhood Health – Kent and Medway

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

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

There are a number of examples of good practice across Kent and Medway, as well as areas where you are leading the way nationally in terms of innovative neighbourhood health approaches.

Examples include:

- Your **Single Neighbourhood Health model,** translating the neighbourhood ambition into a contractual and operational delivery route across all 45 single neighbourhood footprints, supporting proactive care for complex cohorts, weekly multidisciplinary team working, structured care planning, comprehensive geriatric assessment, medication reviews, care home support and escalation. Its transferable value is that it provides a clear platform for scaling integrated neighbourhood teams, strengthening anticipatory care and demonstrating impact on avoidable urgent and emergency care demand.
- **The Local Variation to the PCN DES -** Kent and Medway's variation to the PCN DES provides a strong mechanism for aligning primary care delivery with neighbourhood health priorities. It creates a route to improve consistency across practices and PCNs, focus delivery on priority cohorts, support measurable improvement and connect primary care more directly to system transformation objectives.
- **The Folkestone and Hythe National Neighbourhood Health Implementation Programme (NNHIP) pioneer site.** This is a live demonstration of integrated neighbourhood working bringing primary care, community services and wider partners together around people with frailty, complex multimorbidity and rising risk. Its learning

is helping to shape the wider Kent and Medway model and provides a practical exemplar that can be documented, evaluated and shared locally and nationally.

- **Medway Central neighbourhood model for multiple disadvantage.** Medway Central is an emerging best practice example of neighbourhood health shaped by local population need. The Chatham pilot focuses on residents aged 20–50 experiencing complex multiple disadvantage, including homelessness or risk of homelessness, substance misuse, mental health need, physical frailty and high use of urgent and emergency services. Its strengths are the targeted cohort definition, partner-led wrap-around support, co-location through James Williams Healthy Living Centre, joint governance and focus on reducing fragmentation, improving engagement and reducing crisis demand.
- **Strong performance on community waiting times** reflects a sustained, system-wide improvement approach. The ICB commissioned a single lead provider for adult and children's community health services across Kent and Medway, working through a partnership delivery model. This creates clearer system accountability and a consistent framework for access standards, pathway design, data definitions, waiting-list validation, clinical prioritisation and performance management across all areas. It enables activity, capacity and waiting times to be viewed across the whole system rather than through separate organisational contracts, making variation visible and allowing effective practice, workforce and resources to be deployed more consistently to services and communities experiencing the greatest pressure. This is underpinned by transparent performance information, active waiting-list management, pathway redesign, targeted recovery trajectories and rigorous commissioner-provider oversight, helping to reduce unwarranted variation, improve productivity and ensure that people are seen as quickly and equitably as possible.

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

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

As discussed, the key areas of focus over the coming months are to deliver the 6 and 18 month next steps, including, in the near term:

- Confirm accountable leads for all ten requirements for NBH;
- Consolidate the 45 single neighbourhoods and nine multi neighbourhood footprints;
- Strengthen evidence for the single Neighbourhood Health model, with a particular focus on delivering proactive care coverage and evidencing impact on non-elective activities and bed days;
- Confirm adult and children's community waiting time trajectories;
- Produce a single interface and elective pathway improvement plan;

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- Confirm the current data sharing position and prioritise information governance support for wider partner participation, including VCSFE, community pharmacy, optometry and dental.

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

Yours sincerely



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

Annex:

Single slide summary

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NHS Kent and Medway ICB

4 September 2026

ICB at a glance

ICB CEO	Adam Doyle (substantive, 15 Oct 2025)	**Local authorities**	Kent County Council and Medway Council
ICB Chair	Interim Chair Angela McNab CFO Jonathan Wilson (28 Jan 2026)	**Providers**	Acute: DGT and MFT (DGT-MFT Group), MTW, EKHUFT. Community: KCHFT (Lead Provider), HCRG, MCH. MH: KMMH. Ambulance: SECAmb (SCAS Group). GP federation: West Kent PC CIC (all West Kent practices); East Kent GP Confederation (bringing together the federations across East Kent; DGS Health (all DGS practices) or Medway Practices Alliance (all practices in Medway) and Swale (no federation)
Registered population	c. 1.9 million	**Self-reported**	EKHUFT (RSP, Intensive Recovery Programme, capability-rating downgrade); KMMH (warning notice lifted Mar 2026)
Places	Nine multi-neighbourhood footprints (the base unit) over 45 single neighbourhoods; the four HCP Places are superseded	**Workforce**	£198.0m reforecast deficit (c. £300m underlying); one of the more challenged systems nationally
Footprint	Mixed urban, rural and coastal; Marmot Places (Medway; East Kent coastal)	**Pilots and designations**	1 confirmed pioneer (Folkestone and Hythe #106) of 4 applications (#105 DGS, #107 Central Chatham, #108 West Kent); NHC pipeline submitted

Place level maturity score

Multi-neighbourhood	Dartford, Gravesham and Swanley	Medway	Swale	Canterbury and Coastal	Thanet and Deal	Dover, Folkestone and Hythe	Ashford and Rural	Maidstone, Malling and the Weald	Sevenoaks, Tonbridge and Tunbridge Wells
Population	297,955	338,780	109,030	221,200	205,020	180,890	216,000	297,990	241,660
HWB sign-off	11 Mar 2026 (KCC Cttee)	16 Apr 2026 (Medway HWB)	11 Mar 2026 (KCC Cttee)	11 Mar 2026 (KCC Cttee)	11 Mar 2026 (KCC Cttee)	11 Mar 2026 (KCC Cttee)	11 Mar 2026 (KCC Cttee)	11 Mar 2026 (KCC Cttee)	11 Mar 2026 (KCC Cttee)
NbH readiness	#105 applied	#107 Chatham live pilot	None; below 250k MNP guide	No NNHIP application	None; highest deprivation	#106 pioneer + Compact	No NNHIP application	#108 applied	#108 applied
HLE (M/ F)	62.5 / 63.9	59.0 / 60.2	62.5 / 63.9	62.5 / 63.9	62.5 / 63.9	62.5 / 63.9	62.5 / 63.9	62.5 / 63.9	62.5 / 63.9
GP federation /integrator	DGS Health; no host	Medway Practices Alliance; no host	No active federation; no host	East Kent GP confederation; no host	East Kent GP confederation; no host	East Kent GP confederation; pioneer, no host	East Kent GP confederation; no host	West Kent PC CIC; no host	West Kent PC CIC; no host

Examples of practice surfaced across Places

- Folkestone and Hythe: NNHIP pioneer with a signed Compact; a live demonstration of the model, to document and share as an exemplar; two test sites live (April 2026).
- Chatham (Medway): live pilot singled out at the visit; embed the learning across the model, not stand-alone.
- Model of care (layered): primary care levelled up via the contracts; proactive care for the 5% PNG 10-11 + care home and housebound (SMR, care plans, CGA, ReSPECT); reactive team (ARRS plus community; MH and social care not yet); MNH community-trust layer (UCR, hospital at home, virtual ward); two-collaboratives (acute and neighbourhood).
- System: KCHFT single Lead Provider for community (27 Oct 2025); community leadership entering the AFT pipeline; all practices on EMIS; Johns Hopkins PNG; single MH trust (KMMH).
- Younger frailty: earlier-intervention frailty cohorts in Maidstone, Medway and Margate.
- Delivery: PCN DES variant to scale: the PCN DES Local Variation Arrangement scales and levels up the frailty offers, tied to non-elective reductions; year-one 92,360 cohort; ask to the centre a multi-year PCN DES; requirement: additionality not substitution, recurrent payment for 5% proactive care (April 2027).

Five Goals (RAG vs England; see Annex B for scores)

G1 Health outcomes	G2 GP access and experience	G3 Planned care	G4 Urgent and emergency care	G5 Patient and staff satisfaction

Position points vs England (Annex B). G4 urgent and emergency care is the only Goal above England (3.22, Amber-Green); G1 (1.45) and G2 (1.38) Red; G3 (1.78) and G5 (2.00) Amber-Red. Reactive care runs ahead of proactive. G-cell fill shows RAG.

Enablers (Section 4)

Enabler (fill = rating)	Key point
Data	KMCR live across all 175 practices, trusts and LAs; PNG segmentation live; per-PCN dashboard in development.
Workforce	ARRS 1,149.59 WTE across 45 PCNs; no system-wide people plan; GP Medical Director recruitment to the nine MNH in train.
Finance	£198.0m reforecast deficit (c. £300m underlying).
Digital	DDaT Strategy paused Feb 2026, refresh under the Kent, Surrey and Sussex DDI function; SNAP not operational at scale.
Estates	Infrastructure (ICB Explorer): 3 surgical hubs, 6 CDCs, 60 family hubs, no current Neighbourhood Health Service site, but pipeline in place. No InSite map access; NHC pipeline submitted; binding constraint.

Framework readiness: Stage 1 (foundations) and Stage 2 (NbH Plan)

Ref	Stage 1 minimum requirement (2026/27): Ref fill shows rating	Self-assessed score
S1	Reduce non-elective admissions via UCR and reablement	7
S2	Reduce variation; improve access to general practice	6
S3	Neighbourhood footprints agreed	4
S4	INTs for high-priority cohorts; devolved budgets	8
S5	Neighbourhood approach to elective pathways	2
S6	18-week community waits; eliminate 52-week waits	8
S7	BCF pooled funding plans confirmed with LAs	3
S8	Primary / secondary care interface (RTC)	4
S9	Organisational ownership of planned deliverables	5
S10	Data-sharing arrangements for patient identification	4
Stage 1 overall:		**51**

Ref	Stage 2 NbH Plan: seven-step readiness (text colour shows rating)
1	National NHS objectives delivered through the three reform agendas
2	Support wider local goals and reduce inequalities
3	Local objectives informed by the JSNA and other assessments
4	Confirm final geographies partners will work within
5	Confirm which organisations are responsible for delivery
6	Confirm delivery arrangements, governance and operational processes
7	Confirm alignment of other initiatives (Best Start Family Hubs, housing, mental health hubs, Pride in Place, employment support)
Stage 2 overall	

Forward look - Key actions over next 6 months:

1. Confirm accountable leads for all ten requirements and agree a single delivery route through neighbourhood health governance, with named owners for each improvement action.
2. Consolidate the 45 single neighbourhoods and nine multi-neighbourhood footprints, confirming leadership, partner participation and the minimum operating model for integrated neighbourhood teams.
3. Strengthen evidence for the Single Neighbourhood Health model, risk stratification, proactive care coverage and urgent community response links, including the impact on non-elective activity and bed days.
4. Confirm adult and children's community waiting time trajectories, including neurodevelopmental pathways, with a clear route to reduce long waits and eliminate 52-week waits.
5. Produce a single interface and elective pathway improvement plan, prioritising high-volume specialties, red tape challenge actions, referral optimisation and early neighbourhood outpatient models.
6. Confirm the current data-sharing position and prioritise information governance support for wider partner participation, including VCFSE, community pharmacy, optometry and dental.

Forward look – Key actions over next 18 months

1. Move from agreed footprints to a consistently operating neighbourhood model, with integrated neighbourhood teams functioning across all footprints and clear connection to place and system governance.
2. Scale proactive care for the complex care cohort and embed a consistent model for anticipatory care, care planning, medication review, care home support and escalation.
3. Implement neighbourhood-facing elective pathway models in agreed specialties, including community specialist clinics, GPwER services, GP-consultant shared care and population-based specialty relationships where appropriate.
4. Deliver sustained improvement against 18-week community waits and eliminate 52-week waits through pathway redesign, validation, demand management and shared care follow-up models.
5. Strengthen alignment between Better Care Fund, Section 75 arrangements, neighbourhood priorities and inequalities outcomes, including clearer neighbourhood-level investment and evaluation.
6. Embed primary-secondary care interface improvement across providers, supported by clinical leadership, job planning, shared digital access and a sustainable red tape challenge programme.
7. Extend data-sharing arrangements and active use beyond NHS partners so that neighbourhood teams can identify cohorts, coordinate care and evaluate outcomes across the wider partnership.

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Update report on stroke services for Kent and Medway
Key question	Is the Board content that appropriate steps are being taken for delivery of the stroke services?
Executive Lead	Dr Kate Langford, Chief Medical Officer
Author	Dr Kate Langford, Chief Medical Officer Aparna Belapurkar, Chief Allied Health Professional Jim MacDonald, Deputy CMO

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

The Board is asked to:

- **NOTE** the updated evidence relating to ambulance travel times from South East Coast Ambulance Service NHS Foundation Trust (SECAmb).
- **NOTE** progress with commissioning of a comprehensive neurorehabilitation service for Kent and Medway.
- **NOTE** the update from East Kent Hospitals University NHS Foundation Trust (EKHUFT) on progress of the build of the new hyper acute stroke unit (HASU) unit in line with the outcome of the national stroke reconfiguration programme.
- **NOTE** the update on the provision of mechanical thrombectomy services for Kent and Medway residents.

Executive summary:

Following previous presentation to Board, further work has been underway in different aspects of the provision of a comprehensive stroke service for people in Kent and Medway:

- Updated evidence relating to ambulance travel times from SECAmb indicates thrombolysis within 120 minutes would still be achieved.
- The ICB has included commissioning of an integrated Kent and Medway Stroke/Early Supported Discharge (ESD)/neurorehabilitation model, bringing together community stroke rehabilitation, Early Supported Discharge and wider specialist neurorehabilitation services in its commissioning intentions for 2027/28 and has developed a service specification.
- Work has commenced on the build of the new HASU at William Harvey Hospital (WHH).
- The mechanical thrombectomy unit at Kent and Canterbury Hospital (K&C) is rolling out service provision meaning that some stroke patients presenting in east Kent are able to have mechanical thrombectomy at K&C rather than transferring to London for this treatment.

This provides further assurance that the agreed stroke configuration is being progressed and stroke services are improved.

Proposed next steps:

- Socialise travel times data and analysis with external stakeholders.
- Finalise stroke rehabilitation specification via CMDTs through September 2026.
- Engage with external stakeholders and the public from end September 2026 intending to commission co-designed service from April 2027.

Governance pathway to date:

Meeting name:	Date:	Outcome:
Executive committee	06 May 2026	Provide an update to Board on ambulance travel times, workplan on Integrated MDT Stroke rehabilitation model across stroke pathway and embedding this in the Commissioning intentions
Board	21 July 2026	Provide a further update to Board in September 2026
Executive Committee	09 September 2026	Provide a further update to Board in September 2026

Contact for further information	Kate Langford katelangford@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

An equality, health inequalities and quality impact plan was undertaken when developing the original business case.

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?
☐ Yes ☒ No
If yes, please confirm how the conflict has been managed.

There are no known conflicts associated with the author or reporting officer.

FOI status

Is this report disclosable under FOI?
☒ Yes, ☐ No
If no, please specify why:

Financial implications

Are there financial implications associated with this report?
☒ Yes ☐ No
If yes, please describe:

The system also needs to focus on development of community Stroke rehabilitation as part of the rehab and strategic left shift case. This means there may need to be trade-offs against any further investment in acute stroke settings other than already committed. Some of this can be off set through productivity and efficiency opportunities in the acute discharge pathways as part of left shift.

Legal implications

Are there legal implications associated with this report?
☒ Yes ☐ No
If yes, please describe:

COMPLIANCE NOTES:

Given the previous judicial reviews undertaken which went in favour of the reconfiguration plan, there might be legal implications if that decision were to be set aside.

Quality and safety implications

Are there quality or safety implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

No confirmed quality or safety concerns with the existing plans to reconfigure stroke services at William Harvey hospital site have been identified:

- The Stroke service delivery model will remain the same with specialist resource shifting to WHH.
- Ambulance transfer times in totality and door to needle times for patients across East Kent and Kent and Medway, will continue to be monitored and assured through appropriate governance and oversight.

Patient and public engagement

Are there patient and public engagement implications associated with this report?

☒ Yes ☐ No

If yes, please describe. If no, please specify why:

Any changes to the existing plan and option chosen would need patient and public engagement and communication plan.

A communications and engagement plan will be needed to:

- articulate and raise awareness about the Stroke pathways across Kent and Medway, and
- reassure people that the Stroke services offered to them will be high quality, equitable, needs-based and safe.

UPDATE REPORT ON STROKE SERVICES FOR KENT AND MEDWAY

1. INTRODUCTION

At its meeting on 21 July 2026, the Board considered a Stroke Services Update Report and endorsed continuation of the agreed East Kent stroke reconfiguration programme, whilst requesting additional assurance in relation to ambulance travel times to William Harvey Hospital (WHH), implementation planning and the wider stroke pathway.

Since the July Board, further work has been undertaken to strengthen assurance across these areas.

1.1 Independent Assurance on Ambulance Travel Times

In response to concerns raised by Members of Parliament, the Kent and Medway Health Overview and Scrutiny Committee (HOSC) and other stakeholders regarding ambulance travel times from patients' homes to William Harvey Hospital, the ICB has commissioned SECAmb to undertake an independent review of blue light ambulance travel times to the WHH journeys from areas of greatest public interest, including Thanet and Romney Marsh.

SECAmb has undertaken a review of travel times covering the period 2020 to date to test whether there has been significant deterioration in the ambulance travel times to the William Harvey Hospital site from the three postcodes identified as of most concern in the original process i.e. CT9, CT10 and TN 29.

Comparison with Original DMBC Assumptions

Area	Average travel time in 2017-2018 (mins)	Average travel time 2026 (mins)	Max travel time 2017-2018 (mins)	Max travel time 2026 (mins)	% population reaching WHH within 60 mins 2026
CT10-Broadstairs	48	50	55	55	100
CT9-Margate	51 min	50 min	58	70	88
TN29-Romney Marsh / Dungeness	35min	27 min	42	34	100

The findings demonstrate differing patterns across the three geographical areas.

Broadstairs (CT10) has shown an increase in average journey time of approximately 2 minutes. Despite this, the longest journey time has not changed and 100% of journeys are achieved within 60 minutes.

Margate (CT9) demonstrates a marginal improvement in average travel times but a deterioration in the longest travel time. Data from 2020 to date indicate that the longest

travel time peaked in 2023 at 107 minutes and has improved year on year since, but this should remain an area of focus. In the original case a travel time of 60 minutes was used as a proxy for accessing treatment within 120 minutes based on an assumption that time from door of HASU to needle would be around 60 minutes. The current excellent performance of the EKHUFT HASU has a door to needle time of 46 minutes in the Sentinel Stroke National Audit Programme which indicates that for the longest travel time treatment within an envelope of 120 minutes would still be achieved. For clarity the same clinical team will be delivering the EKHUFT HASU service at the WHH as currently at K&C so no deterioration of HASU performance is expected with the move to WHH. Since the WHH HASU will be purpose built with direct ambulance access and an on-unit scanner we would actually expect to see performance improve.

Romney Marsh and Dungeness (TN29) demonstrates improved average and longest travel time with 100% of journeys achieved within 60 minutes.

In conclusion the update analysis indicates that the assumption in the original case that thrombolysis would be started within 120 minutes still holds.

1.2 Community Stroke Rehabilitation

The ICB has developed a comprehensive draft integrated Kent and Medway Stroke/ESD/Neurorehabilitation service specification, aligned with the 2027/28 commissioning intentions. The specification clearly sets out in considerable detail, the proposed model of care, clinical pathways, expected clinical outcomes, quality standards, key performance indicators and outcome measures. It is currently undergoing internal review by ICB Clinical Directors and Commissioning Officers, with feedback being incorporated to refine the model and add further operational detail. This integrated Kent and Medway Stroke/ESD/Neurorehabilitation model will bring together Community Stroke Rehabilitation, Early Supported Discharge (ESD), Stroke Reviews, specialist Neurorehabilitation, Neuro Care Navigation, Neuropsychology, Tone Management, Vocational Rehabilitation and other specialist rehabilitation services which will include access to NHS funded bedded and non-bedded services and working collaboratively with wider VSCE partner stakeholders where providers come together to deliver a high quality, safe and single coordinated multidisciplinary model of care to improve patient outcomes.

The revised specification will be considered through Commissioning MDTs in early September, followed by wider system socialisation and time-limited Task and Finish Groups from the end of September. The intention is to complete engagement and implementation planning and embed the model within commissioning arrangements by the end of 2026/27, supporting delivery from 2027/28.

This work is aligned with the ICB's 2027/28 commissioning intentions. The intention is to complete the necessary engagement, governance and implementation planning during 2026/27, with the model and service specification embedded within commissioning arrangements before the end of the 2026/27 financial year to support delivery from 2027/28.

The model supports the strategic shift towards integrated community-based rehabilitation, reducing unwarranted variation and improving coordination, quality and equitable access to Stroke/ESD/Neurorehabilitation services across Kent and Medway.

1.3 Progress of the Hyper Acute Stroke Unit at WHH

Work is now underway with EKHUFT expecting completion in early 2028. The CEO of EKHUFT will attend September Board to give a verbal update on progress.

1.4 Progress on implementation of a Mechanical Thrombectomy service at the Kent and Canterbury Hospital site

Nationally, approximately 4% of patients with stroke will be expected to undergo mechanical thrombectomy (MT). Historically MT services have been co-located with neurosurgical centres and patients from Kent and Medway have had access to MT in London providers.

The MT unit at the K&C is the first MT unit to be set up remote from a neurosurgical unit and will eventually serve all eligible stroke patients presenting to K&M HASUs. The service is not yet operating at its full planned capacity because of specialist workforce challenges. At present the service is running 0900-1700 on weekdays and is only offered to patients presenting to the East Kent HASU, with other eligible patients continuing to be referred to London thrombectomy centres in accordance with established clinical pathways. A timeline for progressing to 24/7 service for patients presenting to all three K&M HASUs has been requested from the trust and the specialised commissioning team.

2. STRATEGIC ALIGNMENT

This report supports the ICB strategic objectives by:

- commissioning services that deliver improved clinical outcomes for the population
- ensuring workforce sustainability and resilience of specialist services
- supporting evidence-based service planning and system leadership

3. OTHER CONSIDERATIONS

None.

4. KEY RISKS, MITIGATIONS, AND CONTROLS

Risks	Potential Impact	Mitigation
Travel time pressures	Potential delays in treatment	Monitoring and review of ambulance and pathway data
Delay to HASU	National programme not delivered	ICB continues to seek assurance from EKHUFT CEO
Lack of confirmed timeline for implementation of 24/7 MT service	K&M patients have to travel to London for MT	ICB continues to seek assurance from EKHUFT and Specialised Commissioning colleagues

5. REQUIRED OUTCOMES AND NEXT STEPS

The Board is asked to **NOTE** this update.

6. SUPPORTING DOCUMENTATION

There are no supporting documents relevant to this report.

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Q1 review of the transfer of Children and Young People's Mental Health Services (CYPMHS) and the All Age Eating Disorder Service (AAEDS) to Kent and Medway Mental Health NHS Trust (KMMH)
Key question	Has NHS Kent and Medway had sufficient assurance regarding the transfer of CYPMHS and AAEDS to KMMH to continue monitoring progress via the formal Contract Management route?
Executive Lead	Chris Neill, Chief Strategic Commissioning Officer
Author	Sue Mullin, Associate Director Mental Health (Children's) Emily Weitzel, Programme Manager Children's Mental Health Reviewed and agreed by MHLDA CMDT

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

1. To assure the Board that the transfer of CYPMHS and AAEDS has been successfully completed.
2. To confirm to the Board that ongoing monitoring and assurance will take place via the contract management process and update to scrutiny committees will be through established routes for briefing.

Executive summary:
The transfer of Children and Young People's Mental Health Services (CYPMHS) and the All Age Eating Disorder Service (AAEDS) from NELFT to Kent and Medway Mental Health NHS Trust (KMMH) was successfully completed on 1 April 2026. The transfer represents a significant step towards reducing organisational boundaries between children's and adult services and creating a more consistent all-age approach to care: supporting the delivery of the Integrated All Age Mental Health Services model and the wider ambition to provide more integrated, seamless mental health care across Kent and Medway. In recognition of the scale and complexity of the transfer, the ICB implemented a comprehensive assurance framework, governance structure and risk management process to oversee mobilisation. This provided robust scrutiny of clinical safety, safeguarding, workforce readiness, digital preparedness, regulatory compliance and service continuity, ensuring that risks were identified, escalated and mitigated in advance of transfer. Evidence from the first quarter post transfer (April to July 2026) has demonstrated that services transferred safely with no disruption to patient care. All key mobilisation risks were either resolved prior to transfer or subsequently closed, including the final digital risk, which is now being managed through agreed contractual arrangements and ongoing oversight. Feedback from staff transferring into KMMH has been positive, with strong engagement in welcome and listening events and no significant concerns identified regarding the transition. The transfer has demonstrated effective partnership working between the ICB, KMMH and NELFT, together with strong programme governance and commissioning oversight. The arrangements established during mobilisation have provided assurance that quality, performance and risk have been effectively managed while creating a platform for future service transformation and integration across mental health, learning disability and autism pathways.
Proposed next steps:
Final digital transfer components will be monitored under robust contract management arrangements.

Governance pathway to date:

Meeting name:	Date:	Outcome:
Executive Committee	17.12.2025	Assurance of transfer management process, and risks well understood and mitigated
Executive Committee	14.01.2026	Assurance of transfer management process, and risks well understood and mitigated
Executive Committee	11.02.2026	Agreed to conclude future meetings awaiting Q1 review

IOEC	18.11.2025	Risks identified and escalated to Decision Time
HASC	12.03.2026	Formal update of transfer, agreed to return with Q1 review outcome
ICB Board part 2	03.02.2026	Assurance of transfer management process, and risks well understood and mitigated
ICB Board part 1	03.03.2026	Assurance of transfer management process, and risks well understood and mitigated
MHLDA CMDT	23.07.2026	Reviewed and approved.
IAAMHS Contract Management Committee	28.07.2026	For noting and comment
Strategic Commissioning Sub Group	29.07.2026	Subgroup confirmed assurance on the successful transfer and ongoing monitoring would take place via the contract management process
Executive Committee	12.08.2026	ExCo confirmed assurance and ongoing oversight through business-as-usual routes. The Chair has written to both NELFT and KMMH confirming position and thanking them for the efforts over the previous months. The Committee commended the ICB team for leading a robust process.

Contact for further information	Sue Mullin, suemullin@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

Not applicable for this report; however, it should be noted that EQIA was previously completed in 2025 for the transfer of services and included in previous reports.

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?
☐ Yes ☒ No
If yes, please confirm how the conflict has been managed.

COMPLIANCE NOTES:

FOI status

Is this report disclosable under FOI?

☒ Yes ☐ No

If no, please specify why:

Financial implications

Are there financial implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Legal implications

Are there legal implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Quality and safety implications

Are there quality or safety implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Patient and public engagement

Are there patient and public engagement implications associated with this report?

☐ Yes ☒ No

Engagement of patients and staff has been integral to the transfer process and has been monitored as part of the 25/26 transfer and the 2026 Q1 review.

Q1 REVIEW OF THE TRANSFER OF CYPMHS AND AAEDS TO KMMH

1. INTRODUCTION

Following approval of the Integrated All Age Mental Health Services (IAAMHS) contract, Children and Young People's Mental Health Services (CYPMHS) and All-Age Eating Disorders Service (AAEDS) transferred from North East London Foundation Trust (NELFT) to Kent and Medway Mental Health Trust (KMMH) on 1 April 2026. Given the scale and complexity of the transfer, the ICB established a formal assurance process to provide confidence that services would transfer safely and that all operational, clinical, workforce, safeguarding, digital and regulatory requirements would be in place from day one.

This report provides a summary of the assurance arrangements implemented by the ICB, the risks identified during mobilisation, the actions taken to mitigate those risks and the outcomes achieved following transfer. It also considers evidence from the first quarter of delivery, including workforce feedback, operational performance and the effectiveness of the governance arrangements established to support the programme.

The Strategic Commissioning Sub Committee and Executive Committee of the ICB have confirmed their assurance of a successful transfer and the ICB's ongoing assurance processes to monitor quality, performance and risk will continue through formal contract management arrangements.

2. STRATEGIC ALIGNMENT

The successful transfer of CYPMHS and AAEDS to KMMH directly supports the ICB's strategic objectives of commissioning the right services, leading strategy through effective commissioning levers, developing as a high-performing commissioning organisation and ensuring long-term sustainability. The transfer establishes the organisational foundations for delivering the all-age MHLDA model, reducing fragmentation between children's and adult services and enabling more seamless care. By bringing CYPMHS, AAEDS and Adult Mental Health services together within KMMH, the transfer supports pathway integration, reduces organisational barriers to care and creates opportunities to redesign services around population need rather than organisational boundaries. This aligns with the MHLDA commissioning intention to develop a consistent all-age model of care focused on prevention, early intervention, improved outcomes and equitable access to services.

The transfer demonstrates how the ICB is using its commissioning levers to drive improvement and secure delivery of strategic priorities. Through the establishment of a comprehensive assurance framework, robust governance arrangements, risk-based oversight and clearly defined contractual expectations, the ICB maintained strong oversight of quality, safety, workforce readiness, digital preparedness and service continuity throughout the transfer. This reflects the goal set out within the MHLDA commissioning intentions to strengthen quality assurance, improve provider accountability and use contract management arrangements to drive service improvement and outcomes.

The successful mobilisation and transition of services also support the development of a high-performing commissioning organisation by demonstrating effective programme

governance, collaborative working across providers and system partners, evidence-based assurance processes and clear routes for escalation and decision-making. As the programme moves from mobilisation to business-as-usual oversight through the Contract Management Committee, the ICB is embedding sustainable arrangements that enable continued scrutiny of quality, performance, outcomes and risk.

3. Q1 REVIEW OF THE TRANSFER OF CYPMHS AND AAEDS TO KMMH

Background

NHS Kent and Medway confirmed the award of the IAAMHS contract to KMMH through the Provider Selection Regime Regulation 6(3) Direct Award A route in July 2025. The Trust was identified as the single capable provider for the full range of services required and the contract commenced on 1 April 2026.

The contract award meant the transfer of CYPMHS and AAEDS from the existing provider, NELFT, to KMMH, bringing them together with KMMH's existing Adult Mental Health services. The move to an all-age model ensures care closer to communities, remove transitions that lead to fractured pathways and establishes a consistent service offer from childhood through adulthood within the context of a family-approach.

Safe transfer

The ICB considered safe transfer of services as the delivery of uninterrupted, clinically governed services from day one, with statutory compliance, digital operability, workforce readiness and robust governance in place. Practically, this was judged across six domains:

- clinical continuity and prescribing
- safeguarding
- digital infrastructure and clinical applications
- statutory registrations and regulatory compliance
- workforce onboarding and supervision
- contractual mobilisation and financial control.

Assurance governance and oversight

The ICB established an Assurance Framework, Transfer Risk Register and governance structure in July 2025 which introduced a clear route for tracking progress, identifying risks, collecting evidence and escalating concerns that needed executive attention.
Figure 1 outlines the ICB, KMMH and NELFT governance structures. ICB leads worked directly with KMMH subgroup chairs to gather evidence, review variant positions and integrate findings into a monthly report for the ICB Assurance Group. The Assurance Framework was a live tool and provided early visibility of gaps that threatened day one readiness.

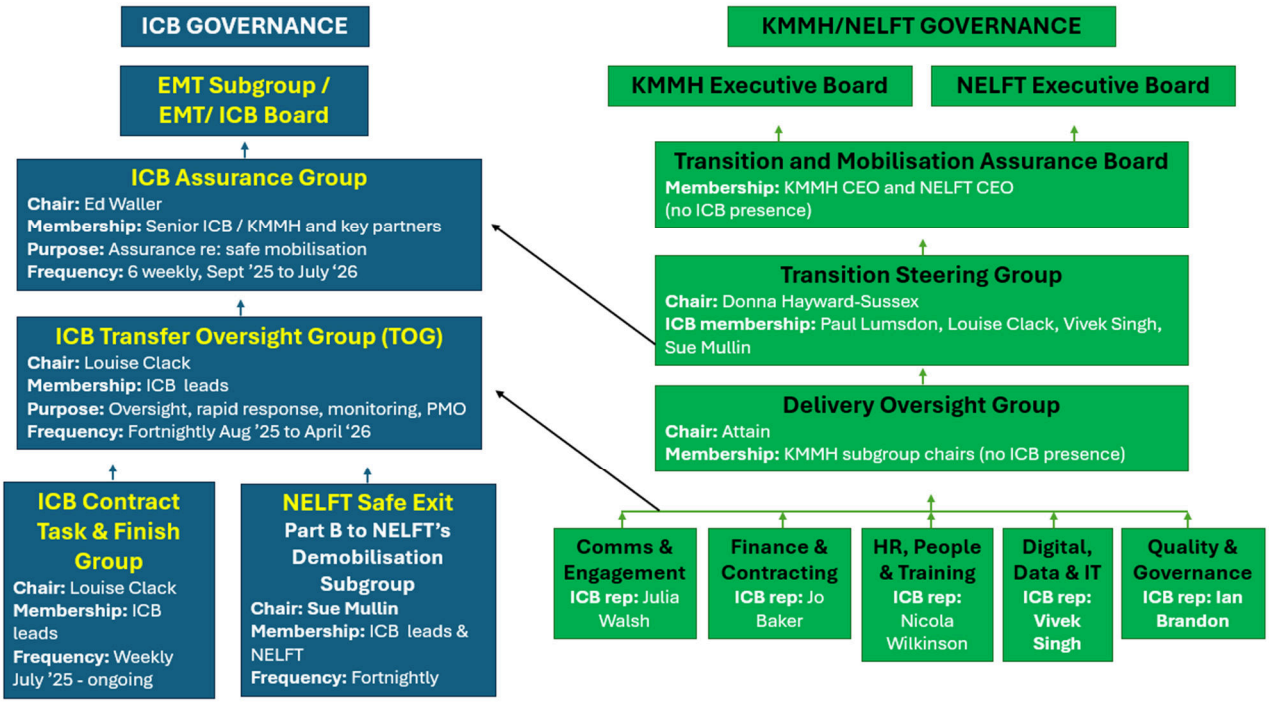


Figure 1

Assurance Process

The Assurance Framework set out the evidence required for each domain with timeframes for submission. The Transfer Risk Register recorded risks, interdependencies and mitigations. Items rated twelve or above were prioritised for ICB Assurance Group meetings.

In November 2025, two key composite risks were reported and related to Quality, Patient Safety and Safeguarding and to Digital, Data and Information Technology.
These risks were formally escalated to the ICB Corporate Risk Register following discussion. KMMH received formal correspondence setting out expectations on contract readiness, incentive funding requirements and day one digital contingencies.

Quality, Patient Safety and Safeguarding

Enhanced quality and safety oversight for the transfer was delivered through weekly monitoring in the initial phase and monthly deep dives via Provider Quality Meetings (PQM) and contract governance, with escalation to Executive and Board where required. By the end of Q4 2025/26, the Quality, Patient Safety and Safeguarding had been resolved, and only the Digital, Data and Information Technology risk remained.

Digital, Data and Information Technology

The composite ICB Corporate Risk relating to Digital, Data and Information Technology was closed in May 2026. NELFT and KMMH signed a service level agreement for NELFT to deliver digital support during 2026/27 whilst a Digital Transfer Plan progresses.
This requires continued oversight from the ICB, which is happening via the contract management approach within the Finance and Technical meeting. The Digital Transfer Plan

and a risk rated assessment of key milestones, produced by KMMH's Digital Mobilisation Team, will be provided monthly by KMMH for assurance. Either the ICB's Chief Technology Officer and/or Deputy Director for Digital Delivery will attend the Finance and Technical meeting during 2026/27 to ensure strategic oversight of this workstream.

Pre-transfer Outcome

The ICB was satisfied that assurance was provided across quality, workforce and operational readiness. The transfer of services happened safely, no risks transpired and the oversight process the ICB had in place was successful.

Continued assurance in Q1

Success measures

KMMH worked with ICB leads to create a pack of Service Transfer Key Performance Indicators which identified the measures of success and were further developed by the KMMH sub-groups. These metrics were reviewed by ICB leads and incorporated into a suite of PMO tools to support the successful service transfer on 1st April.
The measures of success covered:

- Programme structure, governance and management
- Comms and engagement
- HR and people
- Quality and governance
- Finance, contracting and estates
- Digital

The measures outlined, alongside the day-1 to day-90 milestones (as defined in the critical path), were included in the 90-Day Transition Progress Tracker. The 90-Day Transition Progress Tracker was used to track progress following the transfer and support the transition into Business as Usual.

The information collated was also reported to the KMMH led Steering Group the CYPMHS and AAEDS Board Sub Committee.

KMMH's Q1 performance against the identified success measures was reviewed and ratified at their Delivery Oversight Group on 14 July, before being shared with the CYPMH and AAEDS Mobilisation and Transition Steering Group on 20 July.

All six areas of the success measures were RAG rated as green within the July update, except for digital which was RAG rated as amber.

In terms of Quality and Governance, representatives from CYPMHS and AAEDS have been participating in Trust-wide meetings and there have been no complaints or patient safety incidents related to the transition of services. Participation forums have raised no concerns around transitions, and whilst there has been some positive feedback, the majority of patients and families remain largely unaware of the transition, which was one of KMMH's benchmarks for success.

Regarding the financial position of the Trust, the November 2025 due diligence identified a material underlying financial risk. The Quarter 1 review indicates a lower immediate in-year risk than anticipated, reflecting vacancies, lower temporary staffing costs. As the position is based on limited early data, further work is needed to confirm the recurrent cost base and income, including establishment, demand and capacity, commissioning and support costs. This will be monitored within the Financial and Technical meeting (see Contract Management approach section).

KMMH staff welcome and listening events

KMMH Staff Welcome Events and bespoke Welcome Packs were highly valued with 80% attendance and 92% rated face to face events at 4 or 5, out of 5.

KMMH's listening events were held with CYPMHS and AAEDS colleagues who transferred to hear feedback regarding:

- how the transition from NELFT to KMMH went,
- what is going well within teams and what challenges KMMH can support with,
- ideas for future transformation of services, and
- ideas for transition transformation for YP moving into adulthood.

The listening events were facilitated by KMMH's HR business partner, comms lead, Deputy Director of Psychological Therapies, Associate Director of Quality, Associate Medical Director and either the Interim Service Director or an Associate Director deputising. In total, 17 listening events were held, with all children's services (ICB commissioned and CYPMHS Provider Collaborative commissioned) and AAEDS.

Feedback regarding the transfer to KMMH was extremely positive, no disruption to patient care was reported, and some staff said that the transfer had had no noticeable impact. Full findings will be shared with the ICB via the Performance, Service Improvement and Integration Group.

A Pulse Survey was conducted in July to add further insight regarding staff experience; however, findings are not available yet. The directorate pulse survey was delayed to reduce pressure on staff.

Contract management approach

The Contract Management Committee (CMC) is the primary forum through which the ICB oversees the IAAMHS contract with KMMH. The CMC provides executive oversight of contract delivery, performance, quality, finance and risk, ensuring services are safe, effective and sustainable. It is the formal point for assurance, escalation and decision-making within the contract governance framework.

The CMC reviews escalated risks and issues, tests the adequacy of assurance and determines whether further action, escalation or contractual intervention is required. Matters beyond its remit are escalated through the Strategic Commissioning Subgroup and, where necessary, to Executive Committee or Board level.

The CMC sits within the wider contract governance structure and receives assurance and escalation from supporting groups (figure 2) including:

- Performance, Service Improvement and Integration Group
- Provider Quality Meeting
- Finance and Technical Group
- Service-specific groups



Figure 2

The Contract management approach enables continued scrutiny of quality, performance, outcomes and risk. This provides assurance that the benefits of the transfer can be realised over the longer term, while supporting the efficient use of resources and creating the conditions necessary to deliver future transformation of MHLDA services across Kent and Medway, including embedding continued learning.

4. KEY RISKS, MITIGATIONS, AND CONTROLS

Although no significant transfer risks remain open, the following residual risks will continue to be managed through business-as-usual contract management arrangements:

Risk	Mitigation
Digital transition remains dependent on NELFT support arrangements whilst the Digital Transfer Plan is completed.	Monthly oversight through the Finance and Technical Group, milestone tracking and senior ICB digital assurance.
Full recurrent financial position of the transferred services is still being validated using Q1 data.	Ongoing financial monitoring and review through contract governance arrangements.
Benefits of integration and transformation may not be fully realised without continued oversight.	Quality, performance, finance and risk monitoring through the Contract Management Committee and supporting governance structure.

5. OTHER CONSIDERATIONS

There are no other considerations.

6. REQUIRED OUTCOMES AND NEXT STEPS

1. To assure the Board that the transfer of CYPMHS and AAEDS has been successfully completed.

2. To confirm to the Board that ongoing monitoring and assurance will take place via the contract management process and update to scrutiny committees will be through established routes for briefing.

7. SUPPORTING DOCUMENTATION

The following documents are available to support the content of this paper:

- Success measures (July 2026), request via kmicb.mhlda@nhs.net

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Kent and Medway Maternity Service Review Phase 1 Outputs: Co-Designed Terms of Reference Elements and Tabletop Exercise
Key question	Does the Board endorse the co-designed Phase 1 outputs for the Maternity Services Review as the basis for the Review's next steps?
Executive Lead	Jennie Hall OBE, Chief Nursing, Experience and Quality Officer (SRO)
Authors	Akeso (Programme support, and dashboard and data pack development); Jennie Hall OBE, Chief Nursing, Experience and Quality Officer (SRO); Dominic Cox, Interim Deputy Chief Commissioning Officer; Charlotte Gibson, Associate Director for Maternity, Neonatal and Women's Health Services (Programme Lead)

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☒ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☐ Seek assurance ☒ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

The Board is asked to:

- Endorse the co-designed Phase 1 outputs presented within this paper, to be finalised into Terms of Reference elements for the review.

- Recommend the Programme Board Terms of Reference (Appendix 1) to the ICB Board for approval via Chairs Action.
- Note that future recommendations relating to service configuration, commissioning requirements or model of care changes will be developed through subsequent phases of the Review and brought back through appropriate governance routes.

Executive summary:

The NHSE Regional Team commissioned in July 2026 a region wide review of maternity and Neonatal services in all 4 ICBs in response to the Amos Review. Kent and Medway ICB will be an active participant of the regional work, it has been agreed that the Kent and Medway Maternity Services review will continue to progress at pace both the terms of reference for the review and agreed programme timetable, alongside support of the wider review process.

The Kent and Medway Maternity Services Review remains the ICB's primary commissioning response to the national Maternity and Neonatal Investigation (the Amos Review) and to sustained safety, quality and sustainability challenges across local maternity services. Phase 1 of the Review was approved in principle by Executive Committee in June 2026, with the Terms of Reference (ToR) and co-design approach subsequently approved by Board in July 2026.

A multi-agency Provider Engagement Event was held on 5th August 2026 to co-design the elements intentionally left open within the July Terms of Reference. Participants included provider trusts, the Maternity and Neonatal Voices Partnership, local authority partners, primary care representatives, VCSE organisations and system stakeholders. The event achieved agreement on the framing of the case for change, priority review objectives, key lines of enquiry for the Phase 1 tabletop exercise, and the principles underpinning a shared Memorandum of Understanding. These outputs have been validated with participants and re-issued via a co-signed letter from the CEO and CNO to support formal provider endorsement through Trust Board governance processes.

Phase 1 analytical work has established a foundational evidence base across the co-designed domains. The emerging picture is not of a single, uniform maternity challenge across the system. System-level averages are often reassuring, but they mask material variation in population need, pathway use, outcomes, workforce resilience, experience and cost between providers. Specific safety signals require targeted assurance, particularly around neonatal outcomes; earlier booking access has improved but gains are not being experienced equally by women from the most deprived communities; substantive workforce capacity has grown but safe staffing sufficiency is not yet consistently evidenced against a validated methodology; and provider cost variation is substantial but cannot yet be explained by activity and case mix alone. These findings reinforce the need for a full model of care review across all four layers of care, with the response targeted by provider, population and place rather than a uniform system-wide intervention.

This paper seeks Board endorsement of the co-designed Phase 1 outputs and the proposed arrangements for progressing into the next steps for the Review.

Proposed next steps:

The following next steps should be noted:

- Secure provider endorsement of the co-designed outputs. These have been issued via a co-signed letter from the CEO and CNO of the ICB with instructions to take the outputs through the relevant Trust Board endorsement processes.
- Progress the Independent Clinical Chair and Deputy appointment.
- The inaugural Programme Board meeting will take place on 17 September and seek to provide context to the wider commissioning cycle; discuss the programme plan for Phase 2; approve the Programme Board ToR; discuss the Data Subgroup membership and ToR; note the Memorandum of Understanding.
- Return emerging findings and recommendations through future Executive Committee and Board updates.

Governance pathway to date:

Meeting name:	Date:	Outcome:
Executive meeting (Ed Waller, Paul Lumsdon, Kate Langford, Dominic Cox, Becky Fox-Collins, Charlotte Gibson)	16/04/26	Review agreed in principle. For discussion at ExCo 6 May
Executive Committee	06/05/26	Review agreed in principle. Paper outlining Programme Proposal to ExCo 10 June.
Executive Committee	10/06/26	Programme and governance approach approved in principle. Three Phase 1 outputs agreed by September 2026. Monthly ExCo updates and July Board paper committed. Resource case to follow.
Executive Committee	08/07/26	Phase 1 progress notes; Programme Board governance structure approved
ICB Board	21/07/26	Fixed Terms of Reference for the Review elements approved (strategic alignment and scope, methodology, governance, indicative timeline)
Provider Engagement Event	05/08/26	Co-designed Terms of Reference for the Review elements (framing of case for change, objectives of review, scope of review)
Executive Committee	09/09/26	Agreed Terms of Reference and Approach for Phase 2 of the Programme

Contact for further information	Jennie.hall1@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

Not applicable – this phase of maternity work is not yet recommending options for the future model of care, when this is addressed, a EHQIA will be completed. No configuration decisions are being taken through this paper.

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?
☒ Yes ☐ No

One of the authors, Charlotte Gibson, was previously a Consultant Midwife at Kings College Hospital (2013-2022) and MTW (2022–2024)- one of the four provider trusts within the Review's scope. This is a declared conflict of interest, managed through standard ICB governance and clinical oversight arrangements.

FOI status

Is this report disclosable under FOI?
☒ Yes ☐ No

Our understanding is that there is no legal exemption for why this paper should not be disclosable under FOI, unless deemed otherwise by the Committees Team.

Financial implications

Are there financial implications associated with this report?
☒ Yes ☐ No

Financial modelling is deliberately sequenced to follow Phase 1 rather than precede it, so that evidence and engagement inform costed options rather than the reverse. No financial commitment is sought through this paper; full modelling will be brought to Board alongside any future configuration recommendation.

Legal implications

Are there legal implications associated with this report?
☒ Yes ☐ No

This paper does not itself engage the statutory service reconfiguration process. Should the Review's findings lead to a recommendation for configuration change, the full statutory route- including HOSC and HASC oversight, a case for change and public

COMPLIANCE NOTES:
consultation where thresholds are met would apply and would be brought to the Board for decision.

Quality and safety implications
Are there quality or safety implications associated with this report? ☒ Yes ☐ No Central to this paper. The Review is driven by active safety escalation: three of four provider trusts are on NHS England Southeast Enhanced Support and Oversight and its methodology is grounded in MBRRACE-UK safety thresholds and the national Saving Babies' Lives programme, already reflected in the confirmed 2027/28 commissioning intentions metrics.

Patient and public engagement
Are there patient and public engagement implications associated with this report? ☒ Yes ☐ No *If yes, please describe. If no, please specify why:* MNVP have been key stakeholders throughout the co-design elements of this process and will be members of the Programme Board from the outset. Future patient and public engagement will be required, and will be coordinated accordingly with Comms and MNVP and reported to the Board when appropriate.

KENT AND MEDWAY MATERNITY SERVICE REVIEW PHASE 1 OUTPUTS: CO-DESIGNED TOR ELEMENTS AND TABLETOP EXERCISE

1. INTRODUCTION

This paper provides the next Executive Committee update on the Kent and Medway Maternity Services Review, following approval of the programme in principle on 10th June 2026 and subsequent approval by the ICB Board of the fixed elements of the Review on 21 July 2026.

As set out in the July papers to ExCo and ICB Board Part 1, a number of core elements were deliberately reserved for co-design with providers and system partners before being finalised. On 5 August 2026, the ICB convened a Provider Engagement Event bringing together provider trusts, MNVP representatives and wider system partners to undertake that co-design exercise.

The scope and terms of the Review are defined through two governance decisions: the fixed elements approved by the ICB Board in July (strategic alignment, scope, methodology, governance structure and indicative timeline) and the co-designed elements presented in this paper (framing of the case for change, prioritised review objectives, key lines of enquiry and the Memorandum of Understanding). Together, these define what the Review covers and how it is conducted. The Programme Board Terms of Reference (Appendix 1) is a separate document that sets out how the delivery of the Review will be governed and overseen within the agreed scope.

This paper presents the co-designed outputs for endorsement, summarises the foundational analytical work undertaken during Phase 1, and sets out the proposed arrangements for progressing into the next phase of the Review. Full detail of the outputs can be found in the appendices:

Appendix 1: Draft Terms of Reference for the Maternity Review Programme Board

2. STRATEGIC ALIGNMENT

The Maternity Services Review aligns to all five of the ICB's strategic objectives, as set out in the July 2026 Board paper. To avoid duplicating information already reviewed by Executive Committee and Board, the detailed strategic alignment has not been reproduced here. The outputs presented in this paper represent the delivery of Phase 1 commitments previously approved and further support the ICB's objectives to commission the right services, lead strategic commissioning, improve organisational performance, deliver long-term sustainability and ensure future commissioning decisions are evidence-based and co-designed.

3. CO-DESIGN PROCESS OVERVIEW

The Maternity Review Provider Engagement Event was held as a half-day event on 5th August 2026. Consistent with the co-design approach approved by the ICB Board – Part 1

in July 2026, the event focused on the elements of the Review that had intentionally been left open within the approved Terms of Reference. Representatives from the following organisations were present at the event and contributed to the co-design process:

NHS England	East Kent Hospitals University NHS Foundation Trust	VitalHub UK
Medway NHS Foundation Trust	Kent County Council	Maternity and Neonatal Voices Partnership
Maidstone and Tunbridge Wells NHS Trust	Kent Community Health NHS Foundation Trust	South East Coast Ambulance Service NHS Foundation Trust
Dartford and Gravesham NHS Trust	Medway Community Healthcare CIC	NHS Kent and Medway Integrated Care Board
Medway Council (Public Health)	Kent and Medway Mental Health NHS Trust	Maternal Medicine Network

Participants were asked to:

- agree the framing of the case for change;
- refine and prioritise the Review objectives;
- shape the scope and key lines of enquiry for the Phase 1 tabletop exercise;
- agree principles for participation, endorsement and disagreement resolution through a shared Memorandum of Understanding.

Draft outputs were subsequently circulated for validation and amendment before finalisation. The outputs presented in this paper represent the validated co-designed position, which have been re-issued to Providers via CEO letters to be taken through their internal board endorsement processes.

4. CO-DESIGNED OUTPUT 1: PROGRAMME GOVERNANCE

To support the next phase of the Review, a multi-agency Programme Board and supporting Data Subgroup are being established. The Programme Board which will meet fir the first time on 17 September will provide independent clinical and strategic oversight of the Review, ensuring providers, system partners and service users are actively involved in shaping its direction while maintaining an evidence-led approach. Reporting to the Programme Board, the Data Subgroup will oversee development of the Review's analytical framework, including refinement of the co-designed key lines of enquiry, review of emerging findings and assurance of the evidence base underpinning future recommendations. Together, these groups will support transparent decision-making and collective ownership of the Review's outputs.

Joint Memorandum of Understanding

A key output of the co-design process was agreement on the principles that will underpin participation in the Review. These principles have been consolidated within a jointly developed Memorandum of Understanding covering:

- expected behaviours and ways of working;
- organisational participation requirements;
- endorsement processes;
- disagreement resolution mechanisms;
- principles of transparency, evidence sharing and collective problem solving

Co-Designed MoU Statements

#	Agreed MoU Statements Underpinning the Maternity Services Review
1	We will share all data requested by the review team unless a legal restriction prevents this
2	We will prioritise system outcomes over organisational interests where appropriate, whilst recognising statutory responsibilities, operational constraints, and Trust priorities
3	We will be transparent about areas where we know our services could be improved, and support the identification of opportunities for improvement across the system
4	We will commit sufficient executive, clinical and operational leadership time to support timely delivery of the review, working collaboratively to manage competing priorities where they arise.
5	We will jointly own the review findings, and support recommendations, regardless of which organisation is referenced
6	We will support knowledge sharing and access to existing information and documentation where appropriate
7	We will review and comment on draft outputs within agreed timescales and communicate promptly where exceptional circumstances may affect our ability to do so.
8	We will contribute our relevant expertise to the review, including providing support with engaging different stakeholder groups
9	We will participate in governance arrangements where agreed

This was shared with providers for comment, with clear confirmation that no comment defaulted in acceptance of the MOU. This will be shared again for information at the first Programme Board.

5. CO-DESIGNED OUTPUT 2: FRAMING FOR CASE FOR CHANGE

Consistent with the scope approved by Board in July 2026, the Provider Engagement Event focused on co-designing key elements to inform the Review's evidence base and future case for change, rather than seeking agreement on a final case for change. Participants reaffirmed the Review's scope across maternity, neonatal and women's health services and all four layers of care, whilst refining the areas for further investigation through the Phase 1 analytical programme and tabletop exercise.

Case for Change Framing

Stakeholders discussed the national and local context that frame the Review and identified a shared set of strengths, challenges and strategic opportunities that will provide the foundation for the emerging case for change. The agreed themes are summarised below.

Theme	How it Frames the Review
National Context	Investigations, including the nationally conducted Amos Review and Thirlwall Inquiry, identified serious failures in listening to families as well as racism / inequality as critical safety issues, reflected in access, pathway, and prevention outcomes
Local Challenges	Maternity services report facing significant safety, workforce & sustainability challenges, with three provider trusts in NHS England Enhanced Support and Oversight and continued variation in access, experience and outcomes
Strategic Opportunity	As K&M's first system-wide maternity review, this programme will bring together evidence, lived experience and provider expertise to create a shared evidence base for future commissioning decisions and delivery of the 2027/28 Commissioning Intentions
Current Strengths to Preserve	Strong clinical/leadership expertise; active MNVP engagement; good safety and quality outcomes; culture of improvement, learning and transparency
Consistent Pressures Across Trusts	Workforce sustainability; rising complexity and demand; financial and estates constraints; variation across trusts; inequalities in access and outcomes

Finalised Review Objectives

Through the engagement event, a longlist of drafted review objectives were prioritised and amended to a final set as shown in the list below which have been agreed with attendees.

Co-designed Objectives for the Review

1. **To Listen to and Partner with Women, Birthing People and Families** by embedding service user voice in governance, design and delivery of services
2. **To Tackle Racism, Discrimination and Inequality as a Patient-safety Issue,** reducing unequal outcomes through culturally informed care, robust reporting of inequality data and targeted actions plans
3. **To Improve Safety, Quality and Outcomes Accountability,** reducing unwarranted variations and recurring risk through clear, monitored standards
4. **To Strengthen Leadership, Culture and Clinical Parity,** building resilient, shared clinical leadership, through consistent engagement, improved culture and multidisciplinary working
5. **To Define the future configuration of Maternity, Neonatal & Women's health services** across all Four Layers of Care **to deliver sustainable, high-quality personalised care and workforce capacity across K&M**

Identified as a supporting theme across Objectives

- Improve Access, Pathways and Prevention

Outcomes to be achieved by addressing the Agreed Objectives

- Strengthen System Integration and Collaboration
- Strengthen Governance, Accountability & Commissioning Levers
- Improve Financial Sustainability and Value for Money

The co-designed objectives provide the shared framework against which future models of care and configuration options will be assessed. Because they were shaped by providers, service users and system partners before any options exist, the appraisal framework cannot be characterised as having been designed around a preferred answer.

6. CO-DESIGNED OUTPUT 3: PHASE 1 TABLETOP EXERCISE

As agreed by the Board in July 2026, the Phase 1 tabletop exercise provides the analytical foundation for the Review. Using the K&M Maternity Dashboard developed by Akeso for the system, it brings together population health, performance, quality, inequalities, workforce, financial and service user intelligence into a single system-wide evidence base, informed by national maternity policy, ICB strategic priorities and the Four Layers of Care framework.

The scope of the exercise was co-designed through the Provider Engagement Event, which identified seven core domains for investigation listed below:

Tabletop Co-developed Data Domains:	
Safety	Activity
Access	Equity
Workforce	Experience and Engagement
Cost and Value for Money	

These domains reflect the issues most consistently raised by providers, service users, commissioners and system partners, and align with the Review objectives and wider national strategic context.

The tabletop exercise designed to test, rather than assume, the factors influencing the core domains across Kent and Medway maternity and neonatal services. Led by Akeso, the analysis triangulates evidence across providers, pathways and populations to identify areas of strength, variation and potential concern.

A multi-organisational Data Subgroup, reporting to the Programme Board, will be established to refine and prioritise key lines of enquiry, oversee development of the maternity dashboard and supplementary analysis, identify data gaps, and provide assurance that findings are grounded in robust evidence and shared system intelligence.

Phase 1 findings therefore narrow the questions rather than predetermine the answers. They provide an evidence-led basis for identifying where assurance or action may be required, where variation needs to be better understood, and what additional intelligence is needed before future commissioning recommendations or potential changes to models of care are considered, for further refinement by the Data Subgroup.

Findings from the Tabletop Analysis

Phase 1 shows that maternity need is not uniform across Kent and Medway, with full detail of the analysis available in the Appendix. Population health analysis identifies distinct patterns of need, risk and service use by population and place, providing the strategic commissioning frame through which provider and pathway variation should be interpreted. The Four Layers of Care provide a complementary lens for testing whether prevention, community, acute and specialist provision are aligned to that need. Against this context, system averages can mask important differences in access, outcomes, workforce resilience, experience and cost. The evidence therefore supports a more population-led response, while retaining common standards, rather than a single system wide intervention or conclusions on any future configuration at this stage.

Domain	What the evidence says	What this means
Population	**Pregnancy and service use patterns differ materially by population and place.** The highest pregnancy rate cohort is Black, Black British, Caribbean or African women aged 30–39 in more deprived areas; Medway PCNs feature strongly in high maternity inpatient use, while coastal areas show greater proportional reliance on urgent care. Neighbourhood clustering identifies materially different population and service use profiles.	Population need should frame interpretation of all subsequent domains. Commissioning should test whether prevention, pathway design and capacity across the Four Layers of Care match local volume, risk and utilisation.
Equity	**Need and risk are not evenly distributed.** National MBRRACE evidence gives the local ethnicity finding direct safety relevance, while lived patient experience describes language barriers, discrimination, fragmented pathways and women not feeling listened to.	Equity should be embedded as a core principle throughout the review and across the whole pathway, with outcomes, access and experience systematically segmented by ethnicity, deprivation and geography.
Access	**Significant provider variation exists.** 10-week booking has improved overall but trust performance varies. Women from the most deprived deciles appear less well represented in timely booking than the national average. Recorded Continuity of Carer (CoC) by 28 weeks is 1–2% versus 17–19% nationally, and 0.5%-1% in later pregnancy creating an access, equity and safety risk against national guidance.	Improved access is not being delivered equally across the system and is not translating into consistent care continuity. Phase 2 should distinguish genuine pathway barriers from population composition and data-quality effects.
Safety	**The evidence does not identify a common system-wide safety failure.** EKHUFT has the clearest emerging neonatal mortality signal. MFT has recurring preterm birth / low-birth-weight signals	Target assurance and improvement where safety signals cluster, while testing case mix, population risk, service configuration and

	alongside higher population complexity, while mortality outcomes have improved and finish below peer average.	referral / transfer patterns before attributing cause.
Activity	**Overall maternity activity is broadly stable, but aggregate volumes mask increasing complexity and significant variation in pathway use and capacity.** C-section rates have recently been above national levels across all Robson groups at nearly all providers, with particularly high obesity rates at EKHUFT and MFT. Capacity is also unevenly utilised, with high NICU occupancy at MMH alongside comparatively low utilisation at WHH.	Capacity planning should therefore reflect the distribution, complexity and nature of demand not historic birth volumes alone and with particular focus on intervention rates, population risk and how specialist capacity is utilised across the system.
Workforce	**Substantive registered midwife capacity has increased and agency use is negligible, but growth is uneven.** MFT has seen the highest increase while EKHUFT remains below its Apr-24 position. Absence is 6.1% vs. 4.7% regionally and bank use is concentrated at MTW and MFT.	The workforce model is less agency-dependent, but resilience remains uneven. Funded establishment fill is not a proxy for safe staffing sufficiency or alignment to pathway need.
Experience	**Provider and group variation persist** despite comparatively positive system-level maternity recommendation measures. Recent deterioration and limited postnatal community experience evidence warrant follow-up. Workforce experience also shows pressure, including low 'feeling valued' and recognition scores.	Patient and staff experience provide an additional resilience lens and should be triangulated with access, safety and capacity rather than interpreted in isolation.
Cost	**Indicative costing shows substantial provider variation.** DGT is the largest obstetric cost outlier and MTW shows a significant midwifery cost despite being lower acuity sites, but differences are not consistently explained by activity alone and known coding / data-quality issues remain.	Cost variation is a line of enquiry, not yet an efficiency conclusion. Provider activity, case mix, pathway configuration and costing methodology must be reconciled first.

Implications for Strategic Commissioning

Phase 1 points towards a more differentiated approach to commissioning, reflecting variation in population need, pathways and providers. The next phase should test drivers of this variation and expand on what this means for services across the Four Layers of Care.

Strategic Implication	What this means
Plan around population need and pathways	Use PHM and the Four Layers of Care to test whether prevention, community, acute and specialist provision reflects local need. Common system standards may require different responses by population, place and pathway.
Differentiate assurance by provider	The evidence does not support treating provider variation as a single issue. • EKHUFT requires focused cross domain assurance. • MFT needs further testing of complexity, outcomes and utilisation. • DGT and MTW have distinct access, workforce, cost and data quality challenges to address.
Separate immediate priorities from longer term change	Use validated findings to inform quality improvement and FY27/28 commissioning priorities, while longer term model of care or configuration decisions are developed through subsequent Review phases.
Establish the evidence needed for future decisions	Safe staffing requirements and material data quality gaps must be resolved before drawing conclusions on capacity, sustainability, value or future service change.
Test relationships that could change commissioning decisions	• Phase 2 should test how population need, access and continuity relate to intervention and outcomes • How complexity drives workforce demand • How activity and case mix influence cost

Phase 1 supports	Phase 1 does not support
Targeted provider assurance, differentiated population and pathway analysis, formal closure of evidence gaps, testing commissioning implications and development of a robust case for change.	A conclusion that any provider is inherently unsafe, a single uniform system response, relative efficiency judgements or reconfiguration options based on current data alone.

Key Evidence Gaps and Immediate Priorities

Phase 1 has narrowed the questions materially. The priority now is for the Data Subgroup to validate the findings, close the gaps that constrain assurance and deepen only the analysis that could change quality, commissioning or future service model decision.

Priority area	Material gap	Action
Clinical & safety assurance	EKHUFT neonatal mortality detail, MFT risk adjustment, site level outcomes, referral / transfer flows and wider clinical context.	Validate priority findings through providers, Maternity Data Subgroup and appropriate clinical / CMDT and quality governance. Progress focused on EKHUFT assurance through existing routes.
Workforce & capacity	Provider safe staffing requirement, Birthrate+ / PWR reconciliation, NHSE neonatal staffing and cot capacity, MTW establishment denominator.	Reconcile recognised requirement → funded establishment → substantive / temporary workforce → activity / acuity across maternity and neonatal care.
Population, access & experience	Validated CoC denominators, fuller ethnicity / deprivation segmentation, pathway barriers by cohort and place and limited postnatal community experience.	Issue targeted data requests and link population, access, continuity, experience and outcomes across the Four Layers of Care.
Activity, cost & data quality	MSDS / activity completeness, provider coding anomalies, PLICS / SUS reconciliation, case-mix and direct-cost baseline.	Validate coding, activity and costing with providers before productivity or value judgements, assign ownership and resolution dates for material data quality issues.

Next phase of the review

Phase 1 provides a stronger evidence base for the Review and a clear plan for the next phase: validate the priority findings, progress targeted assurance where required and close the evidence gaps that materially affect decision making. This will provide the basis for future commissioning and model of care recommendations, providing sufficient opportunity for continued coproduction, without predetermining service configuration.

Key takeaway

Maternity need is not uniform across Kent and Medway and the evidence does not support a single system wide response. PHM provides the strategic lens for understanding where need and risk sit and the Four Layers of Care give the framework for testing if services address that need. Phase 1 therefore infers a more population-led and differentiated approach to future commissioning, subject to validation through subsequent phases.

7. KEY RISKS, MITIGATIONS, AND CONTROLS

Risk	Mitigation	Control
Delay in appointing an Independent Clinical Chair impacts establishment of Programme Board governance arrangements.	• Progress recruitment and appointment process through agreed channels • SRO to chair initial Programme Board meetings until appointment confirmed	• Appointment progress monitored through programme governance • Governance arrangements reviewed and approved at Programme Board
Provider endorsement is not secured across all Trust Boards, weakening shared ownership of the Review and its outputs.	• Confirm endorsement routes and timelines with each trust • Agree dispute resolution and escalation mechanisms through the validation process	• Regular tracking of endorsement status across providers • Escalation of emerging concerns through Programme Board governance
As the review gains public visibility, any output or briefing framed as implying a predetermined configuration outcome compromises the legal defensibility of any future consultation.	• Review all outputs against pre-determination criteria before publication • Maintain a clear audit trail demonstrating an evidence-led and co-designed process	• Communications and outputs subject to governance review • Ongoing compliance with agreed review scope, objectives and decision-making framework
Incomplete availability of the data required to support the tabletop exercise limits the ability to test, validate and evidence co-designed lines of enquiry, affecting the robustness of review findings and recommendations.	• Establish Data Subgroup to prioritise and coordinate data requests • Document and communicate data limitations transparently where evidence is unavailable	• Regular review of data quality and completeness through the Data Subgroup • Escalation of significant data risks through programme governance
Delays in Programme Board and Data Subgroup nominations impact mobilisation and delivery of Phase 1 activity.	• CEO letter issued requesting nominations by an agreed deadline • Targeted follow-up with organisations where nominations remain outstanding	• Weekly monitoring of membership status and vacancies • Programme Board ToR approved at first meeting and reviewed periodically

8. REQUIRED OUTCOMES AND NEXT STEPS

The meeting is asked to:

- Endorse the co-designed Phase 1 outputs presented within this paper, to be finalised into Terms of Reference elements for the review.
- Recommend the Programme Board Terms of Reference (Appendix 1) to the ICB Board for approval via Chairs Action.
- Note that future recommendations relating to service configuration, commissioning requirements or model of care changes will be developed through subsequent phases of the Review and brought back through appropriate governance routes.

The following next steps should be noted:

- Secure provider endorsement of the co-designed outputs. These have been issued via a co-signed letter from the CEO and CNO of the ICB with instructions to take the outputs through the relevant Trust Board endorsement processes.
- Progress the Independent Clinical Chair appointment.
- The inaugural Programme Board meeting is scheduled for 17th September and will seek to: provide context to the wider commissioning cycle; discuss the programme plan for Phase 2; approve the Programme Board ToR; discuss the Data Subgroup membership and ToR; note the Memorandum of Understanding.
- Return emerging findings and recommendations through future Executive Committee and Board updates.

9. SUPPORTING DOCUMENTATION

The following documents are available to support the content of this paper:

Appendices:

Appendix 1: Maternity Review Programme Board Terms of Reference

Maternity Services Review Programme Board

Terms of Reference

1. Purpose

1.1 The Maternity Services Review Programme Board (the Programme Board) is established to oversee the delivery of the Kent and Medway Maternity Services Review (the Review), provide independent clinical challenge and assurance to the Review process, and support co-design with providers, service users and system partners. The Programme Board is responsible for overseeing the development of the Review's findings and recommendations and providing assurance regarding the robustness of the evidence, engagement, and decision-making process.

1.2 The Programme Board provides assurance and recommendations to the Executive Committee through the Senior Responsible Officer. Executive Committee retains responsibility for executive oversight of the Review and for consideration of matters within its delegated authority. Matters requiring Board approval or assurance shall be escalated through Executive Committee in accordance with the ICBs governance framework.

1.3 The Programme Board is a time-limited body and will remain in place until completion of the Review and submission of its final recommendations, unless otherwise determined by Executive Committee. Responsibility for consideration of recommendations and oversight of any subsequent implementation arrangements rests with the ICB through its established governance framework.

1.3 The Programme Board is the principal forum for overseeing delivery of the Review's co-design approach, ensuring that commitments made to providers, service users, and system partners are reflected in the Review methodology, evidence base, findings, and recommendations.

2. Authority

2.1 The Programme Board is established by ExCo and the ICB Board as a time-limited governance and assurance body for the duration of the Review. These Terms of

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Reference set out the Programme Board's membership, remit, responsibilities and reporting arrangements and may only be amended with the approval of ExCo.

2.2 The Programme Board has delegated authority to agree matters relating to the conduct of the Review including the methodology, analytical approach, the indicator framework, and the data schedule

2.3 The Programme Board is authorised to request information and data from member organisations as necessary to support the discharge of its responsibilities. Member organisations are expected to respond to reasonable requests in a timely manner.

2.4 The Programme Board may establish time-limited working groups to take forward specific technical or clinical tasks. The Programme Board shall determine the membership and terms of reference of any such groups but shall not delegate decision-making authority to them.

2.5 In exercising its responsibilities, the Programme Board shall act in accordance with the ICB's governance framework, including the Constitution, Scheme of Reservation and Delegation, Standing Financial Instructions and any other relevant policies. Matters falling outside the Programme Board's delegated authority shall be escalated through the appropriate governance route.

Responsibilities and Assurance

3.1 Clinical oversight and assurance

3.1.1 The Programme Board shall provide independent clinical oversight of the Review's methodology, evidence base, and emerging findings, ensuring that the analytical approach is robust, transparent, and consistent with national standards and best practice.

3.1.2 The Programme Board shall receive and consider the outputs of the Clinical Senate review at key stages of the Review and ensure that Clinical Senate recommendations are addressed.

3.1.3 The Programme Board shall satisfy itself that the evidence base is sufficient to support the conclusions drawn from it at each stage of the Review and shall flag to the SRO and the ICB Board where it considers the evidence inadequate.

3.2 Co-design and system ownership

3.2.1 The Programme Board shall ensure that the Review's objectives, scope, and emerging findings are shaped through genuine co-design with providers, service users and system partners, and that the co-design commitments established at the provider engagement events are honoured throughout.

3.2.2 The Programme Board shall ensure that the Maternity and Neonatal Voices Partnership (MNVP) and community partners have meaningful influence in the design and governance of the Review, not solely consultative input.

3.2.3 The Programme Board shall maintain a clear record of how provider, service user and partner input has shaped the Review's outputs at each stage, for inclusion in any future pre-consultation business case or commissioning intentions documentation.

3.3 Endorsement and provider governance

3.3.1 The Programme Board shall oversee the endorsement process for the Review's outputs, coordinating with each provider trust's own governance route and Board cycle to ensure timely endorsement at key decision points.

3.3.2 Members shall act as the standing link between the Programme Board and their own organisation's governance, ensuring that their Board or relevant committee is sighted on the Review's progress and that the Programme Board has sight of their organisation's perspective.

3.4 Pre-determination and process integrity

3.4.1 The Programme Board shall satisfy itself that the Review's process is conducted without pre-determination, that options emerge from evidence and co-design rather than preceding them, and that the Review's outputs are structured to meet the requirements of the NHS service change assurance process should a pre-consultation business case be required.

.4. Membership and Attendance

4.1 *Membership*

4.1.1 The Programme Board shall consist of the following members:

- Independent Clinical Chair
- Independent Deputy Clinical Chair
- SRO (Chief Nursing, Experience and Quality Officer)
- ICB Programme Lead (Associate Director for Maternity, Neonatal and Women's Health)
- Director of Midwifery (or equivalent) from each of the four provider trusts
- One further nominee from each of the four provider trusts, bringing obstetric, neonatal or executive-level perspective to complement the midwifery voice
- A representative nominated by the Kent and Medway MNVP
- ICB primary care representative
- ICB finance business partner
- ICB commissioning lead(s)

4.1.2 The Independent Clinical Chair shall be appointed through the process agreed by the ICB Board. In appointing the Chair, regard shall be given to clinical credibility, independence from the four provider trusts and the ICB, and the importance of professional parity between midwifery and medical leadership.

4.1.3 Members may nominate a named deputy to attend in their absence. Deputies must be of sufficient seniority to represent their organisation's position and to participate in decision-making on their behalf. The Programme Board should be notified in advance where a deputy will attend.

4.2 *Standing Invitations*

4.2.1 The following shall have a standing invitation to attend meetings of the Programme Board:

- NHSE South East regional representative (observer)
- South East Coast Ambulance Service (SECAmb) representative
- NHSE specialised commissioning representative
- ICB engagement and communications lead
- Programme support (in attendance)

4.2.2 Standing invitees shall not be members of the Programme Board and shall not count towards quorum.

4.3 *Attendance by Others*

4.3.1 The Chair may invite other individuals to attend specific items where their expertise or organisational perspective is required to support the Programme Board in discharging its responsibilities. Such attendees shall have no voting rights.

5. Proceedings of Meetings

5.1 The Programme Board shall meet monthly during the initial phases of the Review. The Chair and the SRO may vary the frequency of meetings thereafter, having regard to the requirements of the programme and the need for effective oversight.

5.2 The Chair, acting on their own authority or at the request of the SRO, may convene additional meetings to consider matters requiring urgent attention.

5.3 The quorum for any meeting shall be the Chair (or Deputy Chair), the SRO (or nominated deputy), representatives from at least three of the four provider trusts, and at least one representative from the ICB commissioning function.

5.4 Where a member is disqualified from participating in an item by reason of a conflict of interest, that member shall not be counted towards quorum for that item.

5.5 Where a meeting is not quorate, the meeting may proceed for discussion and information-sharing only. Any recommendations arising shall be subject to confirmation at the next quorate meeting.

5.6 Attendance by virtual means shall be permitted and shall count towards quorum, provided that participants can see and hear one another and have access to all meeting papers.

6. Consensus and Decision-Making

6.1 The Programme Board shall seek to reach its conclusions and recommendations by consensus wherever possible. Where differing views exist, these shall be recorded and reflected in any advice or recommendations provided by the Programme Board.

6.2 Where consensus cannot be reached on a matter within the Programme Board's delegated authority, the Chair shall seek to establish the nature of the differing views and facilitate resolution. If the matter remains unresolved, the differing positions shall be recorded and referred through the Senior Responsible Officer for determination through the appropriate governance route. The final record of the meeting shall accurately reflect any material differences of view.

6.3 Matters falling outside the Programme Board's delegated authority shall be referred through the Senior Responsible Officer for consideration and determination in accordance with the ICB's governance framework and delegated authorities.

6.4 The Programme Board shall maintain oversight of risks relating to the delivery and integrity of the Review and shall review the adequacy of associated controls and mitigations. Risks outside the Programme Board's remit, delegated authority or risk tolerance, or which may materially affect the Review's delivery, quality, statutory compliance or intended outcomes, shall be escalated through the Senior Responsible Officer in accordance with the ICB's established risk management and governance arrangements.

6.5 In exceptional circumstances, where a decision within the Programme Board's delegated authority is required before the next scheduled meeting, the Chair may seek member's agreement via written correspondence. All members shall be provided with sufficient information and a reasonable opportunity to respond. The quorum requirements set out in Section 5 shall apply to any decision taken by correspondence Any decision, together with any material differences of views expressed, shall be formally recorded and ratified at the next quorate meeting.

7. Reporting

7.1 The Programme Board is accountable to the ICB Executive Committee through the Senior Responsible Officer.

7.2 The Chair, supported by the Senior Responsible Officer, shall provide a summary report to the ICB Executive Committee following each Programme Board meeting, on the progress of the Review, including key findings, recommendations, risks, issues requiring escalation and matters requiring decision.

7.3 Matters requiring Board approval, including any recommendations relating to service reconfiguration, public consultation, or other matters reserved to the Board, shall be referred through Executive Committee in accordance with the ICB's governance framework and delegated authorities.

7.4 The Programme Board shall provide substantive updates to the ICB Board [ICB Executive Committee] at key milestones of the Review, including at the conclusion of each phase.

8. Governance and Resources

8.1 The Senior Responsible Officer retains overall accountability for the governance of the Review. The Programme Lead is responsible for programme delivery and operational coordination of the Review.

8.2 Secretariat support shall be provided by the ICB Committee Team. The duties of the secretariat include:

- agreeing the agenda with the Programme Lead and the Chair, and circulating papers at least five working days in advance of each meeting;
- taking minutes and maintaining a record of actions, decisions and matters arising;
- maintaining the co-design provenance record, tracking how provider, service user and partner input has shaped the Review's outputs;
- providing administrative and governance support to the Chair and members as required.

8.3 The Programme Board may seek advice from the ICB's Company Secretary and Director of Corporate Affairs and/or the corporate governance function on matters relating to governance, conflicts of interest, decision-making, escalation, and compliance with the ICB's governance framework.

9. Conflicts of Interest

9.1 Members and attendees shall comply with the ICB's Standards of Business Conduct and Managing Conflicts of Interest Policy and shall declare any actual, potential, or

perceived conflict of interest relevant to the business of the Programme Board at the start of each meeting, or as soon as they become aware of it.

9.2 The Chair shall determine the appropriate course of action in respect of any declared interest, having regard to the nature of the interest and the role of the Programme Board. Actions may include noting the interest, restricting participation in discussion, excluding the individual from decision-making on the relevant item, or requiring the individual to withdraw from the meeting for that item.

9.3 Members representing provider organisations, system partners or stakeholder groups may participate fully in discussions relating to their own organisation's services or interests, provided any relevant interests have been declared and are managed appropriately. Such organisational interests shall not automatically preclude participation, recognising the co-design nature of the Review.

9.4 A register of interests declared at Programme Board meetings shall be maintained by the secretariat and recorded in the minutes.

10. Monitoring Effectiveness and Compliance with Terms of Reference

10.1 The Programme Board shall review its effectiveness at the conclusion of each phase of the Review and shall report to the ICB Board on how it has discharged its responsibilities.

10.2 These Terms of Reference shall be reviewed following completion of Phase 1 of the Review, and thereafter as required by the Chair, Senior Responsible Officer, Executive Committee or ICB Board.

Date approved:	[to be completed]
Approved by:	ICB Executive Committee
Next review date:	[to be completed]
Version Control:	v0.2 Draft

NHS Kent and Medway

Report to	NHS Kent and Medway Integrated Care Board
Meeting date	Tuesday, 22 September 2026
Report title	Urgent and Emergency Care Clinical Pathway
Key question	How should urgent and emergency care be commissioned across the four layers of care to shift activity from hospital to community and support move from reactive to sustainable, proactive care?
Executive Lead	Chris Neill, Chief Commissioning Officer Kate Langford, Chief Medical and Outcomes Officer
Author	James MacDonald, Deputy Chief Medical Officer (Secondary Care) Mark Atkinson, Director of UEC and Flow

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☐ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☐ Seek assurance ☒ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

The Board is asked to approve the proposed direction of travel for the UEC clinical pathway and approve progression to the next stage of detailed planning, including demand and capacity modelling, workforce, estates, digital, financial and implementation plans. This approval will enable further development of a system-wide performance and benefits framework and the preparation of any future specific commissioning proposals for decision through the appropriate governance route.

NHS
Kent and Medway

Executive summary:

Urgent and Emergency Care (UEC) services across Kent and Medway are experiencing a significant mismatch between demand and available capacity, leading to sustained access and performance challenges. In some providers, these pressures are also contributing to quality and patient safety concerns.

Demand for UEC continues to rise. Combined type 1 and type 3 attendance activity has increased from fewer than 800,000 attendances in 2018/19 to more than 1 million attendances in 2025/26. This level of growth is financially unsustainable and places considerable pressure on acute hospital services, adversely affecting performance, quality, and patient outcomes.

To address these challenges, the UEC pathway must be transformed to ensure that each of the four layers of care is appropriately sized and resourced to meet population need. Key priorities for the pathway are to:

- Ensure sufficient access to same and next day general practice appointments, enabling people to receive timely care and reducing avoidable presentations to layers 3 and 4.
- Deliver the proactive components of the Neighbourhood Health model within layer 2, supporting prevention and early intervention in our frailest patients[1].
- Provide a comprehensive same and next day urgent care offer within layer 3, with services wrapped around the needs of patients.
- Standardise and appropriately scale admission avoidance services within layer 3, with a particular focus on the frailest 5% of the population.
- Ensure layer 4 providers operate consistently with national policy, clinical standards, and best practice guidance.
- Transform and right-size discharge pathways between layers 3 and 4, embedding a ‘Home First’ approach wherever clinically appropriate.

This pathway document represents the first stage in the development of a comprehensive commissioning plan for UEC across Kent and Medway. It sets out the proposed future-state model and high-level commissioning intentions, while recognising that further work is required to define the detailed delivery framework.

Following discussion at the Executive Committee, it was agreed that the Urgent Treatment Centre (UTC) review would be incorporated into this wider UEC pathway work, rather than progressed as a separate piece of work. This will support a joined-up approach, avoid duplication and ensure that future UTC commissioning intentions are considered within the overall pathway model.

Subsequent phases will establish the workforce, estates, activity, financial, digital, and implementation plans needed to operationalise the model. This work will include detailed

[1] Delivered by the Primacy care and neighbourhood health team – but fundamental to UEC demand management.

demand and capacity modelling, workforce and affordability assessments, benefits realisation, risk management, and the development of phased delivery plans to support sustainable implementation across the system.
Proposed next steps:
Following Board discussion, the next steps are to confirm governance, complete detailed modelling and planning, develop a delivery roadmap, agree the benefits framework, and bring forward any specific commissioning proposals through the appropriate route.

Governance pathway to date:		
Strategic Commissioning SubGroup	24/06/2026	Approved
Executive Committee	12/08/2026	Approved

Contact for further information	James MacDonald, Deputy Chief Medical Officer (Secondary Care)

COMPLIANCE NOTES:

Equality, health inequalities and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable – this paper sets out a strategic direction of travel and does not approve a specific service change. Equality, health inequalities and quality impacts will be completed as individual proposals are developed for decision.

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?
☐ Yes ☒ No

FOI status

Is this report disclosable under FOI?
☒ Yes ☐ No

Financial implications

Are there financial implications associated with this report?
☒ Yes ☐ No
If yes, please describe:
There are potential financial implications linked to activity shifts, service redesign, workforce, estates, digital requirements, admission avoidance and discharge capacity. No

NHS
Kent and Medway

COMPLIANCE NOTES:
specific financial decision is requested in this paper; detailed financial modelling will be developed as part of the next phase.

Legal implications

Are there legal implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

No direct legal implications are identified at this stage. Contractual, procurement and consultation requirements will need to be reviewed as specific options are developed.

Quality and safety implications

Are there quality or safety implications associated with this report?

☒ Yes ☐ No

If yes, please describe:

The paper identifies quality and safety implications associated with sustained UEC pressure, ED congestion, corridor care, delayed admission, delayed discharge, frailty pathways and the need to provide safer alternatives to hospital attendance and admission.

Patient and public engagement

Are there patient and public engagement implications associated with this report?

☒ Yes ☐ No

If yes, please describe. If no, please specify why:

Future pathway or service changes should be informed by patient, carer, public, clinical and provider engagement, particularly around access, service navigation, care closer to home and any proposed changes to urgent care provision.

NHS
Kent and Medway

URGENT AND EMERGENCY CARE CLINICAL PATHWAY

1. INTRODUCTION: The case for change

Urgent and Emergency Care (UEC) comprises a complex network of services and providers responsible for meeting the full spectrum of same and next day healthcare needs, from minor illness and injury through to life-threatening emergencies. For the UEC pathway to function effectively, patients must be able to access the right level of care, at the right time, in the right setting.

Over recent years, patient demand has increasingly shifted towards the higher-acuity parts of the system, with more people accessing Emergency Departments (EDs) and other hospital-based urgent care services for conditions that could be managed safely elsewhere. Combined Type 1 and Type 3 attendances have increased from fewer than 800,000 visits before the pandemic to more than 1 million attendances in 2025/26, representing an increase of over 25%. This growth has been driven by a combination of factors, including difficulties accessing primary and community-based services, increased public familiarity with hospital routes into care, and a perception that specialist and acute services offer quicker access to diagnostics, treatment, and expert clinical advice.

The resulting mismatch between demand and capacity is creating significant operational, quality and safety challenges across the UEC pathway. Patients are experiencing prolonged waits to be assessed in ED, extended delays before admission to an inpatient bed, and longer overall lengths of stay within acute settings. As EDs become increasingly congested, providers have become reliant on temporary escalation areas and corridor care to accommodate demand, creating environments that are not designed to deliver safe, high-quality care. These pressures increase the risk of avoidable harm, including falls, delayed recognition of deterioration, reduced privacy and dignity, delays in treatment and medication administration, and poorer patient experience. They also place considerable strain on staff, impacting workforce wellbeing and the ability of organisations to consistently achieve national access and performance standards.

Without significant transformation, continued growth in demand and patient acuity will place unsustainable pressure on hospital services and finances, while limiting the system's ability to improve outcomes for patients. A fundamental shift is therefore required to ensure care is delivered at the most appropriate layer, with sufficient capacity and capability available within layers 1,2 and 3 to prevent unnecessary attendance and admission in layer 4.

Commissioning must support the development of a UEC pathway that is appropriately configured and resourced at every layer. This will enable patients to access safe, effective and affordable care closer to home, improve patient outcomes and experience, reduce avoidable hospital attendance and admission, and ensure acute hospital capacity is reserved for those with the greatest clinical need.

In describing the future UEC model, it is essential to recognise the significant interdependencies between UEC and other Commissioning Multidisciplinary Teams (CMDTs), particularly Primary Care & Neighbourhood Health and Mental Health. Stronger

alignment across these programmes is required to ensure that these interdependencies are fully understood and addressed, and that a consistent four-layer commissioning approach is adopted across the system.

2. STRATEGIC ALIGNMENT

The clinical pathway supports the ICB's strategic objectives to commission the right services, improve financial sustainability, lead strategy and ensure commissioning levers deliver impact. It aligns with the system direction of travel to shift care from hospital to community, strengthen prevention and proactive care, improve access and reduce unwarranted variation.

The model is dependent on strong alignment with primary care, neighbourhood health, mental health, community services, ambulance services and acute providers. UEC cannot be redesigned in isolation; the pathway depends on sufficient capacity, capability and clinical confidence across all four layers of care.

The commissioning approach should therefore support a consistent four-layer model across all related programmes, with clear roles, referral routes, service standards, performance measures and governance arrangements.

3. UEC CLINICAL PATHWAY ACROSS THE FOUR LAYERS OF CARE

The following sections set out how UEC services should operate within each layer of the future model. The commissioning intentions described throughout this document represent the key changes required to move the clinical pathway towards this future state. Collectively, they provide the strategic direction for service transformation, investment and redesign, enabling Kent and Medway to develop a sustainable, high-performing and patient-centred UEC pathway that delivers safe, timely and effective care at the right layer.

Layer 1: Primary care

Primary care is the bedrock of the system, comprising general practice, community pharmacy, dentistry and optometry.

General practice

General practice manages the great majority of same and next day care needs each year. Over 11 million appointments were delivered across K&M in 2025/26 with roughly 50% being same or next day. Despite this, healthcare needs that could be managed in general practice are often dealt with in layer 3 UTCs or layer 4 Emergency Departments. This inconveniences patients, interferes with efficient hospital processes, drives unnecessary diagnostics and interventions and ultimately delivers a poor patient experience at elevated cost.

General practice should, over time, increase capacity such that it is able to load-bear the entirety of same or next day demand amenable to primary care management – care that

typically does not require pathology, radiology, advanced treatments monitoring or surgical intervention.

General practice should offer a same or next day appointment to every patient whose clinical condition requires one. This should be standard 5 days a week, 8.00am to 6.30pm. Patients should not be directed to other layers within the pathway during these hours except where a specific need for specialist urgent care has been identified.

Across Kent and Medway general practice offers an average of 436 appointments per 1000 registered patients, but with significant unwarranted variation geographically. If this average rose to 500, all in-hours general practice activity could be managed in layer 1, closer to patients' homes with continuity of care and at lower cost.

General practice must continue its transformation:

- Targeted recruitment of GPs and other patient facing roles
- Digital triage
- Ambient Voice Technology
- Video consultation

Community pharmacy, dentistry and optometry

Community pharmacy, dentistry and optometry provide important alternatives to both general practice and higher-acuity urgent care services. Initiatives such as Pharmacy First, emergency dental appointments and community optometry services enable patients to access timely, convenient care within their local communities and help ensure that medical services are focused on patients with more complex needs.

Together, these services play a critical role in strengthening layer 1 capacity, improving access, and reducing unnecessary attendance at urgent treatment centres (UTCs) and EDs.

Layer 2: Single neighbourhood care

Layer 2 provides three elements to the UEC clinical pathway.

1. Extended general practice appointments to 8pm each working day and Saturday mornings.
2. Proactive care for subsets of our population.
3. Proactive and reactive mental health provision.

Extended opening hours

Single Neighbourhoods will offer extended opening hours to 8pm each working day. This will increase capacity in general practice and provide appointments at times our population can more easily access.

Proactive care

Proactive care based on cohorts identified through population health medicine will reduce demand across all UEC pathways. Patient cohorts such as frailty, cardiovascular disease

and mental health contribute significantly to UEC demand and measures to improve their long-term management will reduce the likelihood and severity of potential deteriorations.

Mental health

Mental health contributes significantly to UEC demand and should be a key focus of layer 2 services. Single neighbourhood based mental health teams should provide both proactive and reactive support, working closely with primary care, voluntary sector partners and specialist providers to prevent deterioration and reduce crisis presentations.

Particular emphasis should be placed on high-intensity users of UEC services. Through multidisciplinary case management, personalised care plans and care coordination, neighbourhood teams should proactively support individuals with complex needs who frequently attend EDs, call 111, 999 or require urgent interventions. This approach should improve outcomes, reduce avoidable attendances and provide a credible alternative to hospital-based care wherever clinically appropriate.

Layer 3: Multi-neighbourhood care

Multi-neighbourhoods provide the safety net between community and hospital that both prevents admission but also supports timely discharge.

Care delivered in this layer can be categorised as follows:

- Admission avoidance
- Discharge facilitation
- Wrap around same and next day care

Admission avoidance

Using population health analytics and risk stratification, a cohort of approximately 90,000 people across Kent and Medway has been identified as representing the frailest 5% of the population and those at greatest risk of deterioration leading to ED attendance and hospital admission. This group is significantly more likely to experience prolonged stays in ED while awaiting admission and extended periods in hospital after being deemed to have “No Criteria to Reside” (NCTR), awaiting discharge. Reducing unnecessary attendance and admission for this cohort is therefore a central component of the UEC clinical pathway.

Layer 3 will provide a community-based, load-bearing Home Treatment Service, scaled to meet the reactive needs of this high-risk frailty population. Delivered by a multidisciplinary team including GPs, Advanced Clinical Practitioners (ACPs), consultant geriatricians, nurses, therapists and other specialist professionals, the service will offer a rapid alternative to hospital attendance for frail individuals requiring same or next day assessment and treatment when their needs cannot be met through layers 1 or 2.

Operating 24 hours a day, seven days a week, the Home Treatment Service will be accessible through multiple referral routes, including self-referral for known patients, 111, 999, SECAmb, Single Point of Access (SPOA) services and EDs. Response times will be designed to match, and where possible improve upon, ambulance response standards.

The service will provide a broad range of hospital-level interventions within the patient's own home, including:

- Comprehensive geriatric assessment and point of care testing
- Administration of oral and intravenous medications
- Short and long term oxygen therapy
- Palliative care management and rapid access to hospice services
- Wound care and complex dressing management
- Access to urgent diagnostic imaging through Community Diagnostic Centres with accelerated reporting
- Remote monitoring and escalation to community virtual wards where appropriate

The service aims to provide many of the benefits of hospital-based care while avoiding the harms associated with hospital admission, including deconditioning, hospital-acquired infection and loss of independence. It will also support the preferences of many frail older people to receive care in familiar surroundings, improving patient experience while reducing pressure on emergency and inpatient services.

Discharge facilitation

Layer 3 will play a key role in enabling timely discharge from acute hospitals. The ambition is that all patients requiring pathway 1, 2 or 3 support leave hospital within 24 hours of reaching NCTR status or their 'Discharge Ready Date'. Achieving this will require increased community capacity and new ways of working.

At any one time, around 500 patients across Kent and Medway acute hospitals are classified as NCTR, occupying approximately 20% of the acute bed base. These patients are often highly vulnerable and exposed to avoidable harms including deconditioning, falls, delirium and hospital-acquired complications, while also reducing capacity for patients who need acute care.

The transformation required is to adopt a universal Home First approach. Patients should be discharged as soon as they are medically optimised, with physiotherapy, occupational therapy and social care assessments undertaken in their own homes wherever possible. Evidence shows that people recover better and function more independently in familiar surroundings. Assessing people at home also provides a more accurate understanding of their long-term support needs.

To support this approach, discharge pathways must be appropriately resourced and managed:

- Pathway 1 – Expansion of health and Better Care Fund (BCF) funded bridging packages to enable rapid discharge for patients requiring low levels of domiciliary care. This is the fastest and most cost-effective route to releasing acute capacity.
- Pathway 2 – Rehabilitation beds should be managed with the same focus on flow, seven-day services, multidisciplinary working and length of stay as acute beds. Electronic bed management systems (EBMS) should be expanded across community hospitals, nursing facilities and hospices.
- Pathway 3 – Continue to develop transfer of care hubs and bed brokerage arrangements to improve access to residential and nursing placements. A detailed

assessment of provider capacity will be required to ensure sufficient provision is available to meet future demand.

By combining a Home First philosophy with strengthened community services, Kent and Medway can significantly reduce delayed discharges, improve patient outcomes and release substantial acute hospital capacity.

Wrap around same and next day care

While the majority of same and next day urgent care demand should be met through general practice, there will be periods when practices are closed or when local capacity is constrained by workforce or estate limitations. In these circumstances, patients will be directed to one of nine GP hubs operating across the multi-neighbourhood geographies.

Focussing on weekends and bank-holidays once general practice is load bearing, these hubs will provide a resilient system response to urgent but lower-acuity healthcare needs, offering rapid assessment and treatment closer to home. They will also play a key role in reducing pressure on collocated UTCs and EDs by absorbing activity in layer 3 rather than 4.

Layer 4: Acute hospital care

With the changes outlined above the volume of activity directed to the acute hospital EDs will be reduced, aiming to reverse the 25% increase seen since pre-pandemic. This will allow hospitals to focus on their core business which is rapid diagnosis and treatment and admission of the most critically unwell. Other neighbourhood schemes to reduce the need for acute hospital beds for the frailest 5% of patients will allow hospitals to reduce their NCTR numbers, bed capacity and admission delays.

Although providers will have different demographics and staffing models, there are some principles that should apply to all EDs. Providers are expected to introduce all elements of the NHS England model ED, specifically:

ED streaming

Rapid triage and streaming of patients in both ambulance and walk-in pathways is critical to decongesting EDs. Where clinically appropriate patients should be transferred to non-ED alternatives such as general practice, UTCs, pharmacy first or SDEC areas.

Ambulance arrival areas

Dedicated ambulance arrival areas should be available in every ED. Ambulance handover should be a key function of EDs with zero tolerance for 45 minute delays.

Collocated UTCs

Each ED should have a collocated UTC open 24/7. This acts to manage the lower acuity activity such as minor illness and injury that may continue to attend despite the measures set out in layers 1,2 and 3. As with community UTCs, patients should have the option to leave and return rather than wait to be seen, if clinically appropriate.

Extended emergency medicine ambulatory care

EEMAC units replace the function of CDUs increasing access to dignified comfortable chaired areas for patients likely to be discharged within 12 hours of arrival in ED.

Same Day Emergency Care

Hospitals should provide SDECs 12 hours a day 7 days a week for key specialties:

- Medicine
- Frailty
- Surgery
- Paediatrics

They should be consultant led, maximising admission avoidance opportunities. SDEC should be the default location for referred patients who are clinically stable and do not require a bed. Collocation with assessment units concentrates the acute clinical workforce. Parity of access to diagnostics with ED is recommended. Referrals should be accepted from all clinicians in primary care, SPOA or the ambulance service with direct access for patients who are clinically stable.

Referral and admission

Patients who are referred to specialties who cannot go to SDEC areas should be admitted to hospital beds within an hour of referral. Trusts should ensure they have embedded the principles of the 'The Model Acute Pathway'. No patient awaiting admission should spend over 12 hours in ED from arrival. There is clear evidence this increases morbidity and mortality.

In-hospital processes

All acute hospitals should follow national guidance on non-elective stays. Daily consultant input, estimated discharge dates, multidisciplinary board rounds and interprofessional standards all contribute to reducing length of stay both pre and post NCTR date.

Discharge process

Discharge from hospital should occur within 24 hours of the NCTR date for all pathways. Discharge of more complex patients should be overseen by a Transfer of Care Hub (TOCH) facilitating a smooth interface between hospital, local authority and community trust.

Hospitals must use 'home first' as their default discharge route. This will require the transfer of OT and PT expertise from acute to community.

Acute hospitals are expected to adopt all aspects of the NHS England ‘model discharge pathway’

Kent and Medway

Layered working coordination functions

Some services in UEC are commissioned across multiple acute hospitals or even across multiple ICBs. Their function is to manage and direct demand to resources in each layer, this is fundamental to managing UEC demand.

111, 999, Single Point of Access and the Clinical Assessment Service

111 and 999 in Kent and Medway manage 1.3 million calls every year with the majority dealt with through advice to self-care. Despite this, significant volumes of activity continue to be directed or conveyed to higher layers of care than they require.

Transformation and standardisation of redirection mechanisms such as SPOA, the CAS and 999 category 2 validation will increase resilience and deliver a 24/7 clinical review of any ED or UTC disposition from either care home, 111 or 999.

NHS Kent and Medway

4. KEY RISKS, MITIGATIONS AND CONTROLS

Risk	Mitigation/control	Owner	Timescale
Continued growth in ED attendance and ambulance conveyance if lower layers are not sufficiently resourced.	Develop load-bearing capacity in primary care, neighbourhood care and multi-neighbourhood services, including same-day access, proactive care, UCR, home treatment and virtual wards.	UEC Programme / Commissioning Leads	Detailed planning phase
Quality and safety risk from ED congestion, corridor care and delayed admission.	Embed Model ED, strengthen streaming, expand SDEC, improve ambulance handover and increase viable alternatives to admission.	Acute Providers / UEC Programme	2026/27 planning and delivery
Delayed discharge and continued high NCTR levels affecting acute flow.	Implement Home First, strengthen pathway 1, 2 and 3 capacity, and improve Transfer of Care Hub coordination.	System Flow / Discharge Leads	Ongoing with winter planning alignment
Financial sustainability risk if activity remains in high-cost settings.	Use demand modelling, activity shift assumptions, cost analysis and benefits tracking to inform commissioning decisions and investment upstream.	Finance and Commissioning Leads	Before specific service decisions
Provider, workforce, estates and digital constraints may limit implementation.	Undertake detailed workforce, estates, digital and affordability assessments before bringing forward specific proposals.	Programme SRO / Delivery Leads	Next phase of implementation planning

NHS Kent and Medway

5. CONCLUSIONS AND COMMISSIONING INTENTIONS

The evidence demonstrates a clear mismatch between demand and capacity across multiple points in the current UEC pathway. Activity has increasingly migrated towards higher-acuity services, creating pressure on emergency departments, ambulance services and acute hospital capacity. Addressing this challenge requires the development of genuinely load-bearing services within layers 1, 2 and 3, enabling patients to receive timely, high-quality care closer to home and reducing avoidable reliance on acute hospital services.

Through targeted commissioning and transformation, Kent and Medway can improve access, quality, patient experience and outcomes, while reducing health inequalities and creating a more sustainable urgent and emergency care system. As demand shifts into primary, neighbourhood and community services, resources can progressively be rebalanced away from expensive hospital-based care and invested upstream in prevention, proactive care and admission avoidance, delivering better value and improving population health.

Commissioning intentions:

Layer 1 – Primary Care

- Increase general practice appointments from 436 to 500 per 1,000 registered patients per year.

Layer 2 – Single Neighbourhood Care

- Establish proactive frailty services in every single neighbourhood
- Deliver extended-hours general practice appointments within every single neighbourhood.
- Develop neighbourhood-based mental health services, including proactive support for high-intensity users of UEC pathways.

Layer 3 – Multi-Neighbourhood Care

- Transform 12 community UTCs into 9 same-day GP hubs aligned to multi-neighbourhood geographies.
- Establish a load-bearing Home Treatment Service, including community virtual wards, as a credible reactive alternative to ED attendance.
- Expand Home First capacity to support discharge within 24 hours of NCTR status across all discharge pathways.

Layer 4 – Acute Hospital Care

- Embed all elements of the NHS England Model Emergency Department, Model Acute Pathway and Model Discharge Pathway.
- Standardise Same Day Emergency Care and rapid assessment services to national standards.
- Standardise and extend the collocated UTC offer to provide a consistent 24/7 service across all sites.

Non-Layered Services

- Transform and consolidate existing clinical validation and revalidation functions into a 24/7 Single Point of Access hub supporting 111, 999, paramedic practitioners, general practice and care home staff.

Progress towards the future-state UEC model should be monitored through a system-wide performance framework focused on patient outcomes, flow and service utilisation. Measures should include, but not be limited to, UEC activity, non-elective admissions, timely access to general practice, ambulance conveyance, patient flow, patient experience, health inequalities and health outcomes. The framework should also assess the impact of targeted interventions for frailty, mental health and high-intensity users of urgent and emergency care services. Detailed baselines, trajectories and performance targets will be developed during the next phase of implementation planning.

Successful delivery of this pathway will transform UEC across Kent and Medway. Patients will receive more care closer to home, experience fewer avoidable crises and achieve better outcomes, while acute hospitals focus on delivering specialist care to the most unwell. This is an ambitious plan is to create a UEC clinical pathway where prevention, proactive intervention and community-based care are the norm, and where hospital attendance is the exception rather than the default response to deterioration.

6. REQUIRED OUTCOMES AND NEXT STEPS

The Board is asked to:

- Endorse the proposed direction of travel for the UEC clinical pathway.
- Support the four-layer model as the organising framework for future UEC commissioning.
- Note the commissioning intentions set out across layers 1 to 4 and coordinating services.
- Approve progression to detailed modelling and implementation planning before specific proposals are brought back for decision.

The following next steps should be noted:

- Complete detailed demand and capacity modelling across all four layers of care.
- Develop workforce, estates, digital, financial and affordability assessments.
- Undertake appropriate clinical, provider, patient and public engagement as proposals are developed.

7. SUPPORTING DOCUMENTATION

The following documents are available on request to support the content of this paper:

- NHS England Model Emergency Department.

- NHS England Model Acute Pathway.
- NHS England Model Discharge Pathway.

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Autism and ADHD Assessment Pathways – 2026/27 in-year financial position, forecast outturn and future transition to a sustainable all age clinical model and financial position.
Key question	Are the steps set out in this report sufficient to enable the ICB to lawfully and fairly manage escalating autism and ADHD demand, prioritise assessment capacity for people with the greatest clinical, safeguarding or vulnerability-related need, strengthen provider and financial controls, and develop a sustainable all-age needs-led neurodevelopmental pathway?
Executive Lead	Chris Neill, Chief Commissioning Officer Jonathan Wilson, Chief Finance Officer
Author	Jimmy Kerrigan - Assistant Director MHLDA George Matuska – Clinical Lead for LD, Autism and ADHD Kate Calvert – Interim Director MHLDA

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☐ Seek assurance ☐ Decision/approval required ☒ For noting/information

Recommendation(s) to the meeting:

The Board is asked to:

- **Note** the challenge and cost pressure to the ICB's ADHD/Autism budget

- **Note** the 2026/27 forecast outturn scenarios against the original £20.02m budget.
- **Note** that any forecast mitigated above the original budget remains subject to material delivery risk.
- **Note** that all providers have been issued with 2026/27 IAPs and that provider engagements and assurance activity remains ongoing.
- **Support** strengthened provider, contract, invoice-validation, tariff, prescribing and data controls for the remainder of 2026/27. This will include routine provider review meetings, implementation of agreed pricing arrangements, enhanced reporting and associated commissioner governance.
- **Note** continued needs-led clinical prioritisation through revised Indicative Activity Plans (IAPs), with consistent escalation and quality oversight.
- **Endorse** the 2027/28 transformation programme to move from diagnosis-led access and reactive purchasing to needs-led, planned and outcome-based commissioning.

Executive summary:

Demand for Autism and ADHD assessment and treatment is substantially above commissioned capacity. Rapid growth in NHS Right to Choose activity, long waits, fragmented pathways, inconsistent provider reporting and limited upstream support have produced simultaneous clinical, equity, operational and financial risks. The system is buying increasing volumes of diagnosis-focused activity without yet having a coherent all-age model that supports people according to need before, during and after assessment.

The immediate objective in 2026/27 is to contain expenditure and ensure clinical priority is in place without unlawfully restricting patient choice. The medium-term objective is to establish a locally coherent, all-age model in which support is available according to need (recognising the differences in potential impact for adults and children/young people), diagnostic capacity is prioritised consistently, and specialist services focus on complexity and risk.

2026/27 management response. Revised provider IAPs, clinically led prioritisation, executive engagement with major providers, invoice validation, tariff and contract work, backlog modelling, prescribing review, communications and monthly activity controls are now being implemented. The mitigated forecast assumes that these measures materially slow growth during the year, however, forecast outturn scenario analysis has been undertaken to quantify and assess potential and residual risk for the ICB.

2027/28 and beyond. The ICB will continue to develop whole-pathway data and knowledge to set a realistic recurrent baseline and progressively redirect resource towards primary care, neighbourhood support, waiting-well and post-diagnostic offers, while retaining specialist capacity for complexity and risk. A single front door will provide advice, triage, risk screening and routing, but will not create a uniform pathway or an additional barrier to lawful choice.

Proposed next steps:
• Continue to actively manage the risk associated with Right to Choose provision for ADHD/Autism. • Continue to explore further options/initiatives to mitigate the budget cost pressure. • Continue with the Neuro-Developmental pathway transformation programme.

Governance pathway to date:		
Meeting name:	Date:	Outcome:
Strategic Commissioning Subgroup	26 February 2026	Approved proposal to implement more robust Indicative Activity Plans for adult and children's autism and ADHD NHS commissioned services and Right to Choose activity for 2026/27.
MHLDA Commissioning Multi-Disciplinary Team	July 26	MDT input into all management actions highlighted in this paper.
Executive Committee	August 12	Recommendation to revise paper for Finance and Performance Committee (and later Board), setting out clearly 2026/27 position, financial risk out-turn and risk; future commissioning for 2027/28 onwards; include clinical model within paper.
Equality, Quality and Health Impact Assessment Panel	17 August 2026	Panel approved the EHQIA.
Finance and Performance Committee	24 August 2026	Committee noted the complexity and challenge especially from a contractual perspective with Right to Choose providers.

Contact for further information	Jimmy Kerrigan jkerrigan@nhs.net Kate Calvert: kate.calvert2@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?
☐ Yes ☒ No
If yes, please confirm how the conflict has been managed.

FOI status

Is this report disclosable under FOI?
☒ Yes ☐ No
If no, please specify why:

Financial implications

Are there financial implications associated with this report?
☒ Yes ☐ No
If yes, please describe:

Legal implications

Are there legal implications associated with this report?
☒ Yes ☐ No
If yes, please describe:

The approach must be implemented in a way that preserves lawful patient choice, including NHS Right to Choose where applicable, and does not create an unlawful barrier or delay. Legal risk may arise from provider challenge, patient complaints or equality-related challenge if prioritisation, communication or pathway controls are not applied consistently and transparently.

Quality and safety implications

Are there quality or safety implications associated with this report?
☒ Yes ☐ No
If yes, please describe:
There are quality and safety implications associated with long waits, prioritisation of assessment capacity and consistency of provider practice. The mitigations include clinically led categorisation, clear escalation routes, provider reporting, patient communications, quality oversight and ongoing monitoring of activity, waiting times, diagnosis rates, prescribing and outlier activity.

COMPLIANCE NOTES:
Patient and public engagement
Are there patient and public engagement implications associated with this report? ☒ Yes ☐ No *If yes, please describe. If no, please specify why:* Communication with the public, providers, partners and stakeholders related to the management action taken by the ICB has been published following approval from ICB Executive level. Further engagement will include patient and carer feedback as we continue to develop our model of care.

AUTISM AND ADHD ASSESSMENT PATHWAYS – 2026/27 IN-YEAR FINANCIAL POSITION, FORECAST OUTTURN AND FUTURE TRANSITION TO A SUSTAINABLE ALL AGE CLINICAL MODEL AND FINANCIAL POSITION

1. INTRODUCTION

Demand for autism and ADHD assessment and treatment continues to exceed commissioned capacity across children, young people and adults in Kent and Medway. Rapid growth in referrals and NHS Right to Choose activity, combined with long waiting times, fragmented pathways, inconsistent provider information and limited support outside diagnostic services, has created significant clinical, equality, operational and financial challenges. The current model is increasingly unsustainable and does not consistently enable support to be provided according to need before, during and after assessment.

Expenditure increased from £0.64 million in 2023/24 to £28.91 million in 2025/26. The 2026/27 opening budget of £20.02 million was materially below the previous year's expenditure and did not fully reflect existing backlog commitments, assessments and treatment already commenced, priority cases, prescribing costs or continued market growth. The current most likely forecast outturn is £32.1 million, representing a £12.1 million pressure against the opening budget and an increase of £3.2 million compared with 2025/26 expenditure. The forecast remains subject to material delivery risk.

The ICB must manage this position while balancing its responsibilities to preserve lawful patient choice, operate within available resources and ensure that assessment capacity is prioritised fairly for people with the greatest clinical, safeguarding, statutory or wider vulnerability-related needs.

2. STRATEGIC ALIGNMENT

Alignment with the strategic priorities

Improve health outcomes and tackle inequality
The current position creates particular risks for people whose clinical, safeguarding, statutory or wider vulnerability-related needs require earlier support or assessment. The introduction of needs-led clinical prioritisation, consistent escalation arrangements and quality oversight will help ensure that limited diagnostic capacity is directed fairly towards those with the greatest need. The future pathway will also provide support before, during and after assessment, reducing reliance on diagnosis as the gateway to help and improving access for groups currently disadvantaged by long waits or fragmented provision. This places prevention and equity at the centre of pathway redesign.

Shift care from hospitals to neighbourhood
The proposed all-age model will provide more support through primary care, neighbourhood teams, community services, schools and the voluntary and community sector. A single front door will offer advice, navigation, triage and immediate risk screening, while needs-led and waiting-well support will be available closer to home without requiring a diagnosis. Multi-

neighbourhood and specialist services will focus on people with greater complexity and risk, reducing avoidable escalation and reliance on acute or inpatient care.

Stabilise and then improve performance across access, flow, quality and productivity
The immediate 2026/27 actions are intended to improve waiting-list safety, provider oversight and the use of available assessment capacity. Clinically led prioritisation, clearer escalation routes, improved provider reporting, waiting-list validation and routine monitoring of activity, waiting times, diagnostic outcomes and prescribing will provide greater assurance over access and quality. Longer-term pathway redesign will create clearer routes to advice, support, assessment and treatment, enabling faster and more appropriate responses without creating digital exclusion or an additional barrier to lawful patient choice.

Achieve financial balance and system productivity through transformation rather than short-term mitigations
The paper combines immediate financial and contractual controls with a longer-term transformation programme. Revised Indicative Activity Plans, invoice validation, tariff and contract work, prescribing review and strengthened provider reporting will improve financial control during 2026/27. From 2027/28, the ICB intends to move from reactive purchasing of diagnosis-focused activity towards planned, needs-led and outcome-based commissioning. Redirecting resources towards prevention, early support, neighbourhood provision and effective pathway management should improve value and productivity while retaining specialist capacity for people with the greatest complexity or risk.

3. DISCUSSION

The problem we are trying to solve:

3.1 Demand, capacity and waiting times

- Demand for autism and ADHD assessment continues to exceed locally commissioned and provider capacity across children, young people and adults.
- Available information suggests an indicative split of approximately 55% children and young people and 45% adults, but the dataset is incomplete and should not yet be treated as a definitive planning baseline.
- Chronological waiting-list management alone does not protect people whose clinical, safeguarding, statutory or wider vulnerability-related needs require earlier diagnostic input.
- People frequently need practical, educational, mental health, communication, sensory or family support while waiting.

3.2 Fragmented market and weak information

- Right to Choose has expanded the number and range of providers and has made provider oversight, data flows, pathway visibility and financial management more complex.
- Provider reporting is inconsistent. MHSDS/CMHSDS completeness, waiting-list visibility, diagnostic outcomes, prescribing, titration and follow-up information are not yet sufficient for full assurance.
- There is unquantified risk of duplicate waiting-list entries across statutory and Right to Choose pathways which may affect demand estimates and planning assumptions.
- New providers and expanded provider capacity can create liabilities before the ICB has a complete view of demand, quality, activity and whole-pathway cost.

- The ICB currently has incomplete viability of activity undertaken by some providers, creating challenges in forecasting demand, validating invoices and understanding whole-pathway costs.

3.3 Financial exposure

Expenditure has grown from £0.64m in 2023/24 to £28.91m in 2025/26. Growth has been driven by increasing referrals, expansion of the Right to Choose market, increased provider capacity and rising diagnostic and treatment activity. The 2026/27 opening budget of £20.02m was therefore materially below the preceding year's expenditure and did not fully reflect backlog commitments, commenced activity, priority cases, prescribing costs and ongoing market growth.
Without corrective action, expenditure is forecast to continue growing at a rate that is not financially sustainable within available ICB resources.

3.4 Commissioning Challenge

The ICB must balance three duties:

- supporting patients' legal right to choose a clinically appropriate provider where the right applies;
- meeting its statutory duty to operate within available resources; and
- ensuring that children, young people and adults with the greatest clinical, safeguarding or wider vulnerability-related need are supported appropriately.

The current model has previously been reliant on diagnosis as the gateway to support and intervention. As demand has increased, this has highlighted the need to develop a more sustainable, needs-led approach that provides appropriate support before, during and after assessment, whilst maintaining access to diagnostic services for those who require it. A more detailed description of the proposed model of care is attached for your information (Appendix One)

The actions we are taking in 2026/27:

3.5 Clinical prioritisation and waiting-list safety

- Applied needs-led clinical categories to prioritise immediate risk, safeguarding, placement stability, complex treatment, statutory and vulnerability-related need.
- Asked providers to prioritise, in order: people meeting priority criteria; people who have commenced assessment or treatment; people with an existing booked appointment; and then longest waiters, including agreed backlog transfers.
- Require providers to review categorisation when circumstances change and provide clear escalation routes through the provider and referring clinician.
- Asked providers to 'protect' accepted referrals from cancellation while being transparent that routine waits may increase.
- Completed the Equality and Health Inequalities Impact Assessment, with clinical, quality and patient-safety oversight.
- Developing a clinical audit and assurance approach to test provider application of prioritisation criteria and support consistency across the market.

3.6 Provider and financial control

In order to mitigate the financial risk from our *Right to Choose* providers, we have undertaken the following:

- Issued written confirmation to providers on 2026/27 activity (IAP) arrangements, including prioritisation criteria, activity assumptions and patient communications. To note that whilst IAPs provide an essential commissioning and planning tool, they are indicative rather than absolute contractual limits. Providers are not required to formally accept an IAP. Accordingly, the ICB's contractual position is reliant not solely on delivery against IAP values, but also on provider compliance with agreed activity management arrangements, prioritisation requirements, reporting obligations, contract variations, data submission requirements and other NHS Standard Contract provisions.
- Defaulting new and emerging providers to zero activity where appropriate unless an alternative position is agreed through the appropriate route.
- Held executive-led meetings with the highest-spend and highest-volume providers to seek capped activity agreements and reinforce in-year controls.
- Progressed contract variations with contracted providers to align pricing with local and national guide tariff arrangements. To note, our Clinical Lead for Learning Disability and Autism has engaged with the NHS England national team regarding the development of a national mandatory guide price for ADHD and autism diagnostic assessments. We formally expressed our interest in contributing to the forthcoming national consultation, recognising the potential for a nationally mandated guide price to support greater consistency, quality assurance and improvement across commissioned services. We have subsequently been advised that Kent and Medway ICB will be invited to participate once the consultation is launched. No timeline has been confirmed at this stage.
- Required providers to confirm that they will comply with the 2026/27 arrangements; as of 7 September, we have five providers that we are currently following up with.
- Developed invoice validation controls, including a local data template and regular invoice review process.
- Strengthened data reporting expectations, including MHSDS and CMHSDS compliance and local reporting where national data is incomplete.
- Developed provider and patient communications to explain the changes, the rationale, escalation routes and support available while people wait.
- Developed financial forecast and scenario modelling to quantify potential expenditure, assess residual risk and inform executive decision-making.
- Reviewing medication and prescribing costs to understand the full pathway cost and avoid hidden cost shifts between budgets. We are currently reviewing our shared care prescribing pathway, working with General Practice.
- Progressing longer-term all-age pathway redesign, including triage, needs-led support, waiting-well support and future 2027/28 IAP improvements.

3.7 Support while waiting and pathway development

- Expanded practical, self-management, family, school, voluntary-sector and mental health support that does not require a diagnosis. For example, we have progressed a “This is Me” schools initiative (This is Me) and a proposal for a more consistent and cost-effective ADHD shared-care offer.
- Tested the draft patient journey with people and carers and used feedback to shape pathway design.

- Developed clearer all-age screening, triage and navigation arrangements that support - rather than obstruct - lawful choice.
- Developed patient-facing communications to explain changes, available support and escalation routes where needs change whilst waiting.

2026/27 forecast outturn and residual risk

3.8 Forecast Outturn Scenarios

The opening position budget of £20.02m was based on affordability for the ICB. At the end of Quarter 1, an outturn position of £24.5m, (£6.5m over budget) was forecast, which assumed 25% of the backlog would be completed in 2026/27;10% of the budget would account for new referrals being high priority and therefore being assessed in year; and a three-month grace period would be allowed for providers to sign up to the national tariff.

However, to better understand and quantify the level of potential risk to the opening budget position, we have now undertaken further forecast outturn scenario analysis, as shown in the table below.

This shows *worst case*; *most likely*; and *best case* scenarios, considering the actions we have and are taking as set out above. It should be noted that the best-case scenario is deemed unlikely based on the current position/conversations with providers regarding their IAPs and our proposed shift to the national tariff.

ADHD Right to Choose -2026/27 Financial Pressure Scenarios based on Intervention Framework				**Worst Case**	**Mid Case - Most Likely**	**Best Case**
Basis	**Best Case Assumption**	**Most Likely Case Assumption**	**Worst Case Assumption**	**2026/27 Budget £20.02m**		
IAP issued but no billing till M4	No costs for the year	Costs for the year	Costs for the year	£0.06	£0.06	£0.00
IAP issued but currently at zero and already includes backlog activity	No further spend beyond pre-booked appointments	Ave. based on M1-M3 Run Rate extrapolated	Ave. based on M1-M3 Run Rate extrapolated	£3.58	£3.58	£1.29
IAP issued but currently over the value	No further spend beyond pre-booked appointments	Same as worst case but Psicon Ltd back to IAP at £9m	Ave. based on M1-M3 Run Rate extrapolated	£28.10	£14.28	£11.24
IAP issued but currently under the value	Provider will meet IAP value	Ave. based on M1-M3 Run Rate extrapolated	Ave. based on M1-M3 Run Rate extrapolated	£14.04	£14.04	£8.23
College Health 10% of the IAP	No costs to date but assume provider will do priority cases by year-end	No costs to date but assume provider will do 50% allocated backlog	Ave. based on M1-M3 Run Rate extrapolated	£0.36	£0.18	£0.04
Agreeing the IAP	Providers agree to the National Tariff	75% Providers don't agree to the Non-Mandatory National Tariff	Ave. based on M1-M3 Run Rate extrapolated	£0.00	£0.00	£0.00
				£46.13	**£32.14**	**£20.80**
			(Over)/ Under Performance	**(£26.11)**	**(£12.12)**	**(£0.78)**

It is important to note that 2025/26 outturn was £28.9m and although there were no mitigations in place, the expenditure reflects the level of run rate and increased demand, as well as an increasing number of providers entering the market and therefore increased capacity to meet that demand.

The most likely forecast of £32.1m is a £12.1m cost pressure to this year's opening budget and an increase of £3.2m over last year's actuals. It is worth noting that we have seen a slight reduction in expenditure in month 4 and expect the reduced expenditure to continue/level out over the remainder of the year. We will have a more complete dataset following month 5 and will therefore update our forecast outturn position at that point, whilst we continue to actively mitigate the residual risks we are holding via the actions we are taking.

In addition, we will continue to complete the work that we are doing in regard to:

- Validation of provider waiting lists, referrals and provider activity
- Proactive monitoring of the run rate and activity, taking further action as needed, including prior authorisation of expenditure above IAP cap, noting that only those who meet clinical priority requirements will be approved.
- Exploring all options to mitigate risk and offset budget pressure.

4. KEY RISKS, MITIGATIONS, AND CONTROLS

Residual risk	Why it remains	Mitigated position / control	Assessment
Provider non-compliance or engagement with contractual arrangements	IAPs or tariffs are exceeded or challenged. Some providers have not formally responded to IAPs, pricing arrangements or reporting	Monthly run-rate monitored; contract escalation. Formal provider meetings, contract escalation, executive oversight and contractual correspondence	High
Priority activity higher than assumed	Published criteria may increase requests and eligible cases.	Clinical governance, category monitoring and audit.	High
Backlog / commenced liabilities	Assessment, titration, prescribing and review costs continue.	Improved oversight through reporting and forecasting	High
Prescribing and shared-care costs	Whole-pathway cost is not fully visible.	Separate prescribing review and shared-care scheme.	Medium-High
New market entrants / demand growth	Additional referrals may create unplanned cost.	Accreditation, central provider database and IAP controls.	High
Clinical prioritisation criteria in public domain and widely shared	Puts the 10% budget provision for new referrals being high priority at risk	Work within legal requirements for sharing information	High

Overall residual risk: HIGH.

5. OTHER CONSIDERATIONS

In relation to the proposed budget agreed for 2026/27, a £2m CIP reduction was applied at the beginning of the year and subsequently reversed as a scheme that is unachievable due to the current run rate.

6. REQUIRED OUTCOMES AND NEXT STEPS

The meeting is asked to:

- **Note** the challenge and cost pressure to the ICB's ADHD/Autism budget
- **Note** the 2026/27 forecast outturn scenarios against the original £20.02m budget,
- **Note** that any forecast mitigated above the original budget remains subject to material delivery risk.
- **Note** that all providers have been issued with 2026/27 IAPs and that provider engagements and assurance activity remains ongoing
- **Support** strengthened provider, contract, invoice-validation, tariff, prescribing and data controls for the remainder of 2026/27. This will include routine provider review meetings, implementation of agreed pricing arrangements, enhanced reporting and associated commissioner governance.
- **Note** continued needs-led clinical prioritisation through revised Indicative Activity Plans (IAPs), with consistent escalation and quality oversight.
- **Endorse** the 2027/28 work programme to move from diagnosis-led access and reactive purchasing to needs-led, planned and outcome-based commissioning.

The following next steps should be noted:

- Continue to actively manage the risk associated with Right to Choose provision for ADHD/Autism.
- Continue to explore further options/initiatives to mitigate the budget cost pressure.
- Continue with the Neuro-Developmental pathway transformation programme.

7. SUPPORTING DOCUMENTATION

There is no further supporting documentation

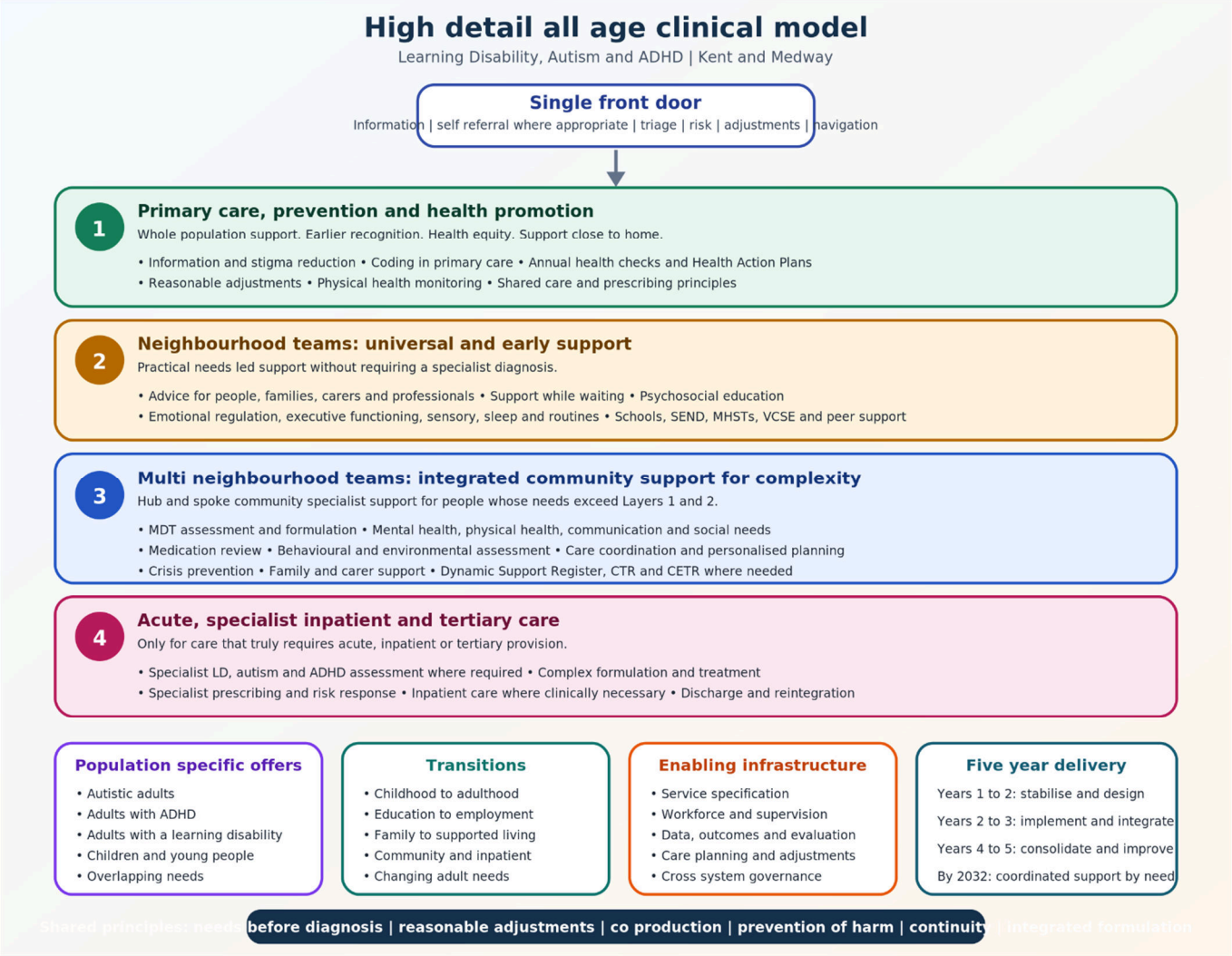
Appendices:

Appendix 1: Proposed Model of Care

Appendix 1. Proposed Model of Care

Moving to an all-age, needs-led, clinical model

The future model is needs-led, preventative, strengths-based and delivered as close to home as possible. Learning disability, autism and ADHD remain distinct lifelong characteristics, but the model recognises overlap with mental health, physical health, communication, sensory, social and environmental needs. Support will therefore not depend solely on diagnosis.



Single front door and differentiated pathways

A single front door will provide accessible advice, navigation, triage, immediate risk screening, identification of reasonable adjustments and routing to the appropriate level of support. It will not mean a single uniform clinical pathway: children and adults require different consent, safeguarding, developmental and professional arrangements, and patient choice must remain lawful and clear.

Four layers of care

Layer	Purpose	Core offer
1. Primary care, prevention and health promotion	Whole population and first clinical contact	Accessible information; earlier recognition; annual health checks and plans; reasonable adjustments; shared-care principles; suicide prevention; routes to additional support.
2. Neighbourhood teams - early support	Needs-led help without requiring diagnosis	Advice; waiting-well support; emotional regulation; communication and sensory support; family and school support; peer/VCSE input; practical post-diagnostic support.
3. Multi-neighbourhood teams - complexity	Integrated community capability across a larger footprint	MDT formulation; mental health support; medication review; behaviour and environment; care coordination; crisis prevention; DSR, CTR and CETR alignment.
4. Acute, inpatient and tertiary care	Highest risk, complexity and specialist need	Specialist assessment and prescribing; complex formulation; crisis response; inpatient care only where necessary; tertiary care; reintegration planning.

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	ICB Finance Report Month 4
Key question	What is the financial position of the ICB at the close of Month 4 2026/27?
Executive Lead	Jonathan Wilson, Chief Finance Officer
Author	Dilani Russell, Director of Financial Assurance and Improvement

Which of the organisation's strategic objectives does the report support:	
☐ Commission the right services each year	☒ To ensure financial sustainability over three years
☐ Lead strategy and ensure commissioning levers deliver impact	☐ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☐ Seek assurance ☐ Decision/approval required ☒ For noting/information

Recommendation(s) to the meeting:
The Board is asked to:

- Note the financial position of the ICB at the close of Month 4

Executive summary:
At Month 4, the ICB is on plan, reporting a year-to-date deficit of £16.9m and forecast outturn of £50.8m. Various cost pressures are emerging and are driving adverse year-to-date variances in several areas: • Out of Sector acute services; • All Age Continuing Care; • Discharge to Assess; • ADHD Right to Choose activity and expenditure; • Prescribing, particularly No Cheaper Stock Obtainable (NCSO) drugs These areas will be subject to close monitoring, with active interventions implemented where feasible to contain expenditure and mitigate further risk.
Proposed next steps:
The proposed next steps are to sustain delivery and acceleration of the CIP efficiency programme and develop additional pipeline schemes to provide headroom against any emerging risks. Continued focus on the management of demand-led cost pressures, particularly in the areas of Mental Health around ADHD, Section 117, All Age Continuing Care, and Prescribing activity, which is driving emerging financial risk is also required. Progressing the embedding of strengthened financial grip and control, including the ongoing tightening of management of activity, expenditure, and workforce-related cost reductions will continue.

Governance pathway to date:

Meeting name:	Date:	Outcome:
Exec Committee	12th August	Assured
Finance and Performance Committee	24th August	Assured

Contact for further information	Jonathan.Wilson6@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities, and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

COMPLIANCE NOTES:	
Conflicts of interest	
Are there any conflicts associated with authors or reporting officers?	
☐ Yes	☒ No
FOI status	
Is this report disclosable under FOI?	
☐ Yes	☒ No
Financial implications	
Are there financial implications associated with this report?	
☒ Yes	☐ No
Legal implications	
Are there legal implications associated with this report?	
☐ Yes	☒ No
Quality and safety implications	
Are there quality or safety implications associated with this report?	
☐ Yes	☒ No
Patient and public engagement	
Are there patient and public engagement implications associated with this report?	
☐ Yes	☒ No

ICB FINANCE REPORT: MONTH 4

1. INTRODUCTION

This report updates the Board on the ICB's financial performance, key risks and actions to maintain control and deliver the agreed plan.

The position is considered against the ICB's statutory duty to achieve financial balance, deliver the approved system plan and NHS England requirements, including significant efficiencies and management of underlying cost pressures.

It covers:

- Performance and forecast against plan;
- Key cost drivers and variances;
- Savings delivery;
- Financial risks and mitigations;
- Governance and oversight.

This supports the Board's scrutiny of performance and assurance over delivery, grip and control.

2. STRATEGIC ALIGNMENT

The financial position and actions set out in this report support the ICB's strategic objective of ensuring financial sustainability while maintaining effective system leadership. The report demonstrates how the ICB is operating within its financial envelope, delivering required efficiencies, and strengthening financial control, while continuing to prioritise resources towards frontline services and longer-term system transformation.

3. OVERVIEW OF ICB FINANCIAL POSITION

At Month 4, the ICB is on plan, reporting a year-to-date deficit of £16.9m and a forecast outturn of £50.8m.

The required CIP value cumulative value of £14.4m and full year outturn of £49.7m are being monitored through the Finance Recovery Group providing oversight and assurance of the ICB's financial performance, ensuring the organisation meets its statutory financial duties and delivers the in-year CIP plan.

There are cost pressures are emerging and are driving adverse year-to-date variances in several areas:

- Out of Sector acute services;
- All Age Continuing Care (AACC);
- Discharge to Assess (D2A);
- ADHD Right to Choose;
- Prescribing, particularly No Cheaper Stock Obtainable (NCSO) drugs.

These areas will be subject to close monitoring, with active interventions implemented where feasible to contain expenditure and mitigate further risk.

Table 1: Overall K&M ICB financial Position Month 4

K&M ICB Board Report 2026-27 Month 4						
	YTD			Forecast		
Description	Plan £'000's	Actual £'000's	Variance £'000's	Plan £'000's	Forecast £'000's	Variance £'000's
Acute Services	860,305	861,907	(1,602)	2,575,898	2,579,903	(4,005)
Mental Health Services	146,510	151,382	(4,872)	439,530	446,032	(6,502)
Community Health Services	175,460	177,866	(2,407)	526,073	530,205	(4,133)
Continuing Care Services	86,797	89,822	(3,025)	259,312	262,527	(3,216)
Primary Care Services	145,141	144,641	501	429,125	434,376	(5,252)
Other Commissioned Services	7,920	7,423	497	14,404	22,320	(7,917)
Other Programme Services	7,122	7,120	2	21,366	20,379	988
Reserves / Contingencies	(4,797)	(6,584)	1,787	(10,478)	(36,459)	25,981
Delegated Specialised Commissioning	192,417	192,417	0	580,913	580,913	0
Delegated Primary Care Commissioning	215,811	207,391	8,420	647,432	647,432	0
ICB Running Costs	10,233	9,508	725	30,698	26,644	4,054
Suspense Account	0	0	0	0	0	0
Total ICB Expenditure	**1,842,919**	**1,842,894**	**25**	**5,514,273**	**5,514,273**	**0**
Budgeted (Deficit) / Surplus	(16,948)	0	(16,948)	(50,847)	0	(50,847)
Total ICB Net Expenditure	**1,825,971**	**1,842,894**	**(16,923)**	**5,463,426**	**5,514,273**	**(50,847)**

Allocations

The 2026/27 Allocation details are confirmed by NHS England. Allocations and spend budgets have been updated in Month 4 where additions or reductions to allocations are confirmed by NHSE.

4. COST IMPROVEMENT PLANS (CIP)

Month 4 CIP delivery is broadly on track, with several schemes exceeding year-to-date expectations and helping to mitigate the impact of schemes experiencing slippage. The forecast outturn of £49.7m continues to be maintained, with ongoing monitoring of run-rate reductions providing assurance over delivery.

Whilst the ICB is fully committed to achieving the full year £49.7m planned target, fluctuations are expected month-on-month as schemes are measured against the originally phased plan profile.

Table 2: Month 4 CIP Performance

Programme	M1 Actual	M2 Actual	M3 Actual	M4 Actual	YTD Actual	Full-Year Forecast Outturn	CIP Target	Variance
F01-SH117 Aftercare and MH	11	11	11	11	44	134	5,743	-5,609
F02-AACC	391	636	896	818	2,741	9,971	14,358	-4,387
F03-Independent Sector	139	377	177	607	1,300	11,521	8,442	3,079
F05-Prescribing	1,318	1,343	1,343	2,399	6,403	16,383	12,505	3,878
F06-Digital	43	50	53	57	203	722	574	148
F07-Estates	9	9	376	47	441	824	1,149	-325
F08-Commissioning	415	415	415	-520	725	2,854	2,149	705
F09-Corporate Gov	2	2	2	6	12	30	17	13
F10-Primary Care	229	229	229	229	916	2,766	1,149	1,617
F13-Programme Cost Review	17	17	17	17	68	201	287	-86
F16-Urgent & Emergency Care	5	5	5	5	20	282	574	-292
F17-Transport Costs	450	225	225	225	1,125	2,700	0	2,700
F21-Adult ADHD	0	0	0	0	0	0	2,000	-2,000
F22-Unwarranted Variation	109	109	109	109	436	1,306	747	559
Total	**3,138**	**3,428**	**3,858**	**4,010**	**14,434**	**49,694**	**49,694**	**0**

CIP schemes are in the process of having savings validated in the financial ledger to confirm delivery. This process is currently underway involving Finance Business Partners and scheme owners. Whilst robust governance arrangements remain in place, ongoing scrutiny is required to ensure risks are identified, escalated and mitigated at the earliest opportunity.

Key programme risks remain within Section 117 Mental Health packages of care and AACC, with Prescribing and other schemes mitigating slippage. These risks are subject to regular review and active management through the weekly Finance Recovery Group, providing oversight of delivery, financial impact and mitigating actions.

5. DEPARTMENTAL REPORTS

5.1 Acute Services

Table 3: ICB In Month and Year To Date overview: Acute Services

Acute Services 2026/27 Month 4						
	YTD			Forecast		
Description	Plan £'000's	Actual £'000's	Variance £'000's	Plan £'000's	Forecast £'000's	Variance £'000's
Local Acute Contracts - MFT	135,669	135,669	0	407,008	407,008	0
Local Acute Contracts - MTW	194,475	194,475	0	583,424	583,424	0
Local Acute Contracts - DGT	107,418	107,418	0	322,255	322,255	0
Local Acute Contracts - EKHUFT	254,224	254,224	0	762,673	762,673	0
Local Acute Contracts - Other	248	248	0	278	278	0
Independent Sector Contracts	21,894	22,234	(341)	63,298	63,298	0
Tertiary Contracts - Guys	21,427	21,427	0	64,282	64,282	0
Tertiary Contracts - Kings	20,419	20,419	(0)	61,257	61,257	0
Tertiary Contracts - Other	23,940	25,180	(1,240)	71,821	75,539	(3,719)
SECAmb Contract	40,693	40,684	9	122,078	122,051	27
Patient Transport Services	9,009	8,976	33	27,028	26,929	99
Acute NCA	6,163	6,163	(0)	18,489	18,491	(2)
High Cost Drugs	3,995	3,995	0	11,984	11,984	0
Other Acute	20,731	20,794	(63)	60,024	60,434	(410)
Total ICB Net Expenditure	**860,305**	**861,907**	**(1,602)**	**2,575,898**	**2,579,903**	**(4,005)**

This section of the report is based on the ICB's validated Contract Finance Report and reflects the Month 3 contractual financial position. The reporting position is aligned to the national timetable for activity and finance submissions, provider validation processes, and the completion of Finance and Technical Contract Subgroup reviews. As a result, the latest validated position available at the time of reporting is Month 3. In-System acute contracts remain broadly on plan as they are subject to capped contract arrangements.

The Acute cumulative adverse variance of £1.6m relates to activity outside the local Acute portfolio, comprising:

- Out of Sector Acute Contracts: £1.2m adverse
- Other Acute services (including Weight Management and ENT): £0.6m adverse.
- Independent Sector activity: £0.3m adverse.

Overall Assessment

The validated Month 2 Freeze position suggests genuine activity variation but no material financial risk at this stage within the local acute portfolio due to capped contracts.
The principal financial risks sit within Out of Sector activity growth rather than in-system acute contracts. While the year-to-date variances are currently manageable, confidence in the position remains dependent on improved provider data quality, successful delivery of

Data Quality Improvement Plans, and the validation of Month 3 Freeze submissions. Southeast London Providers are also likely to “refresh” Q1 data given the host agreements in place.

Active contract management interventions are underway to strengthen compliance with agreed Indicative Activity Plans (IAPs) across tertiary providers. Whilst all available contractual and operational measures will be utilised to manage activity within plan, the ICB has limited direct control over activity levels delivered by out-of-area providers. Consequently, further review of referral pathways and commissioning arrangements will be required to identify opportunities for activity repatriation where clinically appropriate.

This is particularly relevant where contracts operate on a variable funding basis, creating financial exposure from activity growth, whilst several of the ICB's in-system acute contracts remain subject to capped arrangements and are currently underperforming against planned activity levels. Continued monitoring and targeted intervention will therefore be required to mitigate financial risk and optimise activity delivery across the provider portfolio.

Data Quality

Data quality remains the single largest factor affecting interpretation of Acute performance. Whilst Month 2 Freeze data provide a validated baseline, Month 3 remains at Flex stage and is subject to significant coding and completeness concerns, limiting confidence in reported variances and trend analysis. All four local acute providers continue to report material Flex-to-Freeze variances, primarily driven by ungrouped activity, coding delays and incomplete submissions. Data Quality Improvement Plans (DQIPs) are in place with each provider, with trajectories agreed to improve coding completeness and reduce reporting variance.

Monthly Finance and Technical Groups (FTG’s) are in place with each local acute provider and data quality, timeliness and a joint understanding of in month reported positions are sought with providers. It is to be noted that contract reporting arrangements are still maturing, and analytical capacity constraints continue to impact the speed of validation, reconciliation and assurance processes. Consequently, Flex data should be treated as indicative rather than definitive.

5.2: Community Services

Table 4: ICB In Month and Year To Date overview: Community Services

Community Services 2026/27 Month 4						
	YTD			Forecast		
Description	Plan £'000's	Actual £'000's	Variance £'000's	Plan £'000's	Forecast £'000's	Variance £'000's
Community Contracts	99,690	99,693	(3)	299,069	299,072	(3)
Community Local Care	3,080	2,679	402	8,898	8,302	596
Better Care Fund	23,526	23,526	0	70,579	70,579	0
Ophthalmology	9,152	9,768	(616)	26,343	26,558	(215)
Dermatology	5,869	6,279	(410)	17,606	17,692	(86)
Community ERF Income offset	0	0	0	0	0	0
Discharge to Assess	4,828	6,714	(1,887)	14,593	20,143	(5,550)
Physiotherapy	3,345	3,399	(54)	10,035	10,079	(44)
Hospices	3,472	3,472	(1)	10,416	10,416	(1)
Intermediate Care	1,902	1,902	0	5,707	5,707	(0)
Community Equipment	4,004	4,004	0	12,013	12,013	0
Community Other	16,592	16,429	163	50,814	49,644	1,170
Total ICB Net Expenditure	**175,460**	**177,866**	**(2,407)**	**526,073**	**530,205**	**(4,133)**

Community Services is £2.4m adverse year to date, primarily due to overspend on Discharge to Assess (D2A) activity, offset by delays in planned expenditure. Discharge to Assess activity is above plan and is being actively reviewed with the budget holder to identify pathway movement and inter-connections to other parts of the health system. Ophthalmology and Dermatology are both shown as overspent year-to-date with planned savings in the rest of the year expected to bring alignment to plan. Community Equipment is breakeven year-to-date.

5.3 Mental Health

Table 5: ICB In Month and Year To Date overview: Mental Health

Mental Health 2026/27 Month 4						
	YTD			Forecast		
Description	Plan £'000's	Actual £'000's	Variance £'000's	Plan £'000's	Forecast £'000's	Variance £'000's
Mental Health NHS Contracts	89,236	89,717	(480)	267,709	269,090	(1,381)
Mental Health Investment Standard	29,940	29,457	483	89,819	88,438	1,381
Learning Disability and Autism	23,695	28,558	(4,863)	71,086	77,587	(6,502)
Dementia	1,841	1,852	(11)	5,523	5,523	0
Non Mental Health Investment Standard	1,798	1,798	0	5,394	5,394	0
Total ICB Net Expenditure	**146,510**	**151,382**	**(4,872)**	**439,530**	**446,032**	**(6,502)**

As per Month 3, activity and expenditure relating to ADHD Right to Choose continues to exceed planned levels significantly. There are discussions internally and with providers to contain the current run rate to ensure over performance focuses on patient safety and backlog clearance.

This includes a range of controls implemented to manage expenditure and bring activity back within agreed levels. Provider activity levels are being closely monitored through enhanced reporting arrangements, including RAG-rated performance oversight and regular review meetings to assess progress against agreed Indicative Activity Plans (IAPs) and address any barriers to delivery. The position will continue to be subject to enhanced scrutiny through the ADHD Working Group, Financial Recovery Group, routine management accounting processes, and monthly financial reporting to ensure that mitigating actions are delivering the expected reduction in expenditure.

5.4: All-Age Continuing Care (AACC)

Table 6: ICB In Month and Year To Date overview: Continuing Care

Continuing Care 2026/27 Month 4						
	YTD			Forecast		
Description	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Forecast £000's	Variance £000's
Adult Continuing Care	65,465	69,080	(3,615)	195,314	201,436	(6,122)
Funded Nursing Care	13,838	13,176	662	41,513	39,229	2,285
Childrens Continuing Care	5,283	4,898	385	15,849	14,504	1,345
CHC Admin Team	2,212	2,668	(456)	6,636	7,359	(723)
Total ICB Net Expenditure	**86,797**	**89,822**	**(3,025)**	**259,312**	**262,527**	**(3,216)**

There is a cumulative adverse variance of £3.0m at Month 5 mainly due to adult continuing care packages.

5.5: Prescribing

Table 7: ICB In Month and Year To Date overview: Prescribing

Prescribing 2026/27 Month 4						
	YTD			Forecast		
Description	Plan £'000's	Actual £'000's	Variance £'000's	Plan £'000's	Forecast £'000's	Variance £'000's
Prescribing	120,860	121,547	(687)	357,031	362,959	(5,928)
Central Drugs	3,796	3,796	0	11,389	11,389	(0)
Total ICB Net Expenditure	**124,656**	**125,343**	**(687)**	**368,420**	**374,348**	**(5,928)**

In July, additional Prescribing allocations were received of £4.2m in relation to Category M drugs for the first months of the year. NCSO drug price increase remains an unfunded pressure.

5.6: Primary Care including Delegated Primary Care

Table 8: ICB In Month and Year To Date overview: Delegated Primary Care

Delegated Primary Care 2026/27 Month 4						
	YTD			Forecast		
Description	Plan £'000's	Actual £'000's	Variance £'000's	Plan £'000's	Forecast £'000's	Variance £'000's
Delegated GP	148,616	141,721	6,896	445,849	445,849	0
Delegated Ophthalmic	7,638	6,730	908	22,913	22,913	0
Delegated Pharmacy	17,571	17,739	(167)	52,714	52,714	(0)
Delegated Primary Dental	27,974	27,678	296	83,923	84,631	(707)
Delegated Secondary Dental	9,981	9,432	549	29,944	28,669	1,276
Delegated Community Dental	3,993	4,067	(75)	11,978	12,547	(568)
Delegated Property Costs	0	0	0	0	0	0
Delegated Primary Care IT	37	24	12	110	110	0
Total ICB Net Expenditure	**215,811**	**207,391**	**8,420**	**647,432**	**647,432**	**0**

A favourable variance cumulatively reflects the impact of budget phasing together with delays in planned commitments that are forecasted to deliver and breakeven by year end.

Table 9: ICB In Month and Year To Date overview: Primary Care

Primary Care 2026/27 Month 4						
	YTD			Forecast		
Description	Plan £'000's	Actual £'000's	Variance £'000's	Plan £'000's	Forecast £'000's	Variance £'000's
Local Enhanced Services	6,738	6,738	0	19,434	19,434	0
Medicines Optimisation	1,511	1,450	60	4,532	4,442	90
Out Of Hours	6,536	6,537	(1)	19,608	19,261	348
GP Investment	0	13	(13)	15	50	(35)
Oxygen	1,257	1,239	18	3,986	4,004	(18)
Primary Care IT	3,572	3,170	402	10,529	10,203	326
GP Other Commissioned Services	855	112	743	2,565	2,566	(1)
Primary Care - Other	17	38	(21)	50	70	(20)
Primary Care CIP Programmes	0	0	0	0	0	0
Total ICB Net Expenditure	**20,485**	**19,298**	**1,188**	**60,720**	**60,029**	**691**

A favourable variance year-to-date of £1.2m due to delayed spends on IT £0.4m and other commissioned services £0.7m.

5.7: ICB Running Costs

Table 10: ICB In Month and Year To Date overview: ICB Running Costs

ICB Running Costs 2026/27 Month 4						
	YTD			Forecast		
Description	Plan £'000's	Actual £'000's	Variance £'000's	Plan £'000's	Forecast £'000's	Variance £'000's
ICB Board	590	857	(267)	1,769	2,680	(911)
Chair and Non Executives	92	72	20	275	262	13
Delivery and Strategic Commissioning Division	1,389	1,406	(17)	4,166	4,271	(105)
Finance; Contracting; Digital and Assurance Division	3,216	4,417	(1,201)	9,647	11,206	(1,559)
People; Culture; Communications and Engagement Division	910	1,100	(190)	2,731	2,961	(230)
Chief Medical Officer Division	192	110	82	575	443	132
Strategy and Partnership Division	426	66	360	1,279	752	527
Governance; EPRR; Strategic Estate and Sustainability Division	875	930	(54)	2,626	2,681	(55)
Nursing and System Workforce Division	380	550	(171)	1,139	1,387	(248)
ICB Running Cost Savings Target	2,164	0	2,164	6,491	0	6,491
Total ICB Net Expenditure	**10,233**	**9,508**	**725**	**30,698**	**26,644**	**4,054**

The restructuring of the ICB to achieve the mandated Management Costs reduction has been completed and the new staff structure and operating model implemented on 1st of July 2026.

There have been non-recurrent staff costs across the ICB due to staff departure dates and the finalisation of voluntary and compulsory redundancy.

The detailed 2026/27 budgets for each corporate area have been aligned to the new staff structure, and these budgets have been uploaded in Month 4 allowing more detailed budget statements to be sent to relevant managers and reporting to the Executive and Finance and Performance Committees.

5.8: Delegated Specialised Commissioning

Table 11: ICB In Month and Year To Date overview: Delegated Specialised Commissioning

Delegated Specialist Commissioning 2026/27 Month 4						
	YTD			Forecast		
Description	Plan £'000's	Actual £'000's	Variance £'000's	Plan £'000's	Forecast £'000's	Variance £'000's
Spec Comm Acute	151,009	151,009	0	456,692	456,692	0
Spec Comm Mental Health	0	0	0	0	0	0
Spec Comm Drugs	0	0	0	0	0	0
Spec Comm Devices	0	0	0	0	0	0
Spec Comm Collaborative	27,154	27,154	0	81,462	81,462	0
Spec Comm Networks	0	0	0	0	0	0
Spec Comm Staffing	0	0	0	0	0	0
Spec Comm Other	1,810	1,810	(0)	5,430	5,430	0
Spec Comm Contingency	736	736	(0)	2,207	2,207	0
Spec Comm Reserves	11,708	11,708	(0)	35,123	35,123	0
Total ICB Net Expenditure	**192,417**	**192,417**	**0**	**580,913**	**580,913**	**0**

Delegated Specialised Commissioning is on plan in both core and Reserves with the contingency intact.

6.1: Statement of Financial Position

Table 13: Statement of Financial Position

K&M ICB Board Report 2026-27 Month 4				
Statement of Financial Position				
ICB				
	Apr-26	May-26	Jun-26	Jul-26
	£000s	£000s	£000s	£000s
Property, Plant & Equipment	2,111	2,185	2,125	2,039
Total Non Current Assets	**2,111**	**2,185**	**2,125**	**2,039**
Trade & Other Receivables	40,555	51,179	71,985	56,236
Cash & Cash Equivalents	475	1,879	207	237
Total Current Assets	**41,030**	**53,059**	**72,191**	**56,473**
Total Assets	**43,141**	**55,244**	**74,317**	**58,512**
Trade & Other Payables	(330,396)	(302,704)	(326,276)	(186,059)
Short Term Borrowing	(591)	(572)	(552)	(533)
Provisions	(2,669)	(2,669)	(2,669)	(2,684)
Total Current Liabilities	**(333,657)**	**(305,945)**	**(329,498)**	**(189,276)**
Long Term Liabilities	(1,073)	(1,074)	(1,074)	(979)
Total Long Term Liabilities	**(1,073)**	**(1,074)**	**(1,074)**	**(979)**
Total Assets less Total Liabilities	**(291,588)**	**(251,774)**	**(256,256)**	**(131,743)**
Total Taxpayers' Equity	**(291,588)**	**(251,774)**	**(256,256)**	**(131,744)**

Trade and other receivables:

- At month 4 the ICB had outstanding sales invoices of £48.4m of which £47.5m was over 30 days+. The team are actively working on reducing this value.
- The balance of the receivables relates to VAT reclaim (£1.6m) and allowances for credit losses (£11.5m).

Cash:

- The balance at month 4 represents 0.06% of the July drawdown – NHS England target is 1.25%.

- **Trade and other payables**:
  - At month 4 the ICB had outstanding invoices of £123.2m of which £85.9m was over 30 days+, NHS accruals £1.7m, Non-NHS & WGA accruals £34.2m and £69.56m of other payables and accruals.

BPPC

- Measured at 30 days the ICB is achieving the target of 95% in non-NHS value and volume.
- For NHS organisations the ICB is achieving the target of 95% in NHS value and volume.

Table 14: BPPC performance

Better Payment Practice Code	31/7/26 Number	31/7/26 £'000
Non-NHS Payables		
Total Non-NHS trade invoices paid in the year	51,105	501,996
Total Non-NHS trade invoices paid within target	50,919	498,673
Percentage of Non-NHS trade invoices paid within target	**99.64%**	**99.34%**
NHS Payables		
Total NHS trade invoices paid in the year	1,034	1,219,221
Total NHS trade invoices paid within target	1,021	1,218,886
Percentage of NHS trade invoices paid within target	**98.74%**	**99.97%**

5.10: ICB capital

The Capital allocation for 2026/27 is £12.0m.The capital expenditure position at Month 4 shows £0.5m year-to-date spend, being £0.4m adverse to plan.

Table 15: Capital Expenditure Month 4

Capital Scheme	Scheme Reference	Scheme Name	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s	Full Year Plan (20262/7) £000s	Full Year Forecast (20262/7) £000s	Full Year Variance (20262/7) £000s	Capital Forecast (2027/28) £000s
11	QKS-27-022	Folca Development (Folkestone)	0	455	(455)	1,299	1,299	0	0
30	LA0010	Lordswood Community Healthy Living Centre	0	1	(1)	0	3	(3)	1
32	LA0012	Rochester Healthy Living Centre	0	1	(1)	0	3	(3)	0
ALL OTHER	-	-	100	1	99	10,691	10,694	(3)	12,288
TOTAL			**100**	**458**	**(358)**	**11,990**	**11,999**	**(9)**	**12,289**

6. KEY RISKS, MITIGATIONS, AND CONTROLS

The table below presents the key risks, mitigations and controls as at month 4. Continuous work is in progress to evaluate the underlying level of risk for each of these factors as well as continual scrutiny of all activity and spend areas to identify new and emerging risks at the earliest opportunity.

Risk Area	Risk Description & Impact	Mitigation / Controls in Place
Delivery of CIP programme	Delivery is broadly on plan but with slippage in key areas (Section 117, management cost reductions, ADHD) creating risks to delivery of the £50.8m plan.	• Weekly Finance Recovery Group (FRG) scrutiny and challenge with an actin log managed and updated each week. • Ongoing identification of additional CIP opportunities and pipeline • Acceleration of in-flight schemes where feasible • Executive oversight of delivery trajectory and gaps • Use of non-recurrent mitigations where necessary

Demand-led cost pressures (ADHD RtC, S117, AACC)	Underlying demand and activity growth (notably Right to Choose) are driving adverse variances and forecast pressures, expected to add c.£6.5m pressure	• Senior level internal and provider level conversations to strengthen activity controls • Alignment to Indicative Activity Plans (IAPs) • Targeted transformation and demand management programmes • Budget mitigations already identified and applied
Data quality and timeliness (acute & prescribing)	Incomplete/lagged data (acute activity validation and prescribing data delay) creates uncertainty in forecasting the reported position.	• Validation and triangulation with in-system providers on flex to freeze processes • Quarterly reconciliations • Use of accruals and estimates based on best available intelligence • Benchmarking on prescribing data with neighboring and/or similar size ICBs
Out of System acute activity	Emerging overspend in out-of-system activity (£1.2m cumulative) risks further escalation if not controlled	• Enforcement of Indicative Activity Plans with providers • Contractual levers and activity monitoring • Ongoing system-level discussions to manage flow and demand
External cost pressures (prescribing and supply chain)	Potential supply disruption and price inflation (linked to geopolitical factors) may increase prescribing costs beyond plan	• Escalation to Regional Team for national discussions • Close monitoring of national guidance and price movements • Prescribing optimisation via clinical and pharmacy teams • Flexibility within system mitigations where required

Overall Risk Assessment
The ICB remains on plan at Month 4, but several financial risks need to be mitigated:

- All Age Continuing Care Out of Sector acute contractual risks;
- ADHD Right to Choose;
- Discharge to Assess;
- Prescribing, particularly No Cheaper Stock Obtainable drugs.

The principal risks are demand-led pressures over and above the planned position with delivery of recurrent savings required to manage sustainability.

CONCLUSIONS AND NEXT STEPS

At Month 4, the ICB is on plan, reporting a year-to-date deficit of £16.9m and forecast outturn £50.8m.

Delivery of the financial plan is dependent on the following:

- Sustained delivery and acceleration of the CIP programme, with current delivery on plan but with the need to develop additional pipeline;
- Effective management of demand-leading cost pressures, particularly in ADHD Right to Choose, Out of Sector Acute activity, Discharge to Access and Prescribing NCSO drug pressure, which are driving financial risks.
- Continued financial grip and control.

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Commissioning Intentions 2027/28
Key question	Following engagement with our public and partners on our Commissioning Intentions for 2027/28, is Board happy to approve proposed changes and next steps?
Executive Lead	Chris Neill, Chief Commissioning Officer
Author	Dominic Cox, Interim Deputy Chief Commissioning Officer

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☒ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☐ Seek assurance ☒ Decision/approval required ☒ For noting/information

Recommendation(s) to the meeting:

- To **APPROVE** our final Commissioning Intentions for 2027/28
- To **NOTE** next steps regarding mobilisation of our formal contractual arrangements
- To **NOTE** delivery and capacity risks, linked to commissioning/contractual process

Executive summary:

On 21 July, we published our draft intentions and invited feedback from a wide range of stakeholders, up until 1 September. In parallel, we undertook a public survey to test what aspects of healthcare were most important to our residents. This paper provides an overview of process, feedback and seeks approval to our final Commissioning Intentions document for 2027/28. An overview is also provided of next steps regarding contractual

arrangements and a summary of delivery and capacity risks, linked to our commissioning/contractual processes.

Proposed next steps:

- To integrate the commissioning intentions into 27/28 contracting round.
- To develop work plans to deliver Commissioning Intention priorities in 2027/28.

Governance pathway to date:

Meeting name:	Date:	Outcome:
Executive Committee	9 September	Approval
ICB Board	21 July	Approval
Executive Committee	8 July	Approval

Contact for further information	Chris Neill, Interim Chief Commissioning Officer

COMPLIANCE NOTES:

Equality, health inequalities and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)
Assessments will be made at the appropriate time for individual/specific service changes

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?
☐ Yes ☒ No
If yes, please confirm how the conflict has been managed.

FOI status

Is this report disclosable under FOI?
☒ Yes ☐ No
If no, please specify why:

Financial implications

Are there financial implications associated with this report?
☒ Yes ☐ No
If yes, please describe:

COMPLIANCE NOTES:

As we commission more strategically, we will strive to deliver better value and outcomes:

- Outcome-based funding and reduced stability (moving towards quality and outcomes)
- Shift from Acute to Community Care
- Risk sharing

Legal implications

Are there legal implications associated with this report?

☒ Yes ☐ No

If yes, please describe:

Strategic commissioning involves complex legal responsibilities, primarily concerning:

- Statutory duties to involve/consult, reduce inequalities and equality/human rights
- Procurement & Competition Law – Provider Selection Regime & Procurement Act
- Governance of Pooled Budgets & Delegation/Contractual and Risk issues

Quality and safety implications

Are there quality or safety implications associated with this report?

☒ Yes ☐ No

If yes, please describe:

Key quality and safety implications:

- Proactive Safety and Risk Management
- Outcome-based Quality/Integrating Quality into Strategy
- Addressing Inequalities, Safeguarding and Clinical Governance

Patient and public engagement

Are there patient and public engagement implications associated with this report?

☒ Yes ☐ No

If yes, please describe. If no, please specify why:

Key implications of patient and public engagement:

- Transformational shift (continuous and co-designed relationships with local communities)
- Legal Duty and Accountability – needed to justify service reconfigurations/decommissioning
- Tackling Health Inequalities – proactive reaching seldom-heard and vulnerable communities

COMMISSIONING INTENTIONS 2027/28

1. INTRODUCTION

On 21 July, we published our draft intentions and invited feedback from a wide range of stakeholders, up until 1 September. In parallel, we undertook a public survey to test what aspects of healthcare were most important to our residents. This paper provides an overview of feedback, process and seeks approval for our final Commissioning Intentions document for 2027/28.

2. STRATEGIC ALIGNMENT

Our Commissioning Intentions for 27/28 will drive our commissioning priorities, which are aligned to our Kent and Medway 3 Year Commissioning Plan and 5 Year Strategy.

3. OVERVIEW OF APPROACH TO DEVELOP COMMISSIONING INTENTIONS

At our ICB Board on 21/7 we approved our draft intentions and commenced our engagement. On the same day, we published our draft intentions and invited feedback from a wide range of stakeholders, up until 1 September. In parallel, we undertook a public survey to test what aspects of healthcare are most important to our residents.

In addition, we commissioned LAKE Research (Market Research Company) and EK360 (Community Outreach) to support engagement, both face-to-face and survey focus. We have proactively attended Health and Wellbeing Boards and Scrutiny Committees, as well as sessions with VCSE, Providers and Primary Care colleagues. We convened a Maternity Services Provider Engagement Event on 5 August, with a number of other events hosted to facilitate feedback.

We have received a total of 3,343 responses of these 533 work in health and care and/or for an NHS organisation and we have heard from more than 25 organisations, stakeholders and partners.

Our final Commissioning Intentions document is attached for approval. Following a Board Development session on Thursday 27 August, all Board members were sent the draft version for feedback on 4 Friday, prior to sign-off at Executive Committee on Wednesday 9 September.

4. WHAT HAVE WE HEARD THROUGH OUR ENGAGEMENT ?

In grouping feedback and themes, we have categorised by the following:

- Public (including staff)
- Providers
- Primary Care
- Councils
- VCSEF (Voluntary, Community, Social Enterprise and Faith Sector)
- MPs and Political Groups

Feedback is summarised in this section, appendices attached for specific summary reports.

Public (including staff)

Faster and easier access is most important to the public (GP, Hospital waits, Dental Access, Mental Health/Autism/ADHD), with the ranked highest priorities as follows:

- GP access
- Shorter waiting times
- Urgent and emergency care
- Better mental health support
- Support for older people/frailty

Care closer to home is supported, however strong feedback that “local” does not automatically mean “accessible” and transport/travel challenges need considering.

We also heard that the public:

- Have high levels of confidence in Community Pharmacy
- Value joined-up care, shared records and continuity, accountability and ownership
- Welcome digital support but reject digital only – require a balance of telephone, face-to-face and paper options
- Want credible community alternatives to A&E but need an effective discharge and flow system
- View safety of Maternity and Neonatal services as essential moving forward

Providers

Providers are consistently supportive of the strategic direction. There is broad endorsement of prevention, neighbourhood health, integrated care, the Four Layers of Care and a progressive move from activity-based to outcome-based commissioning. The shared ambition is to improve outcomes, reduce avoidable hospital use, strengthen care closer to home and make better use of system resources. Main provider feedback is focussed on the “how” and “when”, there is broad agreement on the “why” and “what”.

The common concern is deliverability: capacity, workforce, digital infrastructure and financial mechanisms not yet being sufficiently aligned to enable activity and funding to move safely from acute to community settings. There is challenge about whether the system can convert ambition into a practical transition plan that creates capacity before removing it elsewhere, aligns resources with responsibility and shares risk fairly.

Providers support a standardised and properly resourced primary/neighbourhood care offer and for urgent and emergency care to be more integrated. KCHFT (Kent Community Health Foundation Trust) seeks faster and more ambitious community investment, emphasising the importance of “levelling-up” and KMMH (Kent and Medway Mental Health Trust) seeks greater definition of mental health pathways, roles and commissioning arrangements, recognising historical underfunding.

Our Maternity Services Provider Engagement Event was held on 5th August. Participants included Provider Trusts, the Maternity and Neonatal Voices Partnership, Council partners, Primary care representatives, VCSEF organisations and other key System stakeholders. Agreement was achieved on priority Review objectives, which included improve safety, quality and outcomes, listen to and partner with women and families and define future configuration of maternity, neonatal and women's services.

Specialised Commissioning feedback regarding importance of aligning commissioning intentions, proposal to add Neurology/Headache services.

Primary Care

Strong support for the direction of travel, with the central role of General Practice and neighbourhood teams being recognised, however feedback is that ambitions understate current workload and capacity pressures. Delivery requires sustained investment, stronger clinical leadership, practice autonomy, clearer accountability and assurance that funding follows transferred activity. Feedback is that the commissioning intentions should state explicitly how the ICB will enable and resource transformation, not only what providers must deliver. Strong support across Primary Care for a "core offer" and importance of Pharmacy, Optometry and Dental in neighbourhood integration.

Relationships between single and multi-neighbourhoods must be explicit, with all providers retaining responsibility for pathway ownership, communication and follow-up. Strong support expressed for more integrated provision to enable neighbourhood working at scale. Importance of more proactive models for patients within high-risk cohorts is recognised as critical, as is the focus on a more preventative approach.

Councils

Both Kent and Medway Councils endorse the focus on prevention, early intervention, neighbourhood-based care, reduced inequalities, care closer to home and commissioning for outcomes. Both want Councils to be recognised as Co-Commissioners and System Leaders, calling for stronger integration with public health, social care, housing, education, employment and the voluntary sector.

Both warn against shifting activity into primary, community and home-based care without adequate funding, workforce, infrastructure and market capacity.

Both support multidisciplinary neighbourhood models but seek clearer roles for councils, social care, housing, public health, community organisations and primary care. The role of unpaid carers is viewed as significantly underdeveloped within the draft commissioning intentions. As more care is expected to be provided at home and within communities, carers will become increasingly important to service delivery.

Extensive feedback and strong support was given to the proposed review of Mental Health, Learning Disabilities, Autism and ADHD services across Kent and Medway. It will retain an all-age perspective, covering children and young people, working-age adults and older people. Challenge was given that the initial review scope was primarily health focussed and needed to be broader and more system-focused, given opportunities for more integrated

joint provision, teams, commissioning and funding. Population growth and infrastructure recognised as needing greater prominence.

VCFSE (Voluntary, Community, Faith and Social Enterprise Sector)

We had a massive response from our VCFSE sector, with a strong call for greater recognition of the sector as a Strategic Delivery Partner. A message strongly received is that grassroots/VCFSE organisations already deliver prevention and early intervention. The VCFSE sector is uniquely placed to reach underserved and marginalised communities, build trust with communities who may not engage with statutory services and address wider determinants of health. The strongest common message is to formally embed grassroots VCFSE organisations within the neighbourhood health model, ensuring a stronger geographical alignment/interface. VCFSE engagement plays an important role, however feedback proposes the need for a clearer route from engagement to funded commissioning.

The critical role of Carers was also recognised and the associated risk of unintentionally moving more responsibility onto Carers, with a shift of activity to home and community.

MPs and Political Groups

MP and Political Group responses are supportive of the overall direction of prevention, neighbourhood health and care closer to home. Concerns included whether digital-first access models can worsen inequalities. They believe fully integrated shared care records across providers are essential to neighbourhood health. GP shortages, poor access to NHS Dentistry and long waits for ADHD and autism assessments are identified as challenges/concerns. Greater recognition of existing prevention and wellbeing initiatives and stronger integration between local government, community organisations and NHS services is recommended. Greater use of community assets is proposed, for example, using schools as hubs for health promotion and community outreach, in development of local neighbourhood care.

5. WHAT HAVE WE CHANGED ? – “YOU SAID, WE DID ”

What our public and partners told us and how it has shaped the final commissioning intentions

The development of the 2027/28 Commissioning Intentions has been informed by one of the most extensive engagement programmes undertaken in healthcare across Kent and Medway in recent years. We heard from over 3300 residents, carers and staff as well as getting responses from community organisations, voluntary sector partners, public health leaders, councils, clinicians and NHS providers through surveys, community conversations, stakeholder submissions, social media feedback and independent research.

While views differed on specific issues, the feedback was remarkably consistent. People supported the need for change and the direction of travel. But they asked us to make sure that improvement is experienced as better outcomes, not simply different care. Feedback has directly influenced revisions to the final commissioning intentions and strengthened how we describe our priorities, expectations and measures of success.

While views differed on specific issues, the feedback was remarkably consistent. People supported the need for change and the direction of travel. But they asked us to make sure that improvement is experienced as better care, not simply different care. Feedback has directly influenced revisions to the final commissioning intentions and strengthened how we describe our priorities, expectations and measures of success.

You said: Access to NHS services should be the top priority

The most consistent message we heard was the need for easier access to care. Residents described difficulties accessing GP appointments, long waits for treatment and challenges navigating services. Feedback repeatedly highlighted the importance of continuity, communication and knowing who is responsible for care. Easier access to GP appointments emerged as the highest priority in both independent research and public engagement.

We did

We strengthened our commitments on access across primary care, elective care, urgent care and mental health. Our commissioning intentions give greater emphasis to improving access standards, reducing waits, simplifying referral pathways, creating clearer routes into services and improving communication while people are waiting for care. We will proceed to agree a clear universal core offer across general practice, community pharmacy and optometry. We plan to build on the foundations of our existing plans and ensure review/follow-up to deliver improvements in access over multiple years.

You said: Focus on Urgent and Emergency Care and support for frail older people

You want credible community alternatives to A&E but need a more effective discharge and flow system.

We did

We will have a greater focus on those with highest care needs, those who live with frailty, multiple long-term conditions, mental health and social care complexity. We will urgently progress an integrated model to deliver impact before April 2027. We will increase our focus on continuity of care for vulnerable people and those with complex needs, strengthening continuity of care as a measurable outcome.

You said: Providers expressed concerns regarding transition and deliverability

The common concern is deliverability: capacity, workforce, digital infrastructure and financial mechanisms not yet being sufficiently aligned to enable activity and funding to move safely from acute to community settings. Challenge as to whether the system can convert ambition into a practical transition plan that creates capacity before removing it elsewhere, aligns resources with responsibility and shares risk fairly.

We did

We will add a new section within the final document regarding how we will work together with Provider/Council partners, including approach to contracting 2027/28.

You said: You welcome digital support but reject digital only

Although many people support digital innovation, they were clear that digital services should not become the only way to access care. Respondents highlighted digital exclusion, language barriers, disability, confidence using technology and the need for face-to-face and telephone alternatives. Many people told us that digital should make access easier, not create another barrier.

We did

We strengthened our commitment that the NHS App and digital services will increasingly support care, while maintaining effective non-digital alternatives for people who need them. We have also placed greater emphasis on digital inclusion, accessibility, patient choice and ensuring technology improves outcomes and experience rather than simply increasing digital adoption.

You said: Mental health support needs to happen before crisis

Many respondents told us that services are too often focused on responding after people reach crisis point. Faster access to support and earlier intervention emerged as priorities. People also told us that support for autism and ADHD should not depend solely on receiving a diagnosis.

We did

The final commissioning intentions place greater emphasis on prevention, early intervention, all-age mental health pathways, support before diagnosis and neighbourhood-based delivery. Our revised scope for proposed review of Mental Health, Learning Disabilities and Autism and ADHD services across Kent and Medway will be broader and more system-focused, given feedback and joint opportunities. We will commit to making faster progress with “This is Me” psychology/neurodiversity support for ADHD.

You said: Local VCFSE organisations and communities must be part of solution

A message strongly received is that grassroots/VCFSE organisations already deliver prevention and early intervention. The VCFSE sector is uniquely placed to reach underserved and marginalised communities, build trust with communities who may not engage with statutory services and address wider determinants of health.

We did

We will commit to a new relationship with the VCFSE sector, facilitating a stronger geographical alignment/interface between Neighbourhoods and Alliances and the potential for active service commissioning. We will plan to identify non-clinical interventions which will support neighbourhood health models.

You said: Carers play an important role and must be considered in planning
We did

We heard the feedback on the important role of Carers and will take account of Carers in the development of neighbourhood models.

You said: Show us how our feedback has made a difference

We did

This section has been included within the final Commissioning Intentions as part of our commitment to transparency, accountability and ongoing dialogue with the people and communities of Kent and Medway. Engagement does not end with publication of this document. We will continue to work with residents, communities, staff, providers and partners as these intentions are implemented, and we will continue to report publicly on the difference that involvement has made.

What we heard that cannot be addressed through the Commissioning Intentions alone

Throughout our engagement, people shared a wide range of views, experiences and ideas about how health and care services could be improved across Kent and Medway. Much of this feedback has directly shaped our Commissioning Intentions. However, some of the issues raised are influenced by national policy, funding decisions, legislation, or the responsibilities of other organisations, meaning they cannot be addressed through the Commissioning Intentions alone.

This does not mean these issues are unimportant. They reflect genuine concerns about the factors that affect people's health and wellbeing, and we will continue to work with partners and national bodies to raise and respond to them where we can.

Increased NHS funding

What we heard: Many people told us they would like to see greater investment in NHS services, staffing and facilities.

Our response: We recognise these concerns. NHS funding allocations are determined nationally, and we must plan services within the resources available to us locally. Our Commissioning Intentions focus on making the best possible use of those resources to improve care and outcomes for residents.

NHS workforce challenges

What we heard: People expressed concerns about staff shortages, recruitment difficulties and the pressure facing NHS teams.

Our response: We share these concerns and are working with providers and partners to support workforce development locally. However, national workforce planning, training

places and pay arrangements are largely determined at a national level and cannot be changed through local commissioning decisions.

Transport and connectivity

What we heard: Many people highlighted difficulties travelling to healthcare appointments, particularly where public transport is limited.

Our response: Access to transport can have a significant impact on people's ability to use health services. While transport services are not commissioned by the ICB, we will continue to work with local authorities and partners to improve how services are planned and delivered for local communities.

Social care funding and eligibility

What we heard: Some respondents raised concerns about social care funding, access to support and eligibility criteria.

Our response: Health and social care services work closely together, but decisions about social care funding frameworks and eligibility are determined through national legislation and local authority responsibilities. These issues cannot be resolved through the Commissioning Intentions process alone though we will continue to work more closely with colleagues in our local authorities to improve how health and social care work together.

Investment in NHS buildings and facilities

What we heard: People told us they would like to see more investment in hospitals, community facilities and NHS estates.

Our response: Investment in major NHS buildings and infrastructure is subject to national capital funding allocations and approval processes. We will continue to prioritise local investment opportunities where funding is available, but larger-scale developments usually depend on decisions made nationally.

Looking ahead

While we cannot address all of these issues through our Commissioning Intentions, the feedback we received helps us understand what matters most to local people and communities. We will continue to use this insight to influence our work, advocate for Kent and Medway where decisions are made nationally, and work with partners to improve health and care services across the system.

6. NEXT STEPS

Focus is now moving towards developing work plans for delivery of our Commissioning Intentions priorities in 2027/28. These work programmes will be led by our Commissioning Multi-Disciplinary Teams (CMDTs). In order to deliver improved outcomes from our commissioning, it is critical that our Chief Officers and their respective teams are aligned and work effectively together across Commissioning, Nursing, Medical and Finance.

To support the transition from strategic commissioning intentions to formal contractual arrangements, all providers will receive a detailed provider-specific commissioning intentions letter no later than 30 September 2026. This letter will set out, in clear and unambiguous terms, the specific outcomes, standards, service requirements, productivity expectations, financial assumptions and transformation commitments that the NHS Kent and Medway Integrated Care Board expects each provider to deliver during 2027/28.

The commissioning intentions letter will represent the formal expression of the ICB's expectations and will form the primary basis for the 2027/28 contractual negotiation process. While the commissioning intentions document establishes the overall strategic direction for the system, the provider-specific letters will translate these strategic intentions into detailed organisational requirements and contractual expectations. System-wide pathways will need to be developed, in order to translate intentions into contract expectations.

The intention of this process is to establish clarity and transparency at the outset of the planning cycle. The ICB wishes to avoid situations where expectations are assumed, interpreted differently across organisations, or challenged for the first time during final contract negotiations. Early and explicit articulation of requirements will provide providers with the opportunity to assess deliverability, identify risks, and engage constructively in the development of final contractual arrangements.

This approach is particularly important given the scale of recovery, reform and productivity improvement required across Kent and Medway. The 2027/28 contracting round is not simply a transactional exercise; it represents a key mechanism through which the system will deliver improved outcomes, reduced inequalities, enhanced productivity, financial sustainability and the implementation of the future operating model set out within these commissioning intentions.

Ultimately, successful contractual agreement for 2027/28 will rely upon transparency, mutual accountability and a shared commitment to delivering the improvements required for the population of Kent and Medway. The commissioning intentions letters and the subsequent negotiation process are intended to provide the discipline, clarity and accountability necessary to achieve that ambition.

7. KEY RISKS, MITIGATIONS, AND CONTROLS

As outlined, our Commissioning Intentions for 2027/28 are ambitious and will require major transformation across Kent and Medway. Clarity on exactly what we intend to buy is subject to contract negotiations with Providers. This level of transformation will demand a significant level of change and new ways of working across the ICB, in line with our new operating model. Our model is founded upon proactive and effective multi-disciplinary working across all teams within the ICB.

It is important to recognise that our CMDTs have just been introduced and are starting to develop. These capacity risks need to be recognised at the outset and incorporated within our Board Assurance Framework, with mitigations to be developed and choices made on an ongoing basis.

8. REQUIRED OUTCOMES AND NEXT STEPS

The Board is asked to:

- **APPROVE** our final Commissioning Intentions for 2027/28
- **NOTE** next steps regarding mobilisation of our formal contractual arrangements
- **NOTE** delivery and capacity risks, linked to commissioning/contractual processes

9. SUPPORTING DOCUMENTATION

The following documents are available to support the content of this paper:

Appendix 1: Final Commissioning Intentions Document 2027/28
Appendix 2: Commissioning Intentions 2027/28 Summary Engagement Report
Appendix 3: Four Layers of Care Document 2027/28

NHS
Kent and Medway



Commissioning intentions for 2027/28

Planning improvements for the people of Kent and Medway



Caring for all

Including everyone

Building trust

Doing what's right

Being courageous

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1. Executive summary

NHS Kent and Medway faces a defining moment. Our population is growing, ageing and becoming more diverse. More people are living with multiple long-term conditions, mental health need continues to rise, and health inequalities remain deeply entrenched. Residents living in our most deprived communities experience significantly poorer health outcomes (earlier death for example) than those living in our most affluent communities, while demand for urgent care, elective services, community support and mental health provision continues to increase. At the same time, the health and care system remains under significant financial pressure and faces a level of clinical and financial challenge that cannot be addressed through incremental change alone. Doing more of the same is not an option.

These commissioning intentions set out how NHS Kent and Medway intend to move from strategy into delivery during 2027/28. They describe the outcomes we expect to achieve, the changes we expect providers to deliver and the contractual, financial, quality and performance mechanisms we will use to secure improvement. They are the commissioning expression of our Five-Year Strategy and establish the priorities, standards and expectations that will shape commissioning decisions, provider contracts and service transformation from 1 April 2027 onwards. The proposals were tested and refined throughout July and August 2026 through a programme of engagement with residents, communities, staff, providers, councils, voluntary sector partners and wider stakeholders. The final commissioning intentions were considered and approved by NHS Kent and Medway's Board in September 2026.

Our approach is built around a multi-year commissioning framework aligned to the Kent and Medway Four Layers of Care model which applies to both physical and mental health. This model recognises that sustainable improvement will only be achieved if we work with partners, provider and local authorities to shift activity, resource and clinical effort towards prevention, proactive care and neighbourhood-based delivery, while making sure acute services remain focused on the most complex and specialist needs. Through primary care, neighbourhood health, multi-neighbourhood care and acute care, supported by strong local authority relationships and provider collaboration, we will commission a more integrated system that is easier for residents to access, more consistent in quality and better able to improve outcomes while remaining financially sustainable. Provider collaboratives are the means by which our providers of healthcare come together to improve their delivery. A neighbourhood collaborative will work across primary and neighbourhood care and the acute collaborative on how acute hospital services will work. Together the collaboratives come together as a provider alliance.

The commissioning intentions are informed by extensive engagement with residents, staff, community organisations, voluntary sector partners, councils and providers. The message has been remarkably consistent. People want services that are easier to access, easier to navigate and better joined up. They want care closer to home where it improves access and experience. They want earlier support, better communication, shorter waits and greater consistency in the quality of the care they receive. Staff have reinforced these priorities and highlighted the importance of integrated working, digital capability, workforce sustainability and reducing unnecessary bureaucracy. The 2027/28 commissioning intentions are designed to respond directly to those priorities.

A central principle of the 2027/28 commissioning intentions is that commissioning must become more outcomes-focused and more accountable. Historically, the NHS has often measured success through activity rather than impact. During 2027/28, we will increasingly work with system partners to commission against outcomes, quality, patient experience, productivity, value for money and reducing health inequalities. We will work with clinical and professional leaders to understand system issues, agree the outcomes we need to deliver for residents, agree the pathways that patients will follow, how we will tackle local variation and what each organisation will need to change. Service specifications will define who will do what and joined up plans will identify which resources will move and which risks will be collectively understood and where mitigations will be delivered. Improving the quality of data, hearing from patients and introducing more explicit performance expectations across all commissioned services will underpin our approach. Contracts will increasingly define not only what providers deliver, but the improvements they are expected to achieve and the standards they will be required to maintain. Providers should expect a more directive commissioning approach, greater transparency of performance, stronger contractual accountability and a clearer link between investment and delivery.

This represents a significant change for providers across Kent and Medway. NHS Kent and Medway will increasingly move away from commissioning based primarily on activity towards commissioning based on outcomes, quality, productivity and value. Providers will be expected to demonstrate improvements in access, patient outcomes, patient experience, productivity and reduction in unwarranted variation, while contributing to the wider sustainability of the health and care system. Community and mental health providers will increasingly be held to the same level of contractual accountability that has traditionally been applied to acute providers, with explicit trajectories, recovery plans and improvement requirements where standards are not achieved.

The most significant area of transformation will be the continued shift towards neighbourhood health and community-based care. We will strengthen the role of primary care as the foundation of the healthcare system and establish a consistent neighbourhood health and care model across Kent and Medway, commissioned in conjunction with our local authority partners. This will bring together primary care, community services, mental health services, voluntary sector partners and councils services around shared populations, shared outcomes and shared responsibility for improving health and wellbeing outcomes. Multi-neighbourhood care services will be redesigned as the bridge between hospital and home, providing a stronger focus on admission avoidance, discharge support, reablement and rehabilitation, virtual care and proactive management of frailty and long-term conditions. As a result, providers should expect a progressive shift of activity, workforce and resources away from hospital-based models and towards prevention, community assets neighbourhood health and community-based alternatives wherever this improves outcomes and value.

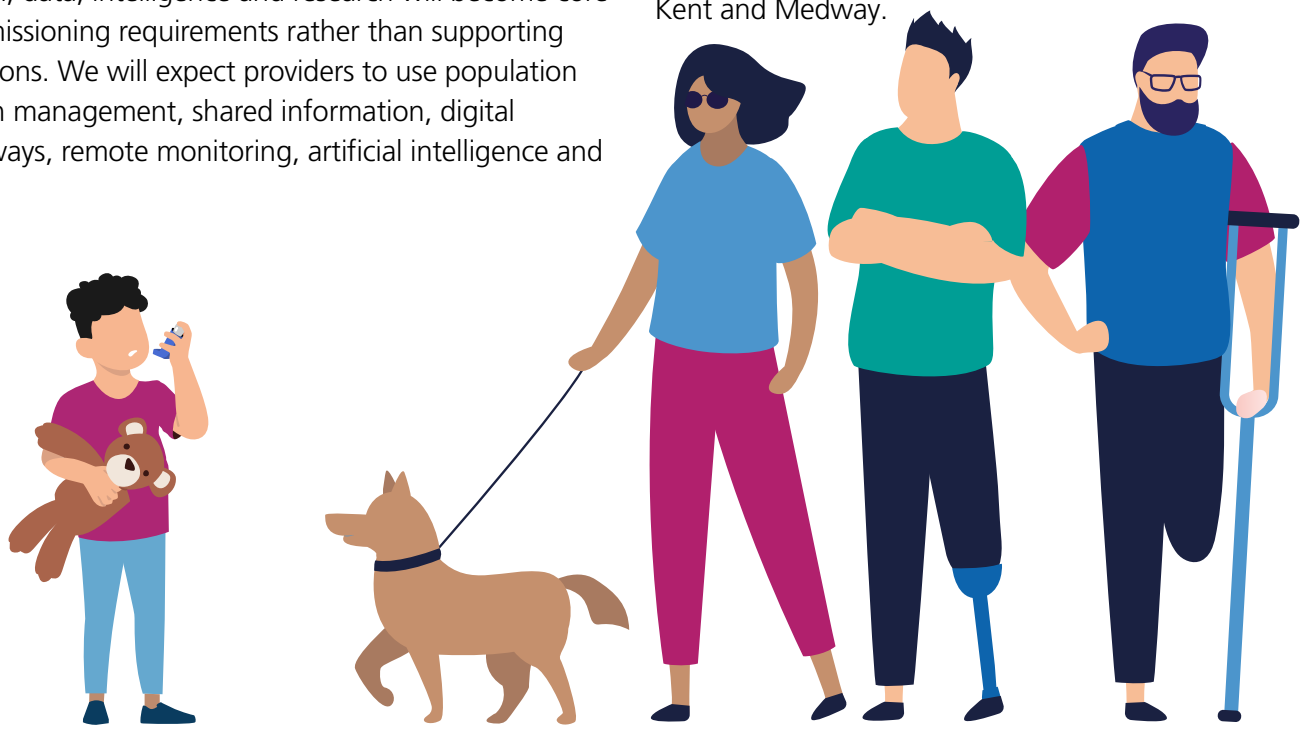
Alongside this, we will reform elective care, urgent and emergency care, mental health services and maternity services. Elective pathways will become increasingly standardised and digitally enabled through the introduction of a Kent and Medway Single Point of Access, greater use of Straight-to-Test pathways, clinically led networked delivery and a system-wide approach to waiting list management. Urgent and emergency care will focus on reducing avoidable hospital attendances, improving patient flow, strengthening alternatives to admission and working with councils and providers to accelerate, support and sustain discharge. Mental health services will be reconfigured around a consistent all-age model that supports earlier intervention, strengthens neighbourhood delivery and improves access. Maternity and women's health services will be commissioned against strengthened quality, safety and inequalities measures informed by the findings of the National

Maternity and Neonatal Investigation and wider system reviews. Commissioning will increasingly take place jointly with our local authority partners. Providers will increasingly be expected to work through the Acute and Neighbourhood Collaboratives, with greater emphasis placed on pathway performance, shared outcomes and clear accountability for delivery.

Improving the quality of care will be a fundamental priority across every service area. National reviews, local quality intelligence, patient feedback and regulatory assessments demonstrate that variation in quality, outcomes and experience remains too great. We will use our commissioning responsibilities to drive the delivery of national models of care in elective and urgent and emergency care in Kent and Medway, and improvements in patient safety, clinical outcomes, patient experience, workforce culture and health equity. Quality will not be treated as a separate programme of work but as a core and integrated requirement of every pathway contract, service specification and commissioning decision. Providers will be expected to demonstrate continuous improvement and will increasingly be measured against agreed quality, safety and outcome indicators as part of routine contractual oversight.

Digital, data, intelligence and research will become core commissioning requirements rather than supporting functions. We will expect providers to use population health management, shared information, digital pathways, remote monitoring, artificial intelligence and evaluation frameworks to support better care, better outcomes and better use of public resources. Improved data quality, interoperability and transparency will become fundamental requirements of provider contracts. We expect digital capability, intelligence and evaluation to be embedded within operational delivery rather than sitting alongside it.

These commissioning intentions represent the continuation of a conversation rather than the end of a planning process. Having tested the proposed priorities, commissioning approaches, outcome measures and contractual expectations with residents, communities, providers, staff and partners, the commissioning intentions have been adapted to respond to local views. While elements of delivery will continue to evolve, the engagement process demonstrated that the direction of travel is clear and agreed. NHS Kent and Medway will move towards a more preventative, neighbourhood-based, outcomes-focused and accountable model of commissioning. Providers will be expected to deliver measurable improvements in quality, outcomes, access, productivity and health inequalities, supported by stronger collaboration and clearer contractual expectations. Through this approach we will create a more sustainable health and care system and deliver better outcomes for the people of Kent and Medway.



2. Strategic alignment

These commissioning intentions sit within a broader programme of transformation and reform across Kent and Medway. They are not a standalone document or a collection of individual service priorities. They represent the joined-up commissioning response to the clinical, operational, workforce and financial challenges facing the health and care system and describe how NHS Kent and Medway intends to translate its strategic ambitions into stronger pathways of care for residents and measurable delivery from April 2027.

Over the last year, NHS Kent and Medway has established a clear strategic direction through the development of its Five-Year Strategy, Three-Year Commissioning Plan, Strategic Commissioning Policy and supporting clinical workstreams covering neighbourhood health, primary care, elective care, urgent and emergency care, mental health, learning disability and autism, maternity and women's health. Collectively, these set out the future model of care required to improve outcomes, reduce inequalities, improve productivity and place the system on a more sustainable footing.

The purpose of the 2027/28 commissioning intentions is to move beyond describing that future and begin delivering it through a joined-up system-wide commissioning process ultimately expressed in contracts. They set out what providers will be expected to deliver, where investment will be prioritised, how activity and resources will shift across the system, and the contractual and performance frameworks that will be used to secure delivery.

Central to this approach is the Kent and Medway Four Layers of Care model. This model provides a clear description of the role each part of the health and care system should play and creates a common framework through which services will be commissioned, integrated and held to account. Rather than viewing services as separate organisations or contracts, the model focuses on how care should be delivered across a coherent population-based system.

Primary care

Primary care remains the foundation of the Kent and Medway health and care system. It is where most resident healthcare contacts take place and where the majority of prevention, monitoring, diagnosis and ongoing clinical management is delivered. General practice, community pharmacy, dentistry and optometry collectively form the front door of the NHS and the long-term clinical home for most residents. The fundamental role of primary care in the delivery of improvements in health and care services was strongly reinforced through the consultation and engagement process.

Building on work carried out to date, over the coming years we will strengthen primary care through the commissioning of a more consistent core offer across Kent and Medway. This will include greater clarity around access standards, prevention, long-term condition management and continuity of care. Primary care will also play a more prominent role in prevention, population health improvement and the management of rising-risk patients, working alongside neighbourhood teams to prevent deterioration and reduce avoidable demand on hospitals.



Neighbourhood health

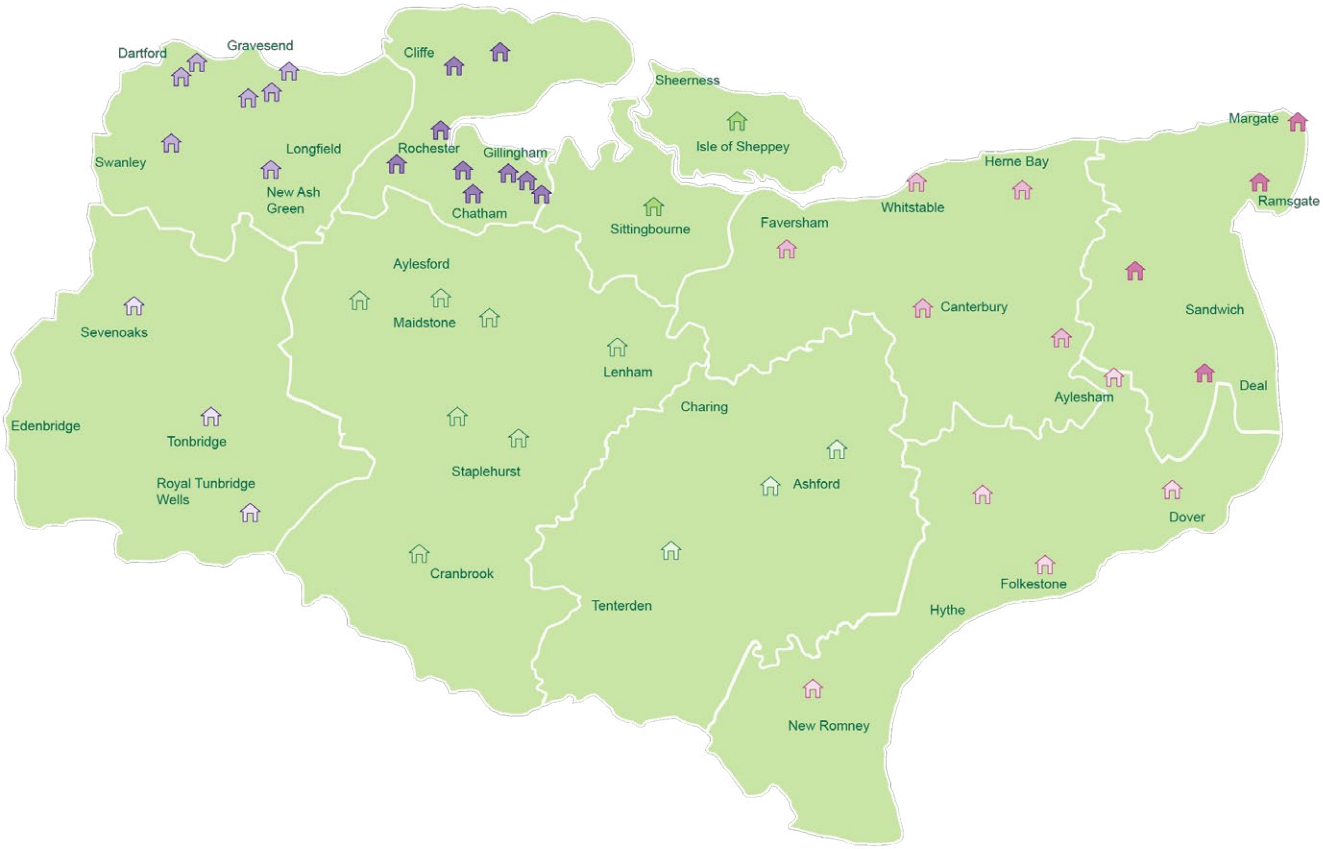
Neighbourhood health will become the principal model for proactive, integrated and preventative care delivery. 45 neighbourhoods have been identified across Kent and Medway, each broadly aligned to primary care network footprints and serving populations of approximately 30,000 to 50,000 residents.

We will work with partners, general practice and local authorities to increasingly bring together services into integrated multidisciplinary teams with shared objectives for improving health and care outcomes and reducing inequalities.

The intention is to move from fragmented service delivery towards clear pathways in which residents experience coordinated care closer to home, with greater emphasis on prevention, proactive management of long-term conditions, support for frailty and earlier intervention for those at risk of deterioration.

Neighbourhoods will increasingly be commissioned against agreed outcomes, population health measures and service standards rather than organisational boundaries making the best use of our community assets, the VCFSE sector and supporting carers.

Kent and Medway's 45 single neighbourhoods



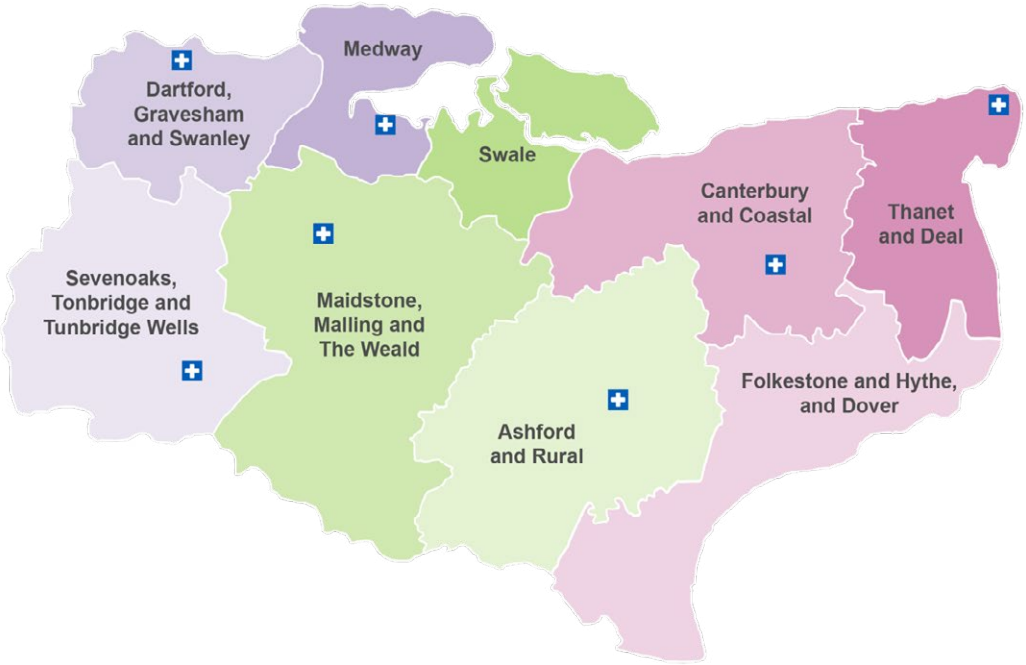
Multi-neighbourhood care

Multi-neighbourhood care will act as the bridge between neighbourhood services and hospital-based services. Nine multi-neighbourhood footprints have been established across Kent and Medway to provide the scale required to deliver integrated community and multi-neighbourhood care services whilst maintaining strong local identity and responsiveness to local need.

Multi-neighbourhood care will become a major delivery vehicle for admission avoidance, discharge support, rehabilitation, frailty care, virtual wards, Hospital at Home services and urgent community response. It will play a critical role in supporting the shift of care from hospital settings into community environments and ensuring residents receive care in the least restrictive and most appropriate setting.

The ambition is to create a consistent multi-neighbourhood care model across Kent and Medway with common service specifications, access standards, outcome measures and performance expectations. These will be supported by clear pathways of care for patients, co-designed and implemented with partners.

Kent and Medway's nine multi-neighbourhoods



	Multi-Neighbourhood Footprints	Population Count
1	Dartford, Gravesham and Swanley	c.297,955
2	Medway	c.338,780
3	Swale	c.109,030
4	Canterbury and Coastal	c.221,200
5	Thanet and Deal	c.205,020
6	Dover, Folkestone & Hythe	c.180,890
7	Ashford and Rural	c.216,000
8	Maidstone, Malling and The Weald	c.297,990
9	Sevenoaks, Tonbridge and Tunbridge Wells	c.241,660

Acute care

Acute services remain essential to the future sustainability of the NHS and will continue to provide specialist, complex and emergency care for the population of Kent and Medway. However, acute services must increasingly focus on the care that can only be delivered within hospital settings.

As neighbourhood and multi-neighbourhood care services mature, acute providers will be expected to support a significant shift in activity towards prevention, community-based care and integrated pathways. This will allow hospitals to focus their resources on specialist treatment, complex interventions, emergency care, research, innovation and centres of excellence.

The Acute Collaborative will become an increasingly important mechanism for reducing unwarranted variation, improving productivity, standardising clinical pathways and delivering consistent outcomes across Kent and Medway.

Provider collaboratives and alliance working

The Four Layers of Care model will be supported through the continued development of two formal provider collaboratives: the Neighbourhood Collaborative and the Acute Collaborative.

These collaboratives are intended to move the system beyond organisationally focused delivery and towards shared responsibility for outcomes, productivity and transformation. Increasingly, providers will be expected to work together to redesign pathways, manage demand, improve outcomes and deliver system priorities.

Future commissioning arrangements will increasingly focus on pathways and populations rather than individual organisational performance alone. Providers will therefore be expected to demonstrate both organisational delivery and collective contribution to system improvement.

Working with local authorities

Partnership working across the NHS and local government is critical with a key role for health and wellbeing boards.

First and foremost, the Kent and Medway councils have a critical local leadership role, accountable to and advocating for residents. Their responsibilities directly impact on the wider determinants of health, including education, employment, regeneration and housing. Achieving the community shift in Kent and Medway will only be possible if we are aligned with local government to address the causes of ill health in the first place.

In public health, social care, education and specialist services, local authorities are also our local commissioning partners. In 2027/28, we will work more closely together to coordinate our commissioning so residents and patients experience more joined up pathways and services, and our provider partners experience a joined-up local commissioning approach.

All of this will be taking place in a period of significant change for local government in Kent and Medway as implications of the recently paused local government reorganisation (LGR) programme is understood. Local government and the NHS will work together to align the delivery of local councils with our neighbourhood and multi-neighbourhood teams and their development.

National models of care and modern service frameworks

Alongside local strategy and clinical leadership, commissioning will continue to drive the delivery of national models of care in elective and UEC and evolve as national Modern Service Frameworks are published. These frameworks will provide evidence-based descriptions of best practice, expected outcomes, clinical standards and service models across major service areas including neighbourhood health, elective care, urgent and emergency care, mental health, cancer, cardiovascular disease, maternity, children and young people's services, frailty and long-term conditions.

As these frameworks are released, NHS Kent and Medway will work with providers to incorporate their requirements through pathway changes, transition arrangements, changes to service specifications, contract variations, outcomes measures and quality standards. This will make sure local services remain aligned to emerging national evidence, policy and best practice while maintaining a strong focus on population need and local priorities.



Commissioning for delivery

The 2027/28 commissioning intentions represent the next phase of the Kent and Medway transformation journey. The strategic direction has been established. The models of care are emerging. The challenge for 2027/28 is implementation.

The focus now shifts from describing what good looks like to commissioning it. This will require the input and engagement of local people, clinical and operational leaders to design and facilitate the planned introduction of improved pathways of care.

The commissioning process will be partnership orientated and outcomes focused. System-wide issues will be understood, local variation will be analysed, pathways will be agreed and outcome frameworks will set out what we want to achieve together.

Agreed pathways and outcomes will inform services, eligibility, response times, clinical responsibilities, referral mechanisms, hours, escalation, organisational interfaces, data and reporting.

They will also form the basis for describing what each organisation needs to change and how. Transition plans will describe who will do what, which resources will move, how risks will be collectively understood and what this will mean for service delivery.

Clear and agreed pathways will inform clearer service specifications, stronger accountability arrangements, increasingly outcome-based contracts, greater collaboration through provider alliances and a more explicit link between investment, delivery and measurable improvement in outcomes.

The overall ambition is straightforward: to create a more preventative, neighbourhood-based, integrated and financially sustainable health and care system that delivers consistently better outcomes for the people of Kent and Medway. The mechanism for delivering this will be partnership-based pathway redesign and the phased introduction of improvements for residents.

3. Population health, outcomes and inequalities: Why change is important

Improving the health of the population is the fundamental purpose of the 2027/28 commissioning intentions. Every commissioning decision, contract, service specification, investment choice and transformation programme should ultimately contribute to longer lives, better health outcomes, reduced inequalities and a more sustainable health and care system.

Kent and Medway is home to more than two million residents and is experiencing significant demographic change. The population is growing, ageing, and becoming increasingly diverse. While many people enjoy good health and long lives, the benefits of this are not shared equally. Large differences in life expectancy, healthy life expectancy, disease burden, and access to care exist between communities, often driven by deprivation, geography, ethnicity, and wider social determinants of health.

The challenge facing the NHS is therefore not simply one of increasing demand. It is increasingly a challenge of responding to a population with greater complexity, higher levels of multimorbidity and widening inequalities whilst operating within a constrained financial environment. Without significant change, demand for health and care services will continue to outpace available resources, leading to poorer outcomes, longer waits and increasing pressure across every part of the system.



An ageing population

The population of Kent and Medway is changing rapidly. Over the next two decades, the number of residents aged over 85 is expected to grow significantly, while growth amongst younger age groups remains much more limited. By 2045 the population aged over 85 is projected to increase by approximately 84 per cent and those aged 65 to 84 by around 29 per cent.

In contrast, the population aged 0 to 14 is projected to fall by around six per cent. This indicates a narrowing base and widening upper age structure, reflecting lower growth in children and younger people alongside marked expansion in older age groups. This demographic shift has profound implications for health and care services. Older residents are more likely to live with multiple long-term conditions, frailty, dementia, and complex social care needs. They require more coordinated care across organisational boundaries and are more likely to need urgent care, community services, rehabilitation, and ongoing support.

Unless services are redesigned, the growth in demand associated with an ageing population will place increasing pressure on hospitals, primary care, mental health services, social care, and community provision. The 2027/28 commissioning intentions therefore place a strong emphasis on prevention, anticipatory care, neighbourhood health, and integrated service delivery to ensure people remain healthy and independent for longer.

Health inequalities remain unacceptable

The most compelling case for change is the scale of inequality that exists across Kent and Medway. Where a person lives continues to have a significant impact on how long they live and how long they live in good health. Residents living in the most deprived communities can expect to spend considerably fewer years in good health than those living in the least deprived communities. Differences in healthy life expectancy of almost two decades exist between some communities.

These inequalities are reflected in almost every major health outcome. People living in more deprived communities are more likely to develop long-term conditions at an earlier age, experience poorer mental health, suffer worse outcomes from cardiovascular disease and cancer, and require urgent care services more frequently. Inequalities are also evident across maternity outcomes, learning disability, serious mental illness, neurodiversity, and access to preventative healthcare.

Reducing these inequalities is therefore not a separate workstream. It is the central organising principle of the 2027/28 commissioning intentions and guides how we will work with local partners. Every commissioning decision should contribute to narrowing outcome gaps and improving the health of populations that experience the poorest outcomes today.

The growing burden of long-term conditions

The health needs of Kent and Medway are increasingly shaped by a rising prevalence of long-term conditions. Cardiovascular disease, diabetes, chronic kidney disease, respiratory disease, dementia, frailty, and cancer collectively account for a substantial proportion of hospital activity, mortality, avoidable admissions, and healthcare expenditure. Many of these conditions are strongly associated with deprivation and preventable risk factors.

The incidence of multimorbidity is increasing rapidly, with more residents living with multiple physical and mental health conditions simultaneously. These individuals frequently require support from multiple services and often experience fragmented care pathways, duplication of appointments and poor coordination between organisations.

Traditional service models, organised around individual organisations or individual diseases, are no longer sufficient. The future health of the population depends upon commissioning integrated models of care that focus on people rather than organisations, prevention rather than reaction and proactive intervention rather than crisis management.

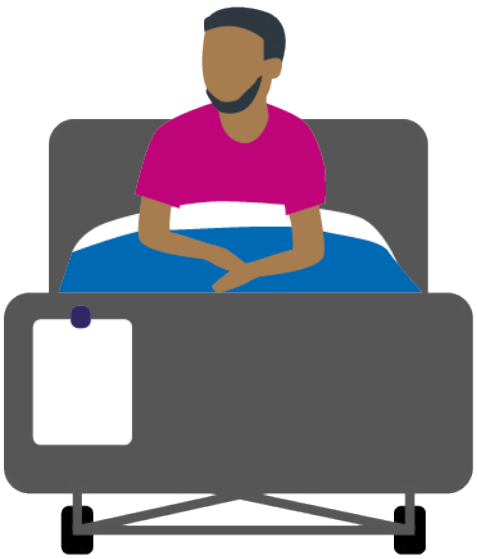
Mental health and neurodiversity

Mental health needs are increasing across all age groups and represent one of the most significant challenges facing the system. Rates of depression, anxiety and other common mental health conditions continue to rise. Demand for specialist mental health services has increased significantly, while many residents continue to struggle to access timely support. Children and young people are experiencing increasing levels of mental ill health, while adults with serious mental illness continue to experience poorer physical health outcomes and shorter life expectancy than the wider population.

At the same time, demand for autism and ADHD assessment has risen dramatically. Waiting lists continue to grow and many people experience extended delays in receiving either diagnosis or support. These delays affect educational attainment, employment, wellbeing, and family life, while increasing the risk of crisis presentations and avoidable escalation into specialist services.

These trends cannot be addressed simply through expansion of specialist services. They require a different model of care, one that strengthens prevention, early intervention, neighbourhood delivery, and practical support much earlier in a person's journey.





Women, children and future generations

The health of future generations remains a significant commissioning priority. Health inequalities emerge early in life and continue through childhood, adolescence, and adulthood. Children living in more deprived communities experience poorer health outcomes across a range of measures, including obesity, dental health, mental health, and emergency admissions.

At the same time, maternal and neonatal outcomes continue to demonstrate variation between population groups, with some women and babies experiencing significantly poorer outcomes than others. The findings of recent national and local reviews have reinforced the need for a stronger focus on safety, continuity of care, early intervention, and tackling inequalities across maternity and women's health services. Improving outcomes for mothers, babies, children, and young people is therefore both a moral imperative and a critical investment in the future health of the population.

The financial consequences of poor health

The challenges described above are not only clinical. They have major implications for financial sustainability. Growing demand, increasing complexity and avoidable illness are placing significant pressure on NHS resources. Much of this demand is driven by conditions that are preventable, manageable, or capable of earlier intervention.

Without a stronger focus on prevention, population health management and earlier support, the system will continue to spend increasing amounts of resource managing avoidable deterioration, emergency admissions, and complex illness. Improving population health is therefore not only essential to improving outcomes. It is also essential to creating a financially sustainable health and care system.



A new population health approach

The 2027/28 commissioning intentions are built on the belief that better health outcomes, reduced inequalities and financial sustainability can only be achieved through a significantly stronger focus on prevention, early intervention, and neighbourhood-based care.

Over the next three years we will increasingly commission services that:

- prevent ill health rather than simply respond to it
- take account of the wider determinants of health
- identify rising-risk populations earlier
- support people to live healthier lives for longer
- reduce avoidable admissions and hospital attendance
- improve management of long-term conditions
- address the wider drivers of health inequality
- target resources towards those communities with the greatest need.
- strengthen partnership working with local authorities, primary care, and the voluntary sector
- deliver measurable improvements in life expectancy, healthy life expectancy, and quality of life.

The purpose of the 2027/28 commissioning intentions is therefore not simply to redesign services. It is to improve the health of the population of Kent and Medway. Every subsequent section of this document should be viewed through that lens. The Four Layers of Care model, neighbourhood health, provider collaboratives, contracting reform, quality improvement, productivity programmes, and digital transformation are not objectives in themselves. They are the mechanisms through which we intend to achieve better health, better care, and better outcomes for the people of Kent and Medway.

There will be difficult choices involved in delivering the change these intentions describe. We will need to reduce the cost of the acute hospital layer in Kent and Medway to improve the care delivered in primary and neighbourhood layers. We will need to streamline pathways. We continue to seek ongoing feedback about the priorities that residents and partners would choose as we deploy limited resources to maximise the impact we can make as we finalise commissioning intentions for next year.



4. Commissioning for quality and outcomes: Why change is essential

The primary purpose of the NHS is to improve outcomes for the population it serves. The purpose of the 2027/28 commissioning intentions is therefore not simply to commission activity, manage demand or improve financial performance. It is to make sure every resident of Kent and Medway receives safe, effective, evidence-based, and compassionate care that consistently delivers better outcomes, a better experience, and a reduction in health inequalities.

While examples of excellent care exist across Kent and Medway, the overall picture remains too variable. Quality indicators consistently demonstrate variation between organisations, services, pathways, and population groups. That variation affects patient outcomes, patient safety, patient experience, workforce experience, and ultimately public confidence in the NHS. Quality improvement therefore sits at the heart of the 2027/28 commissioning intentions because our ability to improve outcomes, reduce inequalities, create a sustainable health and care system depends upon our ability to improve quality.

The evidence for change is compelling. Across the system, staff survey results remain below national averages in a number of areas, with many organisations reporting challenges relating to workforce engagement, wellbeing, culture and staff experience. Since workforce culture is strongly associated with patient safety, service quality and organisational performance, improving staff experience must be viewed as a critical quality objective rather than simply a workforce issue.

Patient safety investigations continue to identify recurring themes across multiple organisations and service areas. Delayed diagnosis, delayed treatment, deterioration not being recognised or acted upon quickly enough, weaknesses in risk assessment and care planning, communication failures between teams, workforce pressures, safeguarding concerns and equipment failures continue to feature repeatedly in investigations, reviews and learning processes. The persistence of these themes indicates that improvement is required at a system level rather than solely through organisational responses.

Mortality outcomes also remain variable across parts of the health economy. Several acute specialties and sites continue to perform outside expected ranges against national benchmarks, particularly within pathways associated with urgent care, respiratory disease, frailty and emergency admissions. Significant variation remains between providers and between specialty pathways. Residents should expect consistently high-quality care regardless of where they access services and reducing variation in outcomes will therefore become a key commissioning priority.

Variable readmission rates further demonstrate opportunities to improve quality and pathway effectiveness. Orthopaedics and general surgery remain particular areas of concern, suggesting opportunities to strengthen clinical pathways, discharge planning, rehabilitation services, outpatient follow-up and care coordination between providers. Avoidable readmissions represent a poor outcome for patients, increase pressure on services and create unnecessary financial costs across the system.

Patient experience is equally inconsistent. Friends and Family Test results, patient surveys, complaints and local engagement activity continue to demonstrate variation between organisations and services. Residents frequently describe difficulties accessing services, uncertainty while waiting for care, poor communication, a lack of coordination between organisations and delays receiving information following appointments or discharge. While clinical outcomes remain critical, people judge the quality of care through their overall experience of the system, their ability to access support and the confidence they have that organisations are working together around their needs.

Across much of the health economy there is also insufficient use of Patient Reported Outcome Measures and Patient Reported Experience Measures. Too often the NHS measures activity rather than understanding whether treatment has genuinely improved a person's quality of life, symptoms, wellbeing or experience. Future commissioning must place greater emphasis on understanding what difference services make to people's lives, not solely how much activity has been delivered.

Regulatory assessments demonstrate that there remains considerable opportunity for improvement. Care Quality Commission ratings across parts of Kent and Medway continue to lag behind the standards we should expect. While significant improvement has been made in some services, overall variation remains too great. The expectation should be simple: Every resident should receive care from services that achieve at least a good standard and demonstrate a commitment to continuous improvement.

Communication and information sharing continue to present avoidable risks and poor experiences for patients. Delays in communication with general practitioners, delays in discharge summaries, inconsistencies in clinic correspondence and poor transfer of information between providers contribute to duplication, errors, avoidable deterioration and a poorer patient experience. In a modern integrated health system, timely and accurate communication should be regarded as a fundamental quality requirement.

Healthcare associated infections continue to perform below required standards in parts of the system. Not all organisations consistently achieve nationally expected thresholds. Alongside the impact on patient safety, these infections contribute to longer lengths of stay, greater use of hospital beds, increased costs and poorer outcomes for patients.

Complaints performance remains variable across providers. Patients should be able to raise concerns confident that they will receive a timely, meaningful response and that learning will occur as a result. Too many complaints continue to fall outside expected timescales. Complaints are one of the most valuable sources of intelligence available regarding quality and therefore must be treated as an important component of quality improvement rather than simply a regulatory requirement.

The findings of the National Maternity and Neonatal Investigation have provided further evidence for change. While focused on maternity services, the lessons are relevant across the wider health and care system. The review highlighted the critical importance of patient voice, organisational culture, safety, accountability, leadership, equality and tackling discrimination. Of particular significance is the recognition that racism, inequality and discrimination are not solely equality issues but patient safety issues that directly affect outcomes. The principles arising from the review will therefore be applied across all commissioned services and not solely within maternity pathways.

Quality also cannot be separated from health inequalities. People with learning disabilities, autistic people, individuals experiencing serious mental illness, residents living in deprivation and several ethnic minority communities continue to experience poorer access, poorer experience and poorer outcomes. A system cannot be considered high quality if outcomes vary significantly depending upon who the patient is, where they live or which provider they access.

For these reasons NHS Kent and Medway intend to move towards a model where quality is commissioned directly rather than monitored separately. Quality expectations will increasingly be embedded within contracts, service specifications, outcomes frameworks, payment mechanisms and performance oversight arrangements. Quality, safety, outcomes and patient experience will be given the same prominence as activity, finance and operational performance.



What this means for providers

The implications for providers are clear. Quality will no longer be viewed as a separate assurance process sitting alongside commissioning, finance and performance. It will become one of the principal mechanisms through which services are commissioned, performance is assessed and future investment decisions are made.

Building on the work this year, from April 2027 onwards providers should expect significantly greater scrutiny of patient safety, patient outcomes, patient experience and health inequalities. NHS Kent and Medway will increasingly assess organisations not simply on the volume of activity delivered, but on the quality and outcomes achieved. Providers will be expected to demonstrate measurable improvement in:

- patient safety indicators
- mortality outcomes
- readmission rates
- healthcare associated infection performance
- Patient Reported Outcome Measures
- Patient Reported Experience Measures
- complaints performance
- workforce experience
- safeguarding outcomes
- delivery of national clinical standards
- reduction of health inequalities.

NHS Kent and Medway will increasingly expect providers to evidence how learning from incidents, complaints, mortality reviews, safeguarding reviews, patient safety investigations and national reviews has resulted in demonstrable improvement. The expectation will be that learning is translated into measurable changes in outcomes, safety and experience.

Providers will be expected to capture and report outcome measures more systematically and demonstrate how patients, carers and communities have influenced service design, quality improvement initiatives and pathway redesign. Organisations will increasingly be expected to demonstrate not only that services have been delivered, but that they have improved people's lives.

Quality expectations will become more explicit within contracts and service specifications. Performance trajectories will be clearer. Quality discussions will increasingly form part of routine contract management arrangements and providers should expect greater use of benchmarking, comparative performance analysis and public reporting of outcomes.

Where providers consistently demonstrate improvement and deliver high-quality outcomes, commissioners will seek to support innovation, service redesign and wider adoption of good practice. However, where quality concerns persist, improvement trajectories are not delivered, or patients continue to experience avoidable harm, poor outcomes or poor experience, commissioners will increasingly use formal recovery arrangements, contractual interventions and financial consequences to support improvement.

The expectation is straightforward. Providers will be expected to demonstrate year-on-year improvement in safety, outcomes, experience and reduction of inequalities. Success will increasingly be judged not by how much activity has been delivered, but by whether care has become safer, outcomes have improved and residents experience a better health and care system.

Commissioning requirements

To support this ambition, the NHS Kent and Medway will:

- Measure quality, focusing on the three core domains of safety, outcomes and experience.
- Operate a Quality Engagement and Risk Escalation Framework aligned to the emerging National Quality Strategy and embedded within contractual arrangements.
- Introduce increasingly explicit quality requirements within provider contracts and service specifications.
- Develop SMART quality indicators linked directly to contractual delivery requirements.
- Embed equality, health inequalities and quality assessments within commissioning decisions to ensure quality and safety impacts are fully understood and addressed.
- Continue implementation of the National Patient Safety Strategy and Patient Safety Incident Response Framework, including within primary care.
- Strengthen accountability for Learning from Deaths reviews, particularly for people with learning disabilities and autism.
- Carry out quality assurance visits to make sure services are delivered consistently with commissioned specifications and standards.
- Use contract management processes, improvement notices, recovery plans and, where necessary, contractual consequences to secure improvement.

Patient safety

Providers will be expected to demonstrate:

- Evidence that learning from patient safety incidents, mortality reviews, safeguarding reviews and statutory investigations results in measurable improvement.
- Compliance with nationally expected healthcare associated infection thresholds.
- Six-monthly safer staffing reviews with evidence that staffing levels remain aligned to national guidance.
- Improved recognition and management of deteriorating patients.
- Consistent implementation of the Patient Safety Incident Response Framework.
- Timely communication with patients and general practitioners following attendance, admission or discharge.

Patient outcomes

Providers will be expected to demonstrate:

- Achievement of at least a good rating at the next Care Quality Commission assessment.
- Systematic capture and improvement of Patient Reported Outcome Measures across pathways.
- Compliance with national audits and Royal College standards.
- Improvement in Standardised Hospital Mortality Indicators and other relevant outcome measures.
- Reduction in readmissions to at least national benchmark levels.
- Reduction in unwarranted variation between services, sites and providers.
- Demonstrable improvement in outcomes for populations experiencing the greatest inequalities.

Patient Experience

Providers will be expected to demonstrate:

- Improvement in Friends and Family Test performance, Patient Reported Experience Measures and national survey outcomes.
- Evidence of co-production with patients, carers and communities.
- Consistent delivery of complaints responses within required timescales.
- Improved communication throughout care pathways.
- Evidence that patient feedback directly influences service improvement.
- Regular reporting on inequalities in experience and outcomes together with improvement plans where variation exists.

The overall ambition is clear. Every resident of Kent and Medway should receive safe, effective, compassionate and equitable care. Every provider should demonstrate a culture of continuous improvement. Every commissioning decision should support better outcomes, better experience and reduced inequalities. Quality is therefore not a separate priority within the 2027/28 commissioning intentions. It is the foundation upon which all other ambitions depend.



5. Financial sustainability and resources allocation: Why change is essential

The Kent and Medway health and care system faces a significant underlying financial challenge. Independent external assessment has confirmed that the health economy continues to carry a substantial underlying structural deficit driven by rising demand, increasing complexity of care, workforce pressures, productivity variation and a service model that remains too heavily focused on responding to illness rather than preventing it.

This matters because financial sustainability is not a finance problem. It is a strategic, clinical and commissioning challenge. If resources continue to be deployed in the same way, the system will struggle to meet future population need, improve outcomes or reduce inequalities. The 2027/28 commissioning intentions therefore seek to create a more sustainable relationship between outcomes, activity, quality and resource allocation.

The starting point for future commissioning decisions will be a robust understanding of activity, demand, population need, workforce utilisation, clinical outcomes, productivity and financial performance. Resource allocation decisions must be grounded in objective evidence rather than historic patterns of expenditure, organisational preference or institutional precedent. Future investment decisions will increasingly be informed by population health intelligence, activity data, benchmarking information, clinical outcomes, productivity measures and evidence of value for money.

The purpose of commissioning is not simply to purchase activity. It is to allocate finite resources in a way that delivers the best possible outcomes for the population while maintaining a financially sustainable health and care system. This means future investment decisions will increasingly be assessed against their contribution to improved outcomes, reduction in inequalities, improved productivity, delivery of the Four Layers of Care model and wider system sustainability.

System financial balance before organisational optimisation

A core principle of the 2027/28 commissioning intentions is that decisions must support the sustainability of the Kent and Medway health economy as a whole. Historically, individual organisations have sometimes been incentivised to optimise their own financial position even where this creates pressure elsewhere in the system. This approach is not sustainable. Future commissioning decisions will increasingly be viewed through the lens of overall system impact rather than organisational impact alone.

Commissioners will therefore place significant weight on the effect that decisions have on the wider health economy. Transparent analysis of risks and transition plans will manage risk. Providers should expect increasing emphasis on collective responsibility, collaborative planning and system-wide decision making.



Resources must follow clinical strategy

Financial flows must actively support the strategic direction set out within the 2027/28 commissioning intentions. If our clinical strategy requires activity to move from acute hospitals into primary care, neighbourhood health, multi-neighbourhood care, virtual wards or admission avoidance services, then commissioning arrangements must support that transition. Equally, where providers are expected to retain activity, there must be evidence that this represents the best outcome for patients and the best use of public resources.

The principle is straightforward: Activity, responsibility and funding should increasingly move together. Future investment decisions will therefore increasingly support services that contribute to prevention, earlier intervention, reduction in inequalities, improved outcomes and care delivered within the most appropriate setting.

Financial allocation methodology and approval framework

Future resource allocation decisions will not be based solely on historical spending patterns, organisational precedent or individual provider positions. NHS Kent and Medway will allocate resources through an agreed financial methodology that supports delivery of the Financial Recovery Plan, the Four Layers of Care model and the strategic priorities set out within the 2027/28 commissioning intentions.

The financial allocation methodology will be designed to ensure that resources are directed towards those services, pathways and population groups that deliver the greatest improvement in outcomes, reduction in inequalities, productivity and long-term sustainability. Allocation decisions will increasingly be informed by activity analysis, population health intelligence, benchmarking, clinical outcomes, productivity measures, health inequalities and system-wide financial impact.

Where investment, disinvestment, activity transfer or service redesign proposals have material financial consequences, decisions will be assessed against the agreed system financial framework and the requirements of the Kent and Medway Financial Recovery Plan. Commissioners and providers will be expected to demonstrate how proposed allocations contribute to delivery of agreed clinical, operational and financial objectives.

As a delegated NHS organisation, significant changes to financial allocations, resource deployment, service transformation funding and the implementation of the agreed financial methodology may require review, support and agreement through NHS England governance processes. Future allocation decisions will therefore need to operate within both local system priorities and the wider financial framework agreed with NHS England.

The expectation is that financial allocation decisions become increasingly transparent, evidence-based and aligned to agreed strategic objectives. Providers should expect resource allocation discussions to be supported through open-book approaches, shared assumptions, robust financial modelling and clear demonstration of how investment contributes to improved outcomes, financial recovery and system sustainability.

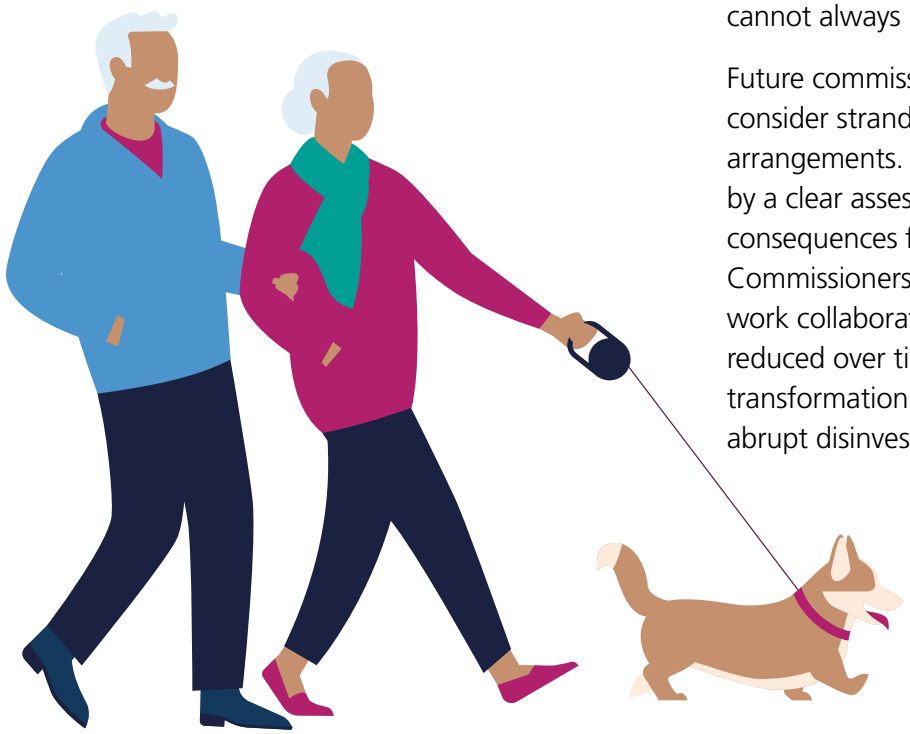
Future investment decisions will increasingly favour organisations, pathways and programmes able to demonstrate measurable improvement in quality, outcomes, productivity, reduction in inequalities and delivery of the objectives set out within the 2027/28 commissioning intentions.

Resource allocation must be driven by population need

Future commissioning decisions will increasingly be informed by evidence regarding where need is greatest and where intervention is likely to deliver the greatest benefit. This includes consideration of:

- population growth
- demographic change
- disease prevalence
- long-term condition burden
- health inequalities
- unmet need
- clinical outcomes
- service utilisation
- future demand projections.

Communities experiencing poorer outcomes, lower healthy life expectancy and higher levels of avoidable illness should increasingly become the focus of commissioning interventions and resource allocation decisions. The intention is to move progressively away from historic patterns of investment and towards a more transparent, intelligence-led approach to resource deployment.



Transparent and open financial relationships

Successful transformation depends upon trust and transparency. Financial flows, activity assumptions, cost allocations and resource transfers must therefore be fully understood by all parties. Providers should expect future discussions regarding activity shifts and service redesign to be supported through open-book approaches, transparent costing methodologies and shared financial modelling.

There should be no hidden subsidies, unrecognised transfers of cost or assumptions that are not explicitly understood by commissioners and providers. Financial sustainability can only be achieved where organisations have confidence in the data, assumptions and decisions that underpin commissioning arrangements.

Recognition of fixed and stranded costs

One of the most important lessons from previous transformation programmes is that activity frequently moves faster than cost. A reduction in activity does not automatically create an equivalent reduction in expenditure. Organisations continue to carry estates, workforce, infrastructure and support costs which cannot always be removed immediately.

Future commissioning decisions will therefore explicitly consider stranded costs, fixed costs and transition arrangements. Changes in activity will be accompanied by a clear assessment of the operational and financial consequences for organisations affected by the change. Commissioners will increasingly expect providers to work collaboratively to identify how those costs can be reduced over time, whilst recognising that sustainable transformation requires managed transition rather than abrupt disinvestment.

Value for money as a core commissioning principle

Future investment decisions must demonstrate clear value for patients and taxpayers. NHS Kent and Medway will increasingly evaluate commissioning decisions through the lens of outcomes, productivity, quality and system impact rather than activity volume alone. Where activity shifts or new investments are proposed, commissioners will seek evidence that the change will:

- align with best practice pathways
- improve outcomes
- improve patient experience
- reduce inequalities
- improve productivity
- reduce unwarranted variation
- improve workforce utilisation
- deliver long-term financial sustainability.

The objective is not simply to reduce expenditure. The objective is to achieve greater benefit from every pound invested.

Risk sharing rather than risk shifting

Transformation inevitably creates risk. However, sustainable transformation requires risk to be managed transparently with clear transition plans and accountability in place. Future commissioning arrangements will increasingly focus on pathway-level oversight, with providers adopting shared/alliance-based delivery models and risk-sharing arrangements.

Risks should sit with the organisations best placed to manage them. Equally, commissioners will seek to avoid incentives that encourage cost-shifting, activity displacement or behaviours that improve organisational performance while worsening outcomes elsewhere in the system. When uncertainty exists, particularly around demand, activity movements or new service models, commissioners will work with providers to develop proportionate risk-sharing arrangements that support innovation while maintaining financial stability.

What this means for providers

For providers, the overall direction of travel is clear. Future resource allocation will increasingly be linked to demonstrable outcomes, delivery of strategic priorities, reduction in inequalities, productivity improvement and value for money.

Providers should expect greater use of outcome, activity and performance intelligence, stronger linkage between funding and delivery, increasing scrutiny of variation, more explicit expectations regarding productivity and quality and a stronger emphasis on collaboration where it makes sense for patients.

The organisations most likely to thrive within this environment will be those that can demonstrate improved outcomes, effective use of resources, reduction in unwarranted variation, transparency, collaboration and delivery of the Four Layers of Care model.

Financial sustainability is therefore not separate from the ambitions set out elsewhere in the 2027/28 commissioning intentions. It is the mechanism through which we make sure improvements in population health, quality and outcomes can be sustained for the long term, while operating within the resources available to the NHS.



6. What residents, communities, staff and partners have told us – 'You said, we did'

The development of the 2027/28 commissioning intentions has been informed by one of the most extensive engagement programmes carried out in healthcare across Kent and Medway in recent years. We heard from more than 3,300 residents, carers and staff as well as getting responses from community organisations, voluntary sector partners, public health leaders, councils, clinicians and NHS providers through surveys, community conversations, stakeholder submissions, social media feedback and independent research.

While views differed on specific issues, the feedback was remarkably consistent. People supported the need for change and the direction of travel. But they asked us to make sure improvement is experienced as better outcomes, not simply different care. Feedback has directly influenced revisions to the final commissioning intentions and strengthened how we describe our priorities, expectations and measures of success, and how we will deliver them.

You said **Access to NHS services should be the top priority**

The most consistent message we heard was the need for easier access to care. Residents described concerns about accessing GP appointments, NHS dentistry, long waits for treatment and challenges navigating services. Feedback repeatedly highlighted the importance of continuity, communication and knowing who is responsible for care. Easier access to GP appointments emerged as the highest priority in both independent research and public engagement.

We did

Our commissioning intentions give greater emphasis to improving access standards, reducing waits, simplifying referral pathways, creating clearer routes into services and improving communication while people are waiting for care. We will proceed to agree a clear universal core offer across general practice, community pharmacy and optometry. We plan to build on the foundations of our existing plans and ensure review/follow-up to deliver improvements in access over multiple years.

You said — Focus on urgent and emergency care and support for frail older people

You want credible alternatives to A&E but need a more effective discharge/flow system.

We did

We will have a greater focus on those with highest care needs, those who live with frailty, multiple long-term conditions, mental health and social care complexity. We will urgently progress an integrated model to deliver impact before April 2027. We will increase our focus on continuity of care for vulnerable people and those with complex needs, strengthening continuity of care as a measurable outcome.

You said — NHS providers expressed concerns regarding transition and deliverability

The common concern is deliverability: Capacity, workforce, digital infrastructure and financial mechanisms not yet being sufficiently aligned to enable activity and funding to move safely from acute to community settings. The challenge posed is whether the system can convert ambition into practical transition plans that create capacity before removing it elsewhere, align resources with responsibility and share risk fairly.

We did

Further information has been included in the final commissioning intentions document on the approach to delivering the commissioning intentions. This includes the approach we will take to developing and agreeing system-wide pathways of care, providing transparency about the variation in place and the changes required across the system. Integrated outcomes frameworks will support transparency about the implications of any changes, and transition planning (delivered jointly with providers and provider collaboratives, and reflected in contracts), will aid clarity in this regard.

You said — You welcome digital support but reject digital only

Although many people support digital innovation, they were clear that digital services should not become the only way to access care. Respondents highlighted digital exclusion, language barriers, disability, confidence using technology and the need for face-to-face and telephone alternatives. Many people told us that digital should make access easier, not create another barrier.

We did

Our commitment to the NHS App and digital services will increasingly support care, while we also maintain effective non-digital alternatives for people who need them. We have also placed greater emphasis on digital inclusion, accessibility, patient choice and making sure technology improves outcomes and experience rather than simply increasing digital adoption.

You said Mental health support needs to happen before crisis

Many respondents told us that services are too often focused on responding after people reach crisis point. Faster access to support and earlier intervention emerged as priorities. People also told us that support for autism and ADHD should not depend solely on receiving a diagnosis.

We did

The final commissioning intentions place greater emphasis on prevention, early intervention, all-age mental health pathways, support before diagnosis and neighbourhood-based delivery. Our revised scope for the proposed review of Mental Health, Learning Disabilities and Autism and ADHD services across Kent and Medway will be broader and more system-focused, given feedback and the joint opportunities highlighted by patients, service users and our local authority colleagues. We will commit to making faster progress with "This is Me", psychology/neurodiversity support for ADHD.

You said Local VCSE organisations and communities must be part of the solution

A message strongly received is that grassroots/VCSE organisations already deliver prevention and early intervention. The VCSE sector is uniquely placed to reach underserved and marginalised communities, build trust with people and communities who may not engage with statutory services and address wider determinants of health.

We did

We will commit to a new relationship with the VCSE sector, facilitating a stronger geographical alignment/interface between neighbourhoods and alliances and the potential for more proactive service commissioning. We will plan to identify non-clinical interventions which will support neighbourhood health models.



You said — Carers play an important role and must be considered in planning

We did

We heard the feedback on the important role of carers and will take account of carers in the development of neighbourhood models and include their views more explicitly in the service reviews and pathway development in the areas highlighted in the commissioning intentions document.

You said — Show us how our feedback has made a difference

We did

This section has been included within the final commissioning intentions as part of our commitment to transparency, accountability and ongoing dialogue with the people and communities of Kent and Medway. Engagement does not end with publication of this document. We will continue to work with residents, communities, staff, providers and partners as these intentions are implemented, and we will continue to report publicly on the difference that involvement has made.



What we heard that cannot be addressed through the commissioning intentions alone

Throughout our engagement, people shared a wide range of views, experiences and ideas about how health and care services could be improved across Kent and Medway. Much of this feedback has directly shaped our commissioning intentions. However, some of the issues raised are influenced by national policy, funding, decisions, legislation or the responsibilities of other organisations, meaning they cannot be addressed through the commissioning intentions alone.

This does not mean these issues are unimportant. They reflect genuine concerns about the factors that affect people's health and wellbeing, and we will continue to work with partners and national bodies to raise and respond to them where we can.

Increased NHS funding

What we heard:

Many people told us they would like to see greater investment in NHS services, staffing and facilities.

Our response:

We recognise these concerns. NHS funding allocations are determined nationally, and we must plan services within the resources available to us locally. Our commissioning intentions focus on making the best possible use of those resources to improve care and outcomes for residents.

NHS workforce challenges

What we heard:

People expressed concerns about staff shortages, recruitment difficulties and the pressures facing NHS teams.

Our response:

We share these concerns and are working with providers and partners to support workforce development locally. However, national workforce planning, training places and pay arrangements are largely determined at a national level and cannot be changed through local commissioning decisions.

Transport and connectivity

What we heard:

Many people highlighted difficulties travelling to healthcare appointments, particularly where public transport is limited.

Our response:

Access to transport can have a significant impact on people's ability to use health services. While transport services are not commissioned by the ICB, we will continue to work with local authorities and partners to improve how services are planned and delivered for local communities.

Social care funding and eligibility

What we heard:

Some respondents raised concerns about social care funding, access to support and eligibility criteria.

Our response:

Health and social care services work closely together, but decisions about social care funding frameworks and eligibility are determined through national legislation and council responsibilities. These issues cannot be resolved through the commissioning intentions process alone though we will continue to work more closely with colleagues in our local authorities to improve how health and social care work together.

Investment in NHS building and facilities

What we heard:

People told us they would like to see more investment in hospitals, community facilities and NHS estates.

Our response:

Investment in major NHS buildings and infrastructure is subject to national capital funding allocations and approval processes. We will continue to prioritise local investment opportunities where funding is available, but larger-scale developments usually depend on decisions made nationally.

Looking ahead

While we cannot address all these issues through our commissioning intentions, the feedback we received helps us understand what matters most to people and communities. We will continue to use this insight to influence our work, advocate for Kent and Medway where decisions are made nationally and work with partners to improve health and care services across the system.

Residents want an NHS that feels simpler and more joined up

The feedback received on the commissioning intentions has been in line with other feedback received from patients and partners. The strongest messages from residents were not about single services. They were about the overall experience of accessing and navigating the health and care system. Residents described difficulty accessing appointments, uncertainty about where to seek help, repeated referrals between services, delays receiving information and frustration when organisations fail to communicate effectively with one another.

The issue most commonly raised was not necessarily the clinical care itself but the complexity of the system surrounding it. Residents consistently described a desire for clearer access and pathways, better communication and more coordinated care. They want to tell their story once rather than repeatedly. They want professionals to work together and share information more effectively. They want a health and care system that feels integrated rather than fragmented.

Access remains the public's highest priority

Access emerged as the most significant issue throughout engagement. Residents consistently highlighted:

- access to GPs and difficulty obtaining GP appointments
- access to NHS dentistry
- long waits for elective treatment
- delays in diagnostics
- variable access to mental health support
- challenges navigating urgent care services
- uncertainty about waiting times and next steps.

However, communities also recognised that improvement is not simply about increasing capacity. People want simpler access routes, faster advice, more proactive communication and greater certainty while they wait. Many residents described frustration not only with the length of waits but with the lack of information during those waits. They want a system that communicates clearly, supports people while waiting for treatment and intervenes before conditions deteriorate.

Communities support more care closer to home

There was strong support for delivering more care within communities. Residents frequently described the benefits of receiving care locally, including easier travel, greater continuity of care, improved support for carers and stronger connections with local services. However, communities were clear that moving care closer to home should not mean reducing quality or access. Local services must be properly staffed, clinically robust and connected to wider healthcare pathways.

This support for the four layers of care and neighbourhood-based care strongly reinforces the strategic direction described within the 2027/28 commissioning intentions and reflects growing public recognition that hospitals cannot remain the default solution for every health need.

Prevention is increasingly important to residents

Residents consistently described concern about rising levels of preventable ill health. Many highlighted the increasing prevalence of diabetes, obesity, cardiovascular disease, respiratory illness, poor mental health and social isolation. There was widespread support for a stronger emphasis on prevention, early intervention and helping people to remain healthy and independent for longer.

People increasingly expect the NHS to support wellbeing rather than simply respond when illness occurs. Communities consistently spoke about healthier lifestyles, earlier support, improved self-management and stronger partnership working with local authorities, schools, employers and voluntary organisations. There is growing public understanding that long-term sustainability depends upon preventing illness rather than simply treating it.

Health inequalities matter to communities

Engagement showed a clear understanding that health outcomes are not experienced equally across Kent and Medway. People living in deprived communities, ethnic minority communities, individuals with learning disabilities, autistic people, carers, people experiencing homelessness and residents living with multiple long-term conditions frequently described additional barriers to accessing services. These barriers included:

- transport difficulties
- digital exclusion
- language barriers
- lack of accessible information
- difficulties navigating services
- reduced continuity of care
- longer waits for support.

Importantly, residents rarely described these challenges using the language of health inequalities. Instead, they described practical obstacles that affect their ability to access care and achieve good health. This reinforces the need for commissioning decisions to be based not only on current services and activity levels but also on understanding the wider factors that influence access, outcomes and experience.

Staff describe a system under pressure but full of opportunity

Staff engagement closely mirrored feedback received from residents. Across primary care, community services, mental health services, acute trusts and commissioning teams, staff described increasing demand, growing complexity and significant operational pressures. At the same time, they identified substantial opportunities to improve care through better integration and service redesign. The most common themes raised by staff included:

- workforce sustainability
- better integrated working
- stronger neighbourhood health models
- improved use of digital technology
- reducing duplication and bureaucracy
- greater focus on prevention
- better communication between organisations
- more efficient use of multidisciplinary teams.

Staff consistently highlighted that too much effort remains focused on managing demand and responding to crises rather than preventing them. There was strong support for shifting resources towards proactive community-based care and earlier intervention.



Providers and partners want greater clarity and certainty

Providers, local authorities and wider system partners support the strategic direction set out in the 2027/28 commissioning intentions. Partners recognise the scale of the clinical and financial challenge facing Kent and Medway and generally support the ambition to strengthen neighbourhood health, improve population health outcomes, reduce unwarranted variation and shift care into the most appropriate setting. At the same time, providers consistently asked for greater clarity regarding:

- the process of delivering commissioning expectations
- how partners would be recognised and involved
- pathway design, risk and transition arrangements
- resource allocation decisions
- contractual arrangements
- activity shifts between sectors
- risk-sharing arrangements
- transformation timescales
- outcome measures and success criteria.

This feedback has directly shaped the finalised 2027/28 commissioning intentions, which seek to provide much clearer direction regarding how services will be commissioned, how resources will be prioritised and how providers will be held accountable for delivering agreed outcomes.

Continuing the conversation

The commissioning intentions are not the endpoint of engagement. They represent the beginning of a more detailed conversation with the people and communities of Kent and Medway. We will continue a comprehensive programme of engagement and testing using a combination of locally led engagement activity and independent research and insight organisations. Increasingly, we will focus on the detail of peoples' experiences in the way they access and receive services, and use this insight to reshape the care of the future. This combined approach will provide both local understanding and independent challenge, helping make sure the feedback received is credible, representative and reflects the diversity of the Kent and Medway population.

Particular focus will be placed on reaching communities that are traditionally underrepresented in NHS engagement processes and those most likely to experience poorer health outcomes. This includes deprived communities, ethnic minority communities, children and young people, carers, people with disabilities, people with learning disabilities, autistic people, people experiencing mental ill health and residents living with multiple long-term conditions.

Alongside community engagement, we will continue structured discussions with providers, clinicians, councils, Healthwatch, voluntary sector organisations, community leaders, elected representatives, health and wellbeing boards and overview and scrutiny committees.

The final commissioning intentions were presented to the NHS Kent and Medway Board in September 2026. They were strengthened by the extensive public discussion, clinical challenge, partner engagement, independent analysis and community insight the process generated. We will continue to ensure the 27/28 commissioning approach reflects not only the strategic priorities of the NHS, but the voices, experiences and aspirations of the people and communities we serve.

7. How we will commission differently: Pathways, contracts, quality, finance and data

The previous sections of this document set out why change is required. We have described the scale of the population health challenge facing Kent and Medway, the quality improvements required across the health and care system, the financial pressures that threaten long-term sustainability and the views that residents, communities, staff and partners have shared with us. Collectively, they present a compelling case for change. The question that follows is how we will deliver it.

The 2027/28 commissioning intentions represent a significant shift in the role of commissioning. Historically, commissioning has often focused on annual contracting rounds, activity planning, financial management and performance oversight. While these responsibilities remain important, they are not sufficient to deliver the scale of transformation required across Kent and Medway.

Our ambition is to create a commissioning model where pathways, services, contracts, quality, finance, performance and data work together to improve outcomes, reduce inequalities, strengthen quality and support a financially sustainable health and care system. Future commissioning decisions will increasingly be based upon what difference services make to the lives of residents rather than simply the volume of activity delivered.

This does not mean activity becomes unimportant. Activity, demand and capacity information remains the foundation of NHS planning and resource allocation. Providers will continue to be expected to deliver agreed volumes of activity, achieve constitutional standards, manage demand and meet the needs of the population. However, activity alone will no longer be regarded as sufficient evidence of success. We will increasingly expect providers to demonstrate that the activity being commissioned is improving health outcomes, reducing inequalities, delivering better experience and providing value for money for taxpayers.

Contracts will become the primary delivery mechanism

Contracts that reflect the pathways we design and the services specification we agree will be the principal mechanism through which NHS Kent and Medway deliver its Five-Year Strategy and the Four Layers of Care model. Future contracts will increasingly move beyond describing services and funding arrangements. They will also specify the improvements we expect providers to deliver, the outcomes they are expected to achieve and the contribution they are expected to make towards wider transformation across Kent and Medway.

Providers should expect contracts to become increasingly explicit regarding:

- activity levels and agreed demand assumptions
- waiting time and access trajectories
- quality improvement trajectories
- population health outcomes
- reduction in health inequalities
- productivity expectations
- transformation milestones
- workforce expectations
- data quality requirements
- patient experience measures
- collaborative working across provider alliances.

The objective is not to commission more bureaucracy. The objective is to provide greater clarity about what the NHS is purchasing, what outcomes are expected and how success will be measured. We intend to reduce ambiguity within contracts and strengthen the connection between strategic priorities, improved pathways of care and contractual requirements.

Activity will continue to matter

The NHS remains an activity-driven service and future commissioning decisions will continue to be informed by robust activity modelling, demand forecasting and performance information. Providers should expect NHS Kent and Medway to continue specifying:

- elective activity trajectories
- diagnostic activity assumptions
- urgent and emergency care activity expectations
- community activity levels
- mental health activity requirements
- primary care access requirements
- waiting list trajectories
- productivity requirements.

However, activity will increasingly be considered alongside outcomes and value. Future commissioning decisions will be informed by questions such as:

- Is the activity improving health outcomes?
- Is the activity reducing inequalities?
- Is the activity delivering value for money?
- Could the activity be delivered differently?
- Could the activity be delivered closer to home?
- Could prevention or earlier intervention reduce demand?

This represents an evolution of commissioning rather than a replacement of traditional planning approaches.

Quality will be commissioned directly

A central principle of the 2027/28 commissioning intentions is that quality must become embedded within commissioning itself. Historically, quality has often been considered separately from contracts, finance and operational performance. From April 2027 onwards, we intend to bring these disciplines together. Service specifications, quality schedules, outcome frameworks and contractual arrangements will increasingly describe:

- patient safety expectations
- mortality improvement trajectories
- reduction in avoidable harm
- patient experience measures
- workforce indicators
- learning and improvement requirements
- reduction of health inequalities
- compliance with national standards and guidance.

Providers should therefore expect quality performance to be discussed alongside activity, finance and operational delivery rather than as a separate process.

NHS Kent and Medway will increasingly assess organisations on their ability to deliver improvements in outcomes, safety and patient experience as well as their ability to deliver activity.



Finance will support strategic change

Financial sustainability remains one of the most significant challenges facing Kent and Medway. Independent analysis has confirmed that the health economy faces a substantial underlying financial challenge that cannot be resolved through annual efficiencies alone. The system must therefore use available resources differently. Future resource allocation decisions will increasingly be informed by:

- population health need
- clinical outcomes
- health inequalities
- activity and utilisation patterns
- productivity
- financial sustainability
- delivery of strategic priorities.

The intention is not simply to spend less. The intention is to achieve greater value from every pound invested. Future investment decisions will increasingly seek to support:

- prevention
- neighbourhood health
- multi-neighbourhood care
- admission avoidance
- earlier intervention
- community-based models of care
- improved population health outcomes.

At the same time, acute providers will continue to play a central role within the system and will remain critical to delivering specialist, emergency and complex care. The principle is therefore not about taking resources from one part of the sector and giving them to another. It is about ensuring that resources are progressively aligned to the model of care we are seeking to create.

Financial flows must support clinical strategy

If activity moves, funding must increasingly move with it. One of the clearest principles underpinning the 2027/28 commissioning intentions is that financial arrangements should support strategic change rather than act as a barrier to it. Where agreed clinical pathways result in activity moving between providers, sectors or care settings, financial arrangements will increasingly reflect those changes.

Future arrangements will be guided by several key principles:

- system sustainability before organisational optimisation
- resources following agreed clinical strategy
- open-book transparency
- recognition of both fixed and variable costs
- explicit consideration of stranded costs
- demonstration of value for money
- shared accountability and risk-sharing
- alignment between outcomes and investment.

Providers should therefore expect increasing transparency regarding financial assumptions, activity modelling and resource allocation decisions.



Data and intelligence will become core commissioning assets

Delivering the ambitions set out within the 2027/28 commissioning intentions requires significantly better use of information. The future commissioning model will increasingly be underpinned by:

- population health intelligence
- activity data
- understanding variation
- outcome measures
- demand modelling
- predictive analytics
- benchmarking
- financial information
- patient experience data
- quality metrics.

The purpose of data is not simply to monitor performance. It is to improve decision-making. Providers should expect greater emphasis on:

- data quality
- interoperability
- population segmentation
- risk stratification
- evaluation
- benefits realisation
- benchmarking against peers.

Data will increasingly inform commissioning decisions, investment decisions and contractual discussions. The expectation is that commissioning moves from describing historical performance towards actively shaping future delivery.

Integrating delegated commissioning responsibilities

In 2027/28 a new Office of Pan ICB Commissioning (OPIC) will deliver for the four ICBs across the south east on a set of commissioning responsibilities delegated from NHS England. We will ensure an improving coherence across these delegated and core ICB commissioning responsibilities and take the opportunities to improve pathways and deliver on prevention objectives.

On specialised commissioning, we will jointly identify through OPIC the key opportunities. These will include services in which more capacity is required to meet growing need and where new treatments become available. But we will also select key pathways where the opportunity to integrate core ICB commissioned services and specialised commissioning can improve the experience and outcomes for patients. In particular, we want to identify opportunities to intervene earlier to prevent the escalation of needs, meeting those needs in the primary care and single neighbourhood layers and preventing escalation into local acute services and onwards to specialised services. Cardiology is a good example of where such opportunities exist and is a current focus of development work. We will continue to underline our expectation of providers to deliver high-quality, equitable access to specialised services.

The upcoming transfer of public health (screening and immunisation) and health and justice commissioning to the ICB also creates new opportunities for integration and service improvement, especially as Kent and Medway has a significant detained population and because inequalities in screening and vaccination are a key determinant of differential outcomes for our population.

Alliance and pathway-based commissioning

A recurring theme throughout the 2027/28 commissioning intentions is the need for providers to work together differently. The future NHS will increasingly be organised around pathways, populations and outcomes rather than organisational boundaries alone. As the Acute Collaborative and Neighbourhood Collaborative mature, contractual arrangements will increasingly reflect this reality. Providers should expect growing use of:

- shared outcome measures
- pathway-level commissioning
- joint delivery responsibilities
- collaborative improvement programmes
- population-based performance measures
- system productivity measures.

The expectation is not that organisational accountability disappears. It is that it is complemented by stronger accountability arrangements for whole pathways and whole population outcomes.



What this means for providers

For providers, the implications of this approach are significant. The future commissioning model will continue to require delivery of activity, access standards, waiting time trajectories and financial plans. However, we will increasingly expect organisations to demonstrate what that activity has achieved. Providers should expect:

- clearer strategic direction
- more explicit contractual requirements
- stronger focus on outcomes and quality
- greater use of population health intelligence
- more sophisticated performance measures
- increased accountability for inequalities
- stronger links between contracts and transformation
- greater use of benchmarking and comparative performance information
- increasing emphasis on collaborative delivery through provider alliances
- a clearer relationship between investment and delivery.

The organisations most likely to thrive within this environment will be those that can demonstrate improved outcomes, reduced variation, strong productivity, effective collaboration, delivery of transformation and a commitment to improving the health of the populations they serve.

Ultimately, this section represents the bridge between the strategic ambitions described earlier in this document and the commissioning intentions that follow. The subsequent sections describe what we expect to change within primary care, neighbourhood health, multi-neighbourhood care, elective care, urgent and emergency care, mental health, maternity and digital services. This section explains how those changes will be commissioned, funded, monitored and delivered.

8. Primary, community and neighbourhood care

Why this matters

Primary care remains the foundation of healthcare delivery in Kent and Medway and is where the overwhelming majority of healthcare contacts take place each year. General practice, community pharmacy, dentistry, optometry and community services collectively represent the front door of the NHS and are fundamental to improving population health, reducing inequalities and preventing avoidable demand elsewhere in the health and care system.

Despite their importance, significant variation remains in access, quality, outcomes and patient experience across Kent and Medway. The review carried out by the National Association of Primary Care identified substantial variation in both service delivery and outcomes and reinforced the need for a more consistent offer for residents irrespective of where they live.

Quality indicators continue to demonstrate variation across primary and community services. Kent and Medway continues to have a higher proportion of practices rated Requires Improvement by the Care Quality Commission than both national and regional averages, although progress has been made in recent years. The GP Patient Survey continues to show performance below national averages for overall experience of care, with common themes relating to access, workforce pressures, continuity, communication and digital services.

Patient safety reporting from general practice remains significantly lower than would be expected for a mature learning culture and does not yet provide sufficient confidence that opportunities for organisational learning are being consistently identified and addressed. Across primary care and community services, reviews of incidents, Patient Safety Incident Response Framework learning, Central Alerting System (CAS) alerts and Learn from Patient Safety Events (LFPSE) reporting continue to identify recurring themes relating to the recognition of deterioration, medication safety, safeguarding, workforce resilience and information sharing.

There also remains considerable variation in the management of long-term conditions. While Kent and Medway performs above the national average in some areas of the Quality and Outcomes Framework, performance continues to lag behind comparable integrated care systems in several important indicators. Health inequalities remain evident across cardiovascular disease, respiratory disease, diabetes, mental health outcomes and preventative healthcare uptake.

The challenges are not confined to general practice. Significant variation exists in access to NHS dentistry and oral health outcomes across the county, while intelligence regarding quality and outcomes within pharmacy and dentistry services remains limited. Workforce availability, access challenges and unmet need continue to affect large parts of the population.

At the same time, demographic change, increasing frailty, growing prevalence of multiple long-term conditions, rising mental health need and widening health inequalities mean that demand for services will continue to increase. The current model cannot meet future need through additional activity alone. A more proactive, integrated and neighbourhood-based model of care is required.

For these reasons, primary, community and neighbourhood care sits at the centre of the 2027/28 commissioning intentions and will act as the principal mechanism through which NHS Kent and Medway improves population health, reduces inequalities, prevents illness and creates a more sustainable health and care system.

What will change from April 2027

From April 2027, NHS Kent and Medway will increasingly commission primary, community and neighbourhood services as a coherent population health system rather than a collection of individual services. Primary care will remain the foundation of healthcare delivery, but there will be a greater emphasis on prevention, proactive care, continuity of care, neighbourhood delivery and management of defined population cohorts.

General practice, community pharmacy, dentistry, community services, mental health services, social care and the voluntary, community and social enterprise sector will increasingly be commissioned and held accountable through a shared neighbourhood framework. The 45 neighbourhood footprints across Kent and Medway will become the primary unit for planning, service delivery and performance management. Every neighbourhood will operate to a common delivery model, leadership structure, multidisciplinary team approach, care coordination process, outcomes framework and maturity standard.

Commissioning will increasingly focus on improving outcomes for specific populations including:

- people living with frailty
- care home residents
- individuals with multiple long-term conditions
- people with serious mental illness
- children and young people
- housebound residents
- people approaching end of life
- residents at highest risk of emergency admission.

A greater proportion of care will be delivered through proactive neighbourhood teams, integrated multidisciplinary models, virtual wards, Hospital at Home services, Urgent Community Response and preventative interventions.

What providers will be required to do

General practice

From April 2027 all practices will be expected to deliver a defined Kent and Medway core offer. This will include:

- timely and improved access to care
- continuity of care for vulnerable populations
- long-term condition management
- prevention and screening activity
- population health management
- personalised care
- agreed locally commissioned services.

By December 2027, NHS Kent and Medway will finalise the full specification of this core offer. Providers will be expected to:

- deliver 90 per cent same-day access for patients requiring urgent assessment
- improve continuity for residents with complex needs
- reduce unwarranted variation in outcomes
- improve management of cardiovascular disease, respiratory disease, kidney disease and diabetes
- demonstrate equitable access across population groups
- identify and proactively manage rising-risk populations
- implement personalised care adjustments only where required to optimise positive outcomes for all patients
- improve patient experience and GP survey outcomes.

Delivery of the core offer will become a prerequisite for participation in additional commissioned service programmes. Following publication of the National Association of Primary Care action plan, NHS Kent and Medway will implement a targeted improvement programme from April 2027. Practices unable to demonstrate safe, sustainable and effective delivery will be subject to enhanced support, formal improvement arrangements and, where necessary, contractual intervention. At the same time, practices that are able to deliver more to support local patients will be supported and enabled to do so. We will use 2027/28 to develop a further set of commissioning intentions to further address feedback about the criticality of GP access.

Community pharmacy

Community pharmacy will increasingly operate as an integral clinical component of primary care. Providers will be expected to:

- accept referrals from general practice, urgent care and neighbourhood teams
- provide structured feedback to referring clinicians
- increase identification and management of cardiovascular disease
- expand delivery through independent prescribers
- support prevention and population health priorities
- improve hypertension detection and management
- demonstrate measurable improvements in cardiovascular outcomes.

Dentistry

NHS Kent and Medway will carry out a review of all NHS dental contracts. Future commissioning decisions will increasingly be informed by:

- population health intelligence
- levels of deprivation
- oral health outcomes
- access challenges
- unmet need.

Providers will be expected to deliver commissioned activity in full and demonstrate value for money. Organisations consistently failing to deliver agreed levels of activity or quality will be required to improve performance through contract management arrangements or risk activity being redistributed to alternative providers.

From 2027/28, activity redistribution will be actively used as a commissioning tool to increase capacity within underserved communities and improve equitable access to NHS dentistry. Providers will also be expected to support reductions in waiting times for procedures requiring general anaesthetic. Acute providers will be required to collaborate in ensuring sufficient anaesthetic capacity exists across Kent and Medway, and this expectation will form an explicit contractual requirement.



Neighbourhood health

Every provider contributing to neighbourhood delivery will be expected to operate within the Kent and Medway Neighbourhood Model. By April 2027 every neighbourhood will have:

- defined geographic populations
- agreed leadership arrangements
- operational mutli-disciplinary teams (MDTs)
- shared care planning
- risk stratification models
- common outcome measures.

Providers will be expected to demonstrate through a single:

- consistent MDT operation
- management of high-risk cohorts
- reduction in emergency admissions
- reduction in ambulance conveyance
- proactive care planning
- improved experience of coordinated care
- reduction in inequalities.

By October 2026 each neighbourhood will be expected to have a delivery plan for the rest of 2026/27 and by April 2027 a masterplan will be in place for each of our single neighbourhood areas describing how they will develop services and enablers to deliver the required impact.

Multi-neighbourhood care

By April 2027 a single multi-neighbourhood care model will be commissioned across nine multi-neighbourhood footprints. Providers will be expected to deliver a series of improvements, many focussed on supporting the complex care cohort to be supported at home and to return home as soon as possible if a hospital stay is required:

- urgent community response
- hospital at home
- virtual wards
- Home First
- rehabilitation services
- community frailty services
- community nursing
- therapy services
- end-of-life crisis response
- an expanded model of neurorehabilitation to support stroke recovery and wider pathways.

An expansion of home-based services will allow us to review the requirements for community beds in the future, starting with the principle that all care should be delivered at home wherever possible.

Performance expectations will include:

- two-hour urgent community response (UCR) response standards
- same-day urgent assessment
- agreed virtual ward utilisation rates
- consistent discharge to assess pathways
- improved admission avoidance
- improved discharge performance
- improved rehabilitation outcomes.

How this will be commissioned

Contracts will increasingly move beyond service descriptions and activity schedules. From April 2027 contracts will increasingly specify:

- core service requirements
- access standards
- quality trajectories
- outcome measures
- health inequality targets
- neighbourhood delivery expectations
- population health requirements
- activity trajectories
- workforce expectations
- patient experience requirements.

Funding will increasingly be linked to delivery of agreed service standards, quality requirements and outcomes. Neighbourhood health funding will increasingly be aligned to delivery against agreed outcomes rather than solely activity. VCSE organisations will increasingly move from grant-funded arrangements towards formally commissioned neighbourhood services with defined specifications, outcome measures and accountability requirements. We will design the model to support carers and use existing community assets.

Providers that consistently fail to deliver agreed standards will be subject to recovery arrangements, enhanced oversight, contractual intervention or, where appropriate, procurement and redistribution of activity. Community and mental health providers will increasingly be held to the same degree of contractual accountability historically applied to acute providers.



How success will be judged

Success will be judged across six domains:

Outcomes

- improved long-term condition outcomes
- improved cardiovascular outcomes
- reduced avoidable deterioration
- improved frailty outcomes
- improved oral health outcomes
- improved population health measures.

Quality

- all providers rated at least Good by the CQC
- increased patient safety reporting
- demonstrable learning from incidents
- improved Quality and Outcomes Framework performance
- improved safeguarding outcomes
- adoption of the Sexual Safety Charter.

Access

- achievement of urgent access standards
- improved GP Patient Survey results
- improved access to dentistry
- reduced variation between localities
- improved access to community services.

Productivity

- reduced emergency admissions
- reduced ambulance conveyance
- improved utilisation of neighbourhood services
- improved value from commissioned activity.

Health inequalities

- increased referrals into domestic abuse services
- increased referrals into sexual abuse services
- improved access for underserved communities
- reduced variation in outcomes across neighbourhoods.

Patient Experience

- Friends and Family Test response and recommendation rates at or above the national average
- improved GP Patient Survey performance to at least national and peer averages
- improved continuity of care
- evidence of co-production
- improved patient-reported outcomes and experience.

By the end of 2027/28, NHS Kent and Medway expects primary, community and neighbourhood care to be operating as a single integrated neighbourhood-based model, delivering measurable improvements in quality, access, outcomes, patient experience and health inequalities, while reducing avoidable demand on acute services and improving the overall sustainability of the health and care system.

9. Elective care

Why this matters

Elective care remains under significant pressure across Kent and Medway. While waiting lists are reducing nationally, local improvement has not always kept pace with demand, and too many residents continue to wait longer than 18 weeks for first outpatient appointments, diagnostics and definitive treatment. Long waits negatively affect quality of life, increase the likelihood of deterioration, contribute to poorer clinical outcomes and can significantly widen existing health inequalities.

Variation remains evident across Kent and Medway in referral rates, waiting times, pathway design, access to diagnostics, outpatient utilisation, theatre productivity and patient outcomes. Similar patients can experience different pathways and different waits depending upon where they enter the system. This variation is neither clinically desirable nor financially sustainable.

There are also important quality considerations. Persistent patient safety themes include delayed diagnosis, delayed action on abnormal test results, communication failures, diagnostic delays and variation in escalation processes when patients deteriorate whilst waiting. Equipment availability and capacity constraints continue to affect some pathways and can create delays in both diagnostics and treatment.

Although Kent and Medway compares favourably in overall readmission performance, substantial variation exists between specialties, particularly within orthopaedics and general surgery. National Cancer Patient Experience Survey results demonstrate variation across organisations, with patient experience continuing to be influenced by communication, coordination and waiting times. Eight never events were reported across the system during 2025/26, the majority relating to surgical pathways, demonstrating that continued focus on quality and safety remains essential.

The financial challenge facing Kent and Medway reinforces the need for change. Future elective recovery cannot simply be achieved through increasing activity. Providers must improve productivity, reduce variation, optimise pathways and make better use of available capacity. Elective care must increasingly deliver better outcomes, better patient experience and better value from existing resources. For these reasons, NHS Kent and Medway will commission elective care differently from April 2027.



What will change from April 2027

From 1 April 2027 NHS Kent and Medway will increasingly commission elective care on a system basis rather than through individual organisational pathways. The focus will move towards standardised pathways, clinically led networked delivery, shared waiting list management, improved access to diagnostics and stronger accountability for quality, outcomes and productivity.

Cardiology, orthopaedics, gynaecology and neurology/ headache services will be the first priority specialties for pathway redesign. Cardiology will be a particular priority given the scale of waiting lists across Kent and Medway and the current challenges experienced within East Kent pathways. Additional specialties will be added where there is a clear clinical case for change, agreed pathway design and provider readiness to deliver improvement.

By 1 April 2027 all acute providers will be required to operate a single patient tracking list model, enabling capacity to be managed on a system basis rather than organisational boundaries. Patients will increasingly be prioritised according to clinical need and waiting time, ensuring equitable access across Kent and Medway. By 1 October 2027 a Kent and Medway Single Point of Access (SPoA) will become the default route into elective care pathways. The SPoA will support consultant-led triage, rapid clinical advice, redirection into community services, improved diagnostic access and more equitable access to treatment.

NHS Kent and Medway will increasingly commission direct-to-test and straight-to-test models where evidence demonstrates improved access, improved outcomes and reduced unnecessary outpatient activity. This will initially focus on imaging, ENT, osteoporosis and other pathways where traditional models create avoidable delays.

Specialty clinical networks operating through the Acute Provider Alliance will be expected to deliver greater consistency, standardisation and reduction in unwarranted variation. Referral criteria, pathway design, outcome measures and clinical standards will increasingly be consistent across Kent and Medway.

NHS Kent and Medway will also commission more outpatient activity closer to home where clinically appropriate. Neighbourhood-based outpatient models will increasingly be developed in specialties including rheumatology, paediatrics and cardiology, supporting earlier intervention and stronger integration with primary care and neighbourhood health services.

What providers will be required to do

Referral management and access

From April 2027 providers will be expected to:

- participate fully in the Kent and Medway Single Point of Access model
- accept consultant-led triage as a standard commissioning requirement
- expand Advice and Guidance utilisation
- reduce inappropriate referrals
- improve referral quality
- implement agreed direct-to-test pathways
- implement agreed straight-to-test pathways
- improve escalation arrangements for deteriorating patients waiting for care
- participate in system-wide waiting list management.

Waiting list management

All providers will be required to:

- operate within a single patient tracking list model
- prioritise patients by clinical need and wait duration
- participate in the Kent and Medway Waiting Well programme
- undertake routine clinical validation
- undertake harm reviews for patients experiencing extended waits
- identify patients at greatest risk of deterioration
- improve communication with patients while waiting.

Productivity and pathway improvement

Providers will be expected to:

- deliver elective activity at benchmark levels of productivity
- operate at or below tariff costs
- reduce unwarranted variation in follow-up rates
- reduce unnecessary repeat outpatient appointments
- improve theatre utilisation
- improve day-case performance
- implement GIRFT recommendations
- improve utilisation of diagnostics
- standardise pathway design
- reduce procedure-specific variation.

Quality and safety

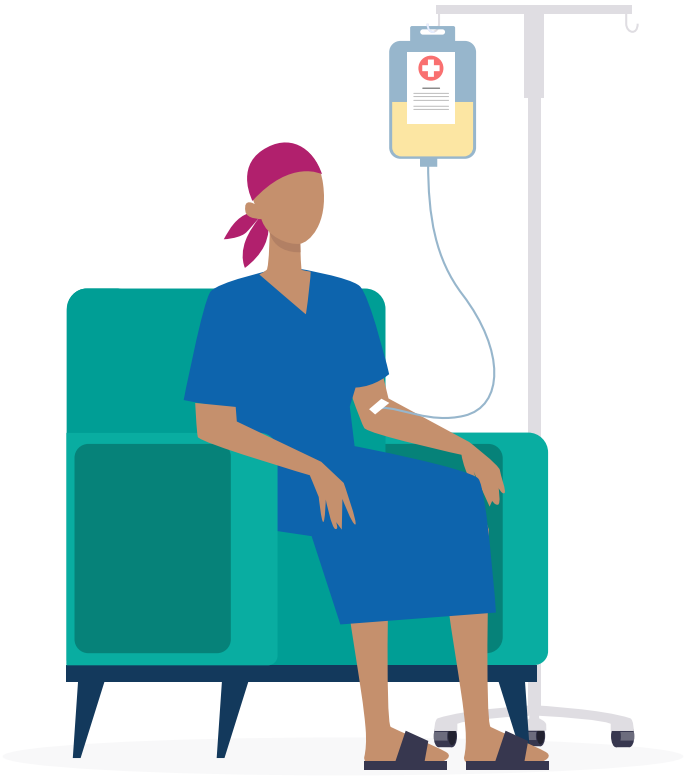
Providers will be required to:

- eliminate never events through compliance with NatSSIPs and LocSSIPs
- ensure all equipment is serviced and maintained within required timescales
- maintain accurate equipment asset registers
- prevent delayed diagnoses resulting from failures in incidental findings pathways
- improve management of abnormal diagnostic results
- undertake routine clinical monitoring of patients waiting more than 18 weeks
- undertake harm reviews for patients experiencing prolonged waits
- reduce specialty-specific readmissions
- improve peri-operative optimisation
- strengthen discharge planning processes.

Clinical networks and alliance working

The Acute Collaborative will be expected to:

- convene specialty clinical networks
- agree common referral criteria
- implement common pathway standards
- share best practice
- reduce unwarranted variation
- improve outcomes across Kent and Medway
- support equitable use of elective capacity.



How this will be commissioned

From April 2027 provider contracts will increasingly focus on access, outcomes, quality, productivity and patient experience rather than activity alone. Contracts will include explicit requirements relating to:

- RTT trajectories
- diagnostic recovery trajectories
- Single Point of Access participation
- single patient tracking list participation
- straight-to-test implementation
- advice and guidance utilisation
- productivity improvement targets
- readmission reduction trajectories
- outcome improvement trajectories
- patient experience requirements
- clinical network participation
- health inequality improvement objectives.

Financial arrangements will increasingly support pathway redesign and capacity utilisation on a system basis. NHS Kent and Medway will commission elective care working through:

- acute provider alliance arrangements
- specialty clinical networks
- formal provider contracts
- service specifications
- quality schedules
- outcome frameworks
- contract management committees.

Providers should expect increasing use of:

- incentive schemes
- comparative benchmarking
- quality improvement trajectories
- improvement notices
- recovery plans
- contractual consequences linked to delivery.

Providers consistently operating outside agreed performance ranges will be expected to implement formal improvement programmes, with quarterly reporting on progress, variation and clinical outcomes.



How success will be judged

Outcomes

Providers will be expected to demonstrate:

- improved Patient Reported Outcome Measures
- improved specialty-specific outcomes
- reduction in readmissions
- improved cancer pathway outcomes
- improved paediatric audiology outcomes
- improved functional outcomes following treatment.

Quality

Providers will be expected to demonstrate:

- implementation of Kingdon Review on audiology recommendations
- zero never events
- elimination of delayed diagnosis caused by incidental findings failures
- reduction in readmissions to at least national average levels
- improved surgical safety compliance
- improved patient safety reporting and learning.

Access

Providers will be expected to demonstrate:

- delivery of national RTT trajectories
- reduction in 18-week waits
- improved diagnostic waits
- faster access to treatment
- reduction in pathway variation
- improved access across all communities.

Productivity

Providers will be expected to demonstrate:

- improved theatre utilisation
- reduced outpatient follow-up variation
- improved day-case rates
- improved use of diagnostics
- delivery of GIRFT opportunities
- activity delivered at or below tariff
- improved value for money.

Health inequalities

Providers will be expected to demonstrate:

- reduction in access variation by deprivation
- reduction in outcome variation across communities
- earlier intervention in populations at greatest risk
- improved access for underserved groups.

Patient experience

Providers will be expected to demonstrate:

- Cancer Patient Experience Survey results at or above the national average
- improved Friends and Family Test performance
- improved communication throughout pathways
- better support through Waiting Well programmes
- reduced complaints relating to waits and communication
- demonstrable patient involvement in pathway redesign.

By March 2028, NHS Kent and Medway expects to see materially shorter waits, greater use of system-wide capacity, reduced unwarranted variation, improved patient experience and better clinical outcomes. Elective care will increasingly operate as a single Kent and Medway system rather than a collection of individual provider pathways, with commissioning focused on outcomes, quality, productivity and value rather than activity alone.

Why this matters

Elective care remains one of the most visible measures of NHS performance and one of the areas patients tell us matters most. Despite significant progress in reducing waiting lists and improving recovery following the pandemic, too many residents continue to wait too long for diagnosis, treatment and follow-up care. Long waits affect quality of life, employment, mental wellbeing and clinical outcomes, with the greatest impact often experienced by those already facing health inequalities.

Variation remains evident across Kent and Medway in referral patterns, specialty pathways, theatre productivity, outpatient utilisation, follow-up rates, day-case performance and patient outcomes. Similar patients can experience different waiting times, different access arrangements and different pathways depending upon where they enter the system. This variation is not sustainable and results in poorer outcomes, inefficient use of resources and inequitable access to care.

The financial challenge facing Kent and Medway also reinforces the need for change. Future elective recovery cannot be delivered through additional activity alone. The system must improve productivity, reduce variation, standardise pathways and make better use of existing capacity. Elective care must increasingly focus on delivering the right intervention, in the right setting, at the right time and by the most appropriate provider.

At the same time, population demand continues to increase. An ageing population, increasing prevalence of musculoskeletal conditions, cardiovascular disease, cancer, obesity and long-term conditions will continue to drive demand throughout the next decade. Without redesign, waiting lists and service pressures will continue to grow.

The objective for Kent and Medway is therefore not simply to recover performance but to create a clinically led, productive and consistently high-quality elective care system that delivers sustainable improvement in outcomes and access.

What will change from April 2027

From 1 April 2027, NHS Kent and Medway will increasingly commission elective care on a system pathway basis rather than as a collection of individual provider services. The focus will move towards standardised pathways, shared waiting list management, networked clinical delivery and system-wide utilisation of available capacity. The aim is to reduce unwarranted variation, improve productivity and ensure that residents receive timely access to care regardless of organisational boundaries.

A Kent and Medway Single Point of Access will progressively become the default route into major elective pathways, enabling improved triage, referral management and allocation of patients to the most appropriate provider.

Single Patient Tracking Lists will increasingly be used across specialities where appropriate to support equitable access, optimise capacity and reduce unnecessary waiting. Providers will increasingly be required to operate as part of system-wide specialty networks rather than independent elective providers.

Straight-to-Test pathways will become the expected commissioning approach wherever clinically appropriate. Providers will be expected to reduce unnecessary outpatient appointments, streamline diagnostic pathways and reduce duplication within referral processes.

Advice and guidance will increasingly become a routine component of pathway management to support faster access to specialist expertise, improve referral quality and reduce unnecessary outpatient demand.

NHS Kent and Medway expects an increasing proportion of routine elective activity to be delivered through standardised pathways, supported by common clinical standards and shared outcome measures across all providers.

What providers will be required to do

From April 2027, acute providers will be expected to demonstrate delivery against both activity and productivity requirements. Providers will be required to:

- deliver agreed Referral to Treatment recovery trajectories
- deliver agreed diagnostic recovery trajectories
- participate in Single Patient Tracking Lists
- operate within specialty network arrangements
- implement Single Point of Access requirements
- increase use of Straight-to-Test pathways
- expand advice and guidance utilisation
- reduce unnecessary outpatient follow-up activity
- improve New-to-Follow-Up ratios
- increase theatre productivity
- improve day-case rate
- reduce procedure-specific variation
- reduce avoidable cancellations
- improve utilisation of diagnostic capacity
- deliver agreed GIRFT productivity standards
- reduce variation between sites and specialties
- improve elective outcomes and patient experience.

Providers will also be expected to demonstrate how they are reducing inequalities within elective pathways, particularly for populations who experience poorer access, later presentation or worse outcomes.

Acute providers will increasingly be expected to collaborate through shared elective programmes and support delivery of activity across organisational boundaries where this improves access and utilisation of capacity. The independent sector will continue to play an important role in elective delivery where it supports improved access, improved value and improved outcomes.

How this will be commissioned

From April 2027, contracts will increasingly move beyond activity schedules alone and will incorporate explicit requirements relating to productivity, outcomes, access and pathway transformation. Contracts and service specifications will increasingly include:

- referral to treatment trajectories
- diagnostic recovery trajectories
- productivity assumptions
- theatre utilisation standards
- day-case targets
- new-to-follow-up ratios
- straight-to-test requirements
- advice and guidance utilisation expectations
- outcome measures
- patient experience measures
- health inequality measures
- specialty network participation requirements.

Commissioning arrangements will increasingly support activity being allocated across the system in line with available capacity and agreed network arrangements. NHS Kent and Medway will use contract management processes, specialty networks and work with provider collaboratives to oversee delivery. Financial arrangements will increasingly support pathway redesign, activity redistribution and productivity improvement where this delivers better outcomes and value for money.

Providers should expect increasing transparency of comparative performance information, benchmarking and elective productivity measures. Where agreed trajectories are not achieved, organisations will be expected to implement recovery plans, improvement programmes and pathway redesign initiatives. Persistent underperformance may result in contractual intervention, redistribution of activity or revision of commissioning arrangements.

How success will be judged

Success will be judged not solely by the volume of activity delivered but by a combination of outcomes, quality, access, productivity and patient experience. Providers will be expected to demonstrate:

Outcomes

- improvements in Patient Reported Outcome Measures
- improved clinical outcomes across major specialties
- reduction in procedure-specific variation
- improved functional outcomes following treatment
- improved cancer pathway outcomes where relevant.

Quality

- reduction in readmissions
- reduction in avoidable complications
- improved safety indicators
- compliance with national clinical standards
- reduction in unwarranted variation between providers and specialties.

Access

- delivery of RTT standards
- reduced waiting times
- improved diagnostic performance
- faster access to treatment
- reduced waiting list variation between communities.

Productivity

- providers will be expected to demonstrate:
- improved theatre utilisation
- improved day-case rates
- improved outpatient productivity
- improved new-to-follow-up ratios
- improved utilisation of diagnostic capacity
- delivery of agreed GIRFT opportunities
- improved value from commissioned activity.

Health inequalities

- improved access for underserved communities
- reduction in variation by deprivation and protected characteristics
- earlier intervention within high-risk population
- improved equity of access across Kent and Medway.

Patient experience

- improved Patient Reported Experience Measures
- improved communication throughout pathways
- reduced uncertainty whilst waiting
- better coordination across providers
- improved Friends and Family Test outcomes
- evidence of co-production and patient involvement in pathway design.

By the end of 2027/28, NHS Kent and Medway expects elective care to operate increasingly as integrated pathways of care rather than a collection of separate provider pathways. Success will be demonstrated through shorter waits, improved outcomes, reduced variation, higher productivity and a more equitable and consistent experience for residents across Kent and Medway.

10. Urgent, emergency care and flow

Why this matters

Urgent and emergency care will be commissioned differently from 1 April 2027 because the current model is not delivering the outcomes, experience or sustainability that residents of Kent and Medway should expect.

Too many residents currently access care through hospitals when their needs could be met safely and effectively through primary care, neighbourhood health, community services, mental health services or multi-neighbourhood care pathways. At the same time, many patients who genuinely require hospital care experience delays entering hospital, delays receiving treatment and delays leaving hospital once they are medically fit for discharge. The consequences are poorer outcomes, poorer patient experience, avoidable harm and significantly higher healthcare costs.

The challenge is particularly concentrated amongst a relatively small proportion of the population. Analysis shows that the five per cent of residents with the highest level of need account for approximately 17 per cent of emergency department attendances, 32 per cent of emergency admissions and around 342,000 hospital bed days each year. These residents often live with frailty, multiple long-term conditions, mental health needs, social complexity or significant health inequalities.

The current system often responds to their needs after deterioration rather than preventing deterioration in the first place. Quality indicators demonstrate that the current urgent and emergency care model is under significant pressure. Crowding, delayed admissions and prolonged waits continue to create unacceptable risks for patients. 12-hour emergency department waits remain a significant challenge across parts of Kent and Medway, particularly during periods of operational pressure. The continued use of temporary escalation spaces and non-designated care areas such as corridors demonstrates a mismatch between demand and capacity and is inconsistent with the standard of care that residents should expect.

Mortality remains a concern across urgent care pathways. Standardised Hospital Mortality Indicators continue to demonstrate variation across the system, with particular concerns relating to pneumonia, urinary tract infection and emergency care pathways. Reviews of patient safety incidents continue to identify recurring themes relating to recognition and management of deterioration, delayed diagnosis, delayed escalation, communication failures and inconsistent adherence to clinical standards.

Patient experience is also significantly affected by waiting times and communication during periods of operational pressure. Friends and Family Test performance remains generally positive but variable, while patient feedback consistently highlights frustrations relating to waiting times, communication and uncertainty regarding next steps in care. Care Quality Commission ratings across several urgent and emergency care services remain below the standards that Kent and Medway should expect, with a higher proportion of services rated Requires Improvement than comparable systems.

Staff continue to deliver high-quality care despite these challenges, but workforce resilience remains under significant pressure. Staffing variability, workforce shortages, medicines management challenges, infection prevention concerns and limitations within some digital systems all increase operational risk when services are under pressure. Improving urgent and emergency care therefore requires more than improving performance against operational targets. It requires a fundamental shift in how care is commissioned, where care is delivered and how providers work together across the Four Layers of Care model.

What will change from April 2027

From 1 April 2027, NHS Kent and Medway will increasingly commission urgent and emergency care as an integrated pathway rather than a collection of individual services. The focus of commissioning will move from managing demand within hospitals towards preventing avoidable attendance, preventing avoidable admission and making sure residents receive the right care in the right setting first time.

The most significant shift will be the movement of activity away from emergency departments and into neighbourhood health, multi-neighbourhood care, community services and proactive management of high-intensity users wherever clinically appropriate.

By April 2027, NHS Kent and Medway will commission an integrated Kent and Medway Single Point of Access and Clinical Assessment Service. This will provide a single clinically led assessment, navigation and coordination function across urgent care services. The objective is to direct residents to the most appropriate service at first contact and reduce unnecessary attendance at emergency departments and urgent treatment centres. We will continue to specify improvements to the way in which 999 and NHS 111 services are integrated into local arrangements, supporting care at the primary care and neighbourhood layers through their contribution to managing demand, supporting admission avoidance, improving patient navigation, and strengthening links into neighbourhood care services.

Urgent treatment centres will be reviewed during 2026/27 to ensure their future role supports the Four Layers of Care model. Over time, primary care needs should increasingly be managed through strengthened general practice and neighbourhood health services where capacity will need to be optimised and serve the whole population including our complex care cohort and children. Urgent treatment centres should focus on genuinely urgent presentations and weekend and out-of-hours demand.

NHS Kent and Medway will increasingly commission alternatives to hospital admission for the complex care cohort, including:

- frailty
- care home residents
- housebound patients
- people with multiple long-term conditions
- residents with complex behavioural needs
- people with learning disabilities
- people requiring neuro-rehabilitation support.

The overall ambition is that hospital admission increasingly becomes the exception rather than the default response for these groups.



What providers will be required to do

Access and front door services

From April 2027, all providers will be expected to use the Kent and Medway Single Point of Access as the default route into commissioned urgent community services.

Providers will be expected to:

- operate to a common access model
- use standardised referral criteria
- support the single Clinical Assessment Service
- reduce duplication of assessment
- reduce avoidable emergency department attendance
- support digitally enabled navigation and care coordination
- demonstrate reduced attendances for conditions appropriately managed within primary care and neighbourhood services
- reduce re-presentations with similar needs within one month.
- reduce mental health presentations waiting beyond six hours in emergency departments.

Admission avoidance

Providers will be required to demonstrate year-on-year reductions in:

- ambulatory care sensitive admissions
- emergency department attendances
- hospital bed utilisation
- conveyance to hospital
- avoidable admission for frailty cohorts.

Community providers will be expected to expand:

- urgent community response
- Hospital at Home
- virtual wards
- enhanced care home support
- frailty services
- neighbourhood multidisciplinary interventions.

Discharge and flow

By April 2027, all providers will be expected to operate a standard Kent and Medway discharge model built around Home First principles.

Providers will be required to:

- deliver Discharge to Assess as the default approach
- operate within a single Kent and Medway Home First specification
- participate within a common Transfer of Care Hub model
- implement standardised discharge pathways
- support system-wide bed brokerage arrangements
- utilise common patient transport arrangements
- operate standardised Virtual Ward pathway
- adhere to the national discharge blueprint
- complete SAFER Patient Flow Bundle requirements.

No discharge should be delayed for reasons within a provider's control.

Acute flow and hospital care

Acute providers will be required to:

- deliver common Kent and Medway access standards
- deliver common flow standards
- reduce delays to admission
- improve Same Day Emergency Care utilisation
- reduce average length of stay
- reduce stranded and super-stranded patients
- improve discharge to usual place of residence
- eliminate routine use of temporary escalation spaces
- eliminate corridor care
- improve patient flow across acute sites.

The acute collaborative will be expected to support common standards, pathway redesign and reduction in variation between organisations.



How this will be commissioned

From April 2027, provider contracts will increasingly focus on outcomes, quality, access, flow and patient experience rather than activity alone. Contracts will include:

- access standard
- emergency care trajectories
- admission avoidance trajectories
- flow standards
- discharge standards
- mortality improvement trajectories
- quality requirements
- patient experience measures
- productivity requirements
- neighbourhood care utilisation requirements.

NHS Kent and Medway will commission:

- a single Kent and Medway Home First specification
- a single Kent and Medway Transfer of Care Hub model
- standardised virtual ward arrangements
- standardised Hospital at Home pathways
- common urgent community response standards
- common same day emergency care specifications
- system-wide discharge arrangements.

Performance will be overseen through contract review meetings, quality committees and alliance governance arrangements. Providers demonstrating sustained improvement will be expected to spread and embed best practice. Providers failing to deliver agreed trajectories will be subject to formal recovery arrangements, enhanced oversight, contractual intervention and financial consequences.

How success will be judged

Outcomes

By March 2028, providers will be expected to demonstrate:

- a 50 per cent reduction in emergency admissions and hospital bed days for the identified complex care cohort compared with the 2025/26 baseline
- improvement in SHMI performance across all acute providers
- reduced mortality variation across emergency pathways
- reduced avoidable deterioration.

Quality

Providers will be expected to demonstrate:

- zero routine use of corridor care
- zero routine use of temporary escalation areas
- no deaths where the standard of care was more likely than not to have contributed to the outcome
- all patients receiving care consistent with fundamental standards of care
- improvement in patient safety reporting and learning
- compliance with national and Royal College guidance
- improvement in CQC ratings, with all urgent and emergency care services rated at least Good at their next inspection.

Access

Providers will be expected to demonstrate:

- fewer than 5 per cent of Type 1 emergency department attendances waiting more than 12 hours for admission
- faster access to urgent assessment and treatment
- reduced avoidable attendance at emergency departments
- improved same-day urgent care provision.

Productivity

Providers will be expected to demonstrate:

- improved same day emergency care utilisation
- reduced average length of stay
- reduction in stranded and super-stranded patients
- reduced delayed discharge
- improved use of community alternatives
- improved utilisation of bed capacity.

Health inequalities

Providers will be expected to demonstrate:

- reduced emergency attendance rates amongst high-intensity users
- improved outcomes for deprived communities
- reduced variation in emergency admission rates
- improved access to alternatives to hospital care.

Patient experience

Providers will be expected to demonstrate:

- emergency department Friends and Family recommendation rates of at least 90 per cent, with no provider below 85 per cent
- improvement in urgent and emergency care patient survey outcomes to at least the national average
- sustained reductions in complaints relating to waiting times, communication and discharge
- timely communication with patients and general practitioners following attendance
- improved experience during discharge and care transitions.



By the end of 2028/29, NHS Kent and Medway expects the majority of urgent primary care presentations to be managed through primary care, neighbourhood health and community services. The complex care cohort should increasingly receive support within homes and communities rather than hospitals. No resident should remain in hospital because appropriate community alternatives are unavailable, and prolonged waits for admission should become exceptional rather than routine. Future investment will increasingly be directed towards providers that can demonstrate measurable improvements in outcomes, quality, patient experience, productivity and population health.

11. Mental health, learning disability, autism and ADHD

Why this matters

Mental health need continues to increase across Kent and Medway. Nationally, the prevalence of probable mental health conditions amongst children and young people has increased significantly over recent years, whilst demand for adult mental health services continues to grow. Around 40 per cent of GP consultations now involve a mental health component, demonstrating the scale of demand presenting across the wider health and care system. At the same time, too many people access support only when they reach crisis point rather than receiving support earlier in their journey. Current pathways remain heavily weighted towards specialist intervention, with insufficient capacity, consistency and confidence within primary care, neighbourhood services and community provision. This creates avoidable demand on specialist services and means that many residents wait too long for support.

The consequences of this are significant. Kent and Medway continues to experience suicide rates above the national average and approximately two-thirds of people affected are not known to secondary mental health services at the time of death. Reviews of serious incidents, incidents of self-harm, homicide reviews, Safeguarding Adult Reviews and patient safety investigations continue to identify common themes relating to risk assessment, care planning, communication, continuity of care and family involvement.

People with learning disabilities and autistic people continue to experience unacceptable health inequalities. The Learning from Deaths Review (LeDeR) programme continues to demonstrate poorer outcomes and earlier mortality than the wider population. Concerns remain regarding the quality of annual health checks, Health Action Plans, reasonable adjustments and access to specialist services. Similar inequalities exist for people living with serious mental illness, who continue to experience significantly poorer physical health outcomes and shorter life expectancy than the wider population.

Demand for Autism and ADHD services has increased dramatically. The current model is no longer sustainable and has created inequitable access, inconsistent support and increasing levels of crisis presentation whilst people wait.

Young adults aged 16 to 25 years old remain particularly vulnerable. This period is associated with increasing mental health need, greater service transition risk and poorer outcomes. Current pathways remain fragmented across organisational and contractual boundaries despite growing evidence that more integrated all-age models improve outcomes. There is a real opportunity to support work to reduce the number of individuals who are not in education or employment/training where mental health need can play a significant part.

Patient feedback also demonstrates the need for improvement. Community Mental Health Survey results, Healthwatch feedback and Care Quality Commission findings consistently describe variation in experience, communication, involvement and access across the system.

Taken together, these challenges demonstrate that continuing with the current service model is not sustainable. A different model is required that focuses on prevention, early intervention, neighbourhood delivery, population health, integrated care and improved outcomes.

What will change from April 2027

From April 2027, NHS Kent and Medway will increasingly commission mental health, learning disability, autism and ADHD services through a single all-age model aligned to the Four Layers of Care framework. An independent Kent and Medway Mental Health, Learning Disability and Autism Review will be completed during 2026/27 and will establish a shared evidence base regarding future population need, current service effectiveness and the most appropriate future model of care. This review will inform a multi-year programme of commissioning reform extending beyond 2027/28.

The future model will increasingly shift activity, resource and responsibility towards primary care, neighbourhood health and multi-neighbourhood care. Specialist services will increasingly focus on people with the highest levels of complexity, risk and clinical need. The intention is to commission a consistent all-age model that:

- supports prevention and earlier intervention
- reduces avoidable crisis presentations
- improves recovery
- reduces inappropriate referrals into specialist services
- improves physical health outcomes
- reduces inequalities
- creates a consistent experience for residents regardless of age or diagnosis.

There will be a continued adherence to the Mental Health Investment Standard (MHIS), monitored through new ICB-led governance and with a clear objective to pivot mental health spending towards prevention and community-based services in layers one to three.

A major priority will be reform of autism and ADHD pathways. Diagnosis will no longer be viewed as the sole gateway to support. Instead, NHS Kent and Medway will commission a needs-led model that provides practical support, advice and intervention whilst people are waiting for assessment and ensures that specialist assessment capacity is focused on those who most need it.

The model will also include:

- a Kent and Medway Single Point of Access for neurodevelopmental assessment
- consistent prescribing arrangements
- shared care agreements
- standardised assessment pathways
- consistent support before and after diagnosis
- greater use of primary care expertise supported by specialist clinical governance.

The consolidation of services within Kent and Medway creates a significant opportunity to redesign services around patient need rather than organisational boundaries and this will be a major focus of reform from 2027 onwards.



What providers will be required to do

Mental health providers

From April 2027, providers will be expected to:

- reconfigure existing services around the all-age MHLDA model
- shift increasing proportions of activity into primary care and neighbourhood health settings
- reduce inappropriate referrals to specialist services
- reduce crisis presentations and emergency department attendances
- improve access standards
- improve recovery outcomes
- improve patient experience
- deliver agreed transformation trajectories through contract
- providers will be expected to demonstrate year-on-year movement of activity towards prevention, neighbourhood delivery and early intervention whilst reducing avoidable reliance on specialist services.

Serious mental illness and learning disability

Providers will be required to:

- improve annual physical health check completion rates significantly above the current position
- improve Health Action Plan quality and implementation
- improve reasonable adjustment identification and delivery
- improve cardiovascular disease management
- improve respiratory disease management
- improve cancer screening uptake
- reduce premature mortality
- implement LeDeR recommendations in full
- demonstrate year-on-year improvements in mortality indicators.

Young adults (16 to 25)

Providers will be expected to:

- deliver integrated transition arrangements
- eliminate avoidable deterioration during service transitions
- improve continuity of care
- improve engagement with services
- reduce self-harm presentation
- reduce emergency admissions
- improve patient-reported experience
- support work to establish how we can improve support to those not in education, employment or training.

Autism and ADHD

Providers will be expected to:

- implement a needs-led support offer
- reduce waiting times
- improve pre-diagnostic support
- improve post-diagnostic support
- standardise prescribing arrangements
- implement shared care pathways
- improve access to medication
- improve school, employment and wellbeing outcomes
- reduce crisis presentations associated with delayed diagnosis.

How this will be commissioned

During 2026/27, NHS Kent and Medway will establish the commissioning architecture needed to support delivery of the new MHLDA model. This will include:

- service specifications
- commissioning policies
- Quality and Outcomes Frameworks
- provider standards
- performance measures
- improvement trajectories
- contractual requirements
- payment arrangements.

From April 2027, all providers will operate against a new Quality and Outcomes Framework which will include explicit reporting arrangements, quality standards and improvement trajectories. Contracts will increasingly include:

- access requirements
- outcome measures
- physical health standards
- learning disability standards
- autism and ADHD standards
- crisis pathway requirements
- population health measures
- patient experience measures
- transformation milestones.

NHS Kent and Medway will increasingly use contractual levers to support delivery, including recovery plans, improvement notices and, where necessary, financial consequences linked to quality failure and non-delivery. Future investment decisions will increasingly prioritise providers able to demonstrate improvements in outcomes, quality, recovery, patient experience and reduction of inequalities.



How success will be judged

Outcomes

Providers will be expected to demonstrate:

- reduced suicide rates
- improved recovery measures
- reduced self-harm presentations
- improved physical health outcomes
- reduced premature mortality for serious mental illness and learning disability populations
- improved autism and ADHD outcomes
- improved transition outcomes for young adults.

Quality

Providers will be expected to demonstrate:

- no suspected suicides where provider failings are judged more likely than not to have contributed
- reduction in incidents involving poor risk assessment, care planning or family involvement
- implementation of LeDeR recommendations
- improved safeguarding outcomes
- improved clinical audit performance
- all services achieving at least a good rating when next assessed by the Care Quality Commission.

Access

Providers will be expected to demonstrate:

- reduced waiting times
- improved access to assessment
- improved crisis response
- improved neighbourhood-based provision
- improved Autism and ADHD pathway access
- improved access for underserved communities.

Productivity

Providers will be expected to demonstrate:

- reduced specialist service dependency
- reduced inpatient utilisation
- reduced crisis presentations
- improved use of neighbourhood-based services
- better value from commissioned services.

Health inequalities

Providers will be expected to demonstrate:

- increased learning disability registers prevalence
- increased annual health check completion
- increased Health Action Plan completion
- increased use of reasonable adjustment flags
- improved outcomes for disadvantaged communities
- reduction in mortality gaps.

Patient experience

Providers will be expected to demonstrate:

- community Mental Health Survey performance at or above national averages
- improved Healthwatch feedback
- improved continuity of care
- better family involvement
- reduced complaints
- demonstrable co-production with service users and carers.

By the end of 2027/28, NHS Kent and Medway expects a significantly greater proportion of mental health, learning disability, autism and ADHD support to be delivered through primary care, neighbourhood health and community-based models, with specialist services increasingly focused on those with the highest levels of need. Success will be demonstrated through earlier intervention, improved recovery, reduced inequalities, shorter waits, improved patient experience and measurable improvements in population mental health outcomes.

12. Maternity, neonatal, women's health and assisted reproductive technology (ART)

Why this matters

Maternity, neonatal and women's health services will be a major commissioning priority from 1 April 2027. Services across Kent and Medway continue to experience significant pressure, variation in performance, workforce challenges and ongoing safety concerns. Three of the four provider trusts are currently subject to enhanced oversight arrangements and there remains substantial variation in outcomes, workforce resilience, patient experience and service configuration across the system.

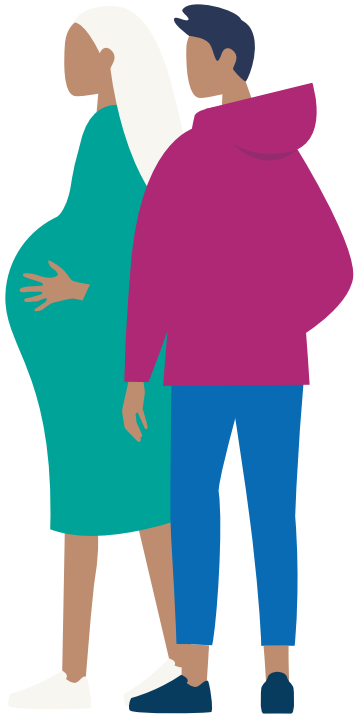
The findings of the National Maternity and Neonatal Investigation, combined with local quality intelligence, service user feedback, Care Quality Commission findings and operational performance information, demonstrate the need for a fundamentally different commissioning approach. The review highlighted the importance of safety, culture, leadership, accountability, racism, discrimination, inequality and service user voice. These themes are not isolated maternity issues; they represent system-wide quality challenges that require a sustained commissioning response.

Variation remains evident across maternity and neonatal pathways. Women from deprived communities, women from ethnic minority communities and women with additional vulnerabilities continue to experience poorer outcomes than the wider population. Access to services, continuity of care, perinatal mental health support and postnatal care remains inconsistent across Kent and Medway. Workforce shortages, variation in leadership capacity and inconsistent service models further contribute to variation in experience and outcomes.

Women's health services face similar challenges. Many women continue to experience delays in diagnosis and treatment, fragmented pathways, inconsistent access to support and variation in outcomes depending upon where they live. Demand continues to increase across gynaecology, reproductive health, menopause services, pelvic health and fertility pathways.

At the same time, financial pressures, workforce constraints and increasing demand mean the current model cannot simply expand its way out of these challenges. Future sustainability depends on a model that is safer, more preventative, more consistent and more focused on outcomes.

For these reasons, NHS Kent and Medway will use the 2026/27 Maternity Services Review and the National Maternity and Neonatal Investigation response programme to redesign how maternity, neonatal and women's health services are commissioned from April 2027 onwards.



What will change from April 2027

The Maternity Services Review starting in 2026/27 will design and develop the future configuration of maternity, neonatal and women's health services across Kent and Medway and establish the long-term model of care across all four layers of care.

This review will consider:

- the role of primary care in maternity pathways
- the future model for community midwifery
- neighbourhood maternity services
- perinatal mental health service
- maternal medicine pathways
- complex antenatal care
- neonatal services
- women's health pathways
- the future configuration of acute maternity services.

By 1 April 2027, all providers will be expected to operate against a common Kent and Medway Maternity, Neonatal and Women's Health Commissioning Framework.

This framework will establish:

- standardised referral pathways
- common service standards
- a single quality framework
- consistent outcome measures
- workforce expectations
- improvement trajectories
- reporting requirements
- contractual accountability arrangements.

Future commissioning will increasingly focus on outcomes, safety, quality and inequalities reduction rather than activity alone. The objective is to create a system where every woman, baby and family receives consistently high-quality care regardless of which provider delivers their care.

Prevention and community-based maternity care

A major focus of commissioning reform will be strengthening prevention, neighbourhood delivery and community-based maternity care. From April 2027, NHS Kent and Medway will commission a strengthened neighbourhood maternity offer that supports women before, during and after pregnancy. This will include a greater role for primary care and neighbourhood health within:

- pre-conception care
- early identification of risk
- antenatal support
- perinatal mental health
- postnatal care
- prevention and population health interventions.

Providers will be required to deliver:

- standardised GP referral and self-referral pathways into maternity services
- referral reporting disaggregated by ethnicity, deprivation and protected characteristics
- consistent antenatal pathways across Kent and Medway
- consistent postnatal pathways across Kent and Medway
- expanded community midwifery provision
- improved access to integrated perinatal mental health services
- earlier identification of women with clinical, psychological or social risk factors
- improved continuity of care for vulnerable populations
- a structured postnatal debrief offered to every woman
- parity between obstetric and midwifery leadership
- board-level oversight of inequality data and maternity disparities
- perinatal pelvic health services delivered through the four layers of care, with scope confirmed through the Maternity Services Review.

The intention is to reduce avoidable non-elective maternity admissions, improve patient experience, improve equity and intervene earlier when concerns emerge.

Safety, quality and outcomes

From 1 April 2027, provider contracts will contain significantly stronger quality, safety and outcome requirements. Quality failures will increasingly be managed through the same commissioning framework as operational performance and financial delivery.

Providers will be required to demonstrate year-on-year improvement in:

- maternity safety indicators
- neonatal outcomes
- non-elective maternity admissions
- pre-term birth rates
- attendance at booking appointments
- continuity of care
- workforce fill rates in critical professions
- compliance with the Saving Babies Lives Care Bundle
- patient-reported experience
- family feedback
- reduction of inequalities
- cultural competence and inclusion measures
- compliance with the National Maternity Triage Specification, assured through provider board sign-off reported to the ICB.

Providers will also be expected to demonstrate:

- strong organisational leadership
- positive workplace culture
- effective multidisciplinary working
- evidence that women and families directly influence improvement
- rapid implementation of review recommendations and safety learning.

The expectation is that delivery of safe and equitable care becomes a core contractual responsibility rather than a parallel quality process.

Women's health services

From April 2027, NHS Kent and Medway will increasingly commission women's health services as integrated pathways rather than isolated services.

The focus will be on:

- earlier diagnosis
- improved access
- reduced variation
- stronger prevention
- better integration with primary care
- improved patient experience.

Providers will be expected to:

- reduce waits for gynaecology services
- improve access to community-based services
- improve menopause support
- improve reproductive health pathways
- strengthen contraception services
- improve pelvic health outcomes
- reduce variation in access and outcomes.

Services will increasingly be delivered through standardised pathways with common expectations regarding outcomes and experience.



Assisted Reproductive Technology (ART) and fertility services

NHS Kent and Medway recognise the significant public, clinical and stakeholder interest in fertility services. Pending completion of a formal review, the previous fertility eligibility criteria will remain in place, including eligibility for NHS-funded treatment up to age 40, with a maximum of two funded cycles and four embryo transfers. A comprehensive Fertility Services Review will commence in September 2026 and conclude in advance of commissioning decisions for implementation from 1 April 2027.

The review will assess:

- clinical effectiveness
- clinical outcomes
- current NICE guidance
- national benchmarking
- comparative commissioning policies
- referral patterns
- demand levels
- financial sustainability
- equity of access
- patient experience.

Following completion of the review, NHS Kent and Medway will implement a revised fertility commissioning policy from April 2027. Providers will be expected to demonstrate:

- equitable access
- consistent eligibility application
- reduced variation
- improved waiting times
- improved patient experience
- clinical effectiveness
- value for money
- transparent reporting of outcomes.

The review will establish a long-term commissioning framework for fertility services, including eligibility criteria, provider standards, activity assumptions, outcomes measures and contractual expectations.

How this will be commissioned

During 2026/27, NHS Kent and Medway will establish the commissioning architecture required to support implementation. This will include:

- service specifications
- commissioning policies
- provider standards
- quality and outcomes frameworks
- workforce expectations
- performance measures
- improvement trajectories
- reporting requirements
- contractual requirements
- payment mechanisms.

From April 2027, contracts will increasingly include:

- safety trajectories
- quality requirements
- outcome measures
- workforce standards
- experience measures
- equality measures
- improvement expectations
- service transformation milestones.

NHS Kent and Medway will progressively strengthen contractual incentives and penalties linked to delivery of agreed standards. Providers not delivering agreed trajectories will be expected to implement formal recovery plans and may be subject to enhanced oversight and contractual intervention. Performance will increasingly be overseen through:

- Maternity and Neonatal Clinical Management Committees
- Women's Health Programme Boards
- Contract Review Meetings
- quality committees
- system safety oversight arrangements.

How success will be judged

Outcomes

Providers will be expected to demonstrate:

- improved maternity outcomes
- improved neonatal outcomes
- reductions in pre-term birth
- reduced avoidable maternity admissions
- improved women's health outcomes
- improved fertility outcomes
- improved perinatal mental health outcomes.

Quality

Providers will be expected to demonstrate:

- delivery of National Maternity and Neonatal Investigation recommendations
- compliance with the Saving Babies Lives Care Bundle
- improved workforce stability
- improved patient safety outcomes
- strong safety culture
- improved safeguarding outcomes
- positive inspection outcomes.

Access

Providers will be expected to demonstrate:

- improved access to maternity care
- earlier booking appointments
- improved access to perinatal mental health services
- improved access to women's health pathways
- improved access to fertility services.

Productivity

Providers will be expected to demonstrate:

- reduction in unnecessary admissions
- improved use of community services
- improved workforce utilisation
- better pathway productivity
- reduced unwarranted variation.

Health inequalities

Providers will be expected to demonstrate:

- reduced maternity inequalities
- reduced variation by ethnicity
- reduced variation by deprivation
- improved outcomes for vulnerable women and families
- improved engagement with underserved populations.

Patient experience

Providers will be expected to demonstrate:

- improved maternity survey results
- improved family experience
- improved continuity of care
- improved postnatal support
- reduced complaints
- evidence of co-production with women and families
- improved fertility service experience.

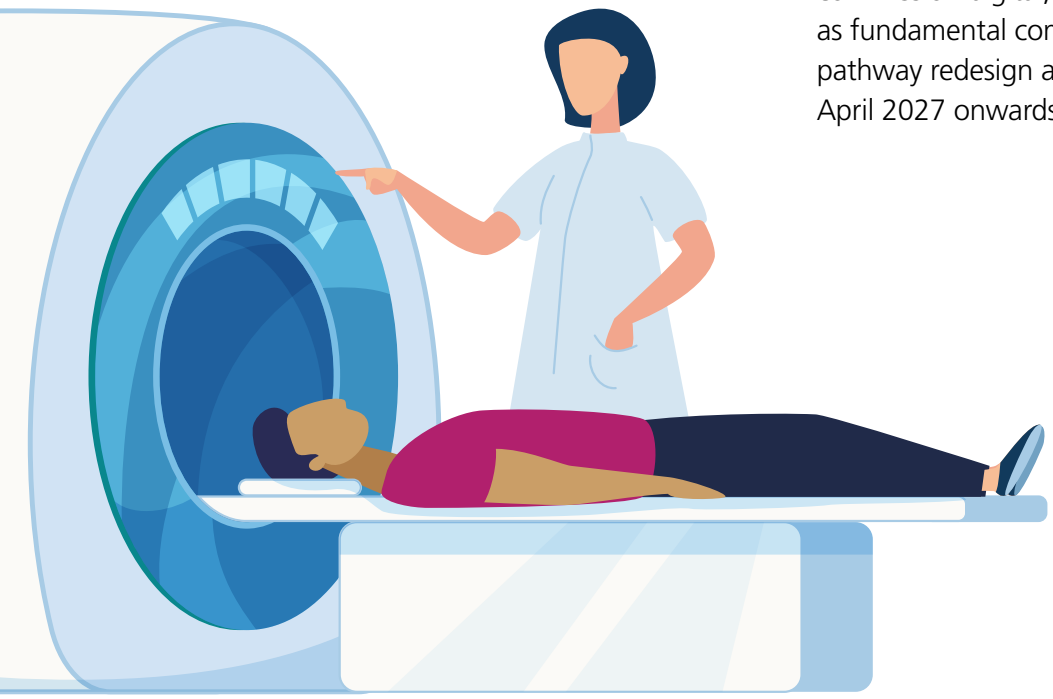
By the end of 2027/28, NHS Kent and Medway expects maternity, neonatal and women's health services to demonstrate measurable improvements in safety, quality, outcomes and experience. Variation between providers should reduce, workforce resilience should improve, inequalities should narrow and every woman, baby and family should receive safer, more consistent and more personalised care. Fertility services will operate within a clear long-term commissioning framework that delivers equitable access, high-quality care and sustainable use of NHS resources.

13. Digital, data, intelligence and research

Why this matters

Digital, data, intelligence and research will become core commissioning requirements from 1 April 2027, rather than supporting functions. Every major ambition within the 2027/28 commissioning intentions depends on our ability to use information, technology, analytics and evidence more effectively. Improving access, reducing inequalities, improving outcomes, managing demand, reducing waiting lists and delivering financial sustainability will require significantly better use of digital capability and intelligence than is currently the case.

Despite significant progress, Kent and Medway continues to experience variation in digital maturity, interoperability, data quality, analytical capability and adoption of technology across providers. Information remains fragmented between organisations, creating duplication, inefficiency and poor experiences for residents and staff. Too often patients are required to repeat information, professionals cannot easily access the information they need and pathway performance cannot be monitored consistently because data is held in multiple systems.



Variation also exists in the use of population health management, risk stratification, predictive analytics and evaluation. Too often services measure activity rather than outcomes and transformation programmes are implemented without robust evaluation frameworks or benefits realisation arrangements. As a result, digital investment has not always translated into measurable improvements in quality, productivity, outcomes or health inequalities. Future commissioning must therefore focus not simply on technology adoption but on demonstrable benefits for patients, communities and the wider health and care system.

The financial challenge facing Kent and Medway reinforces the need for change. Future improvements in productivity, workforce capacity and value for money will increasingly depend upon automation, artificial intelligence, better use of information, shared care records and intelligence-led decision making. Digital capability is therefore no longer a supporting function but a core component of service delivery.

For these reasons, NHS Kent and Medway will commission digital, data, intelligence and research as fundamental components of care delivery, pathway redesign and system transformation from April 2027 onwards.

What will change from April 2027

NHS Kent and Medway will move from commissioning individual digital projects towards commissioning a single Kent and Medway digital, data and intelligence architecture supporting delivery of the Four Layers of Care model. Providers will be expected to demonstrate how digital capability improves access, quality, outcomes, productivity and reduction of health inequalities rather than simply implementing new technology.

Providers will increasingly be expected to operate within common standards for:

- Shared Care Records (sharing data as required to support expanding use of the Kent and Medway Shared Care record, the use of which will become more and more important)
- information sharing
- population health management
- interoperability
- data quality
- digital inclusion
- cyber security
- evaluation and benefits realisation
- research and innovation.

The NHS App will increasingly become the principal digital front door for residents, whilst maintaining effective alternatives for people who cannot or do not wish to use digital services. Artificial intelligence, automation, ambient technologies and predictive analytics will increasingly become routine components of service delivery were supported by evidence, governance and clinical safety arrangements.

What providers will be required to do

Digital front door

From April 2027, all providers will be expected to contribute to a consistent Kent and Medway Digital Front Door to:

- enable access through the NHS App wherever appropriate
- support online appointment booking and management
- enable digital access to clinical correspondence and results
- support two-way communication with patient
- enable access to care plans and self-management tools
- improve digital navigation of services
- integrate digital access routes into commissioned pathways.

Residents should increasingly experience a coherent digital experience across Kent and Medway rather than multiple disconnected systems.

Neighbourhood health intelligence

From April 2027, providers delivering neighbourhood health services will be required to use population health management, segmentation and risk stratification as a routine part of service delivery. This includes:

- consistent identification of rising-risk populations
- proactive call and recall arrangements
- shared care planning across organisations
- integrated VCSE referral pathways
- use of neighbourhood-level dashboards and outcome measures
- remote monitoring to support earlier intervention and prevention.

Digital and intelligence capabilities will be commissioned to support earlier intervention, improved care coordination and reductions in avoidable deterioration, admissions and duplication.

Elective care intelligence

Providers will be required to:

- support Single Points of Access
- implement Advice and Guidance workflows
- deliver Straight-to-Test pathways
- support referral optimisation
- provide system-wide visibility of waiting lists
- share diagnostic capacity information
- support digital patient communication and self-management
- enable system-wide elective capacity management.

Digital capabilities must support consultant-led triage, improved productivity and reduction in unwarranted variation.

Urgent and emergency care intelligence

Providers will be expected to support:

- Single Point of Access and Clinical Assessment Services
- Urgent Community Response
- virtual ward
- Home First
- transfer of care hubs
- remote monitoring
- real-time flow and capacity management.

Providers will be expected to use shared information to identify risk earlier, support safer discharge, reduce avoidable admissions and improve system flow.

Digital maturity and interoperability requirements

From 1 April 2027, NHS Kent and Medway will establish a common Digital Maturity and Interoperability Framework applying to all commissioned providers. Digital maturity will be assessed in the same way as quality, access, activity and financial performance, with providers required to demonstrate year-on-year improvement against agreed standards.

Providers will be expected to demonstrate:

- full participation in Kent and Medway Shared Care Record arrangements
- compliance with agreed interoperability standards
- real-time availability of agreed patient information to authorised clinician
- digital transfer of referrals, discharge summaries, care plans and correspondence
- elimination of avoidable duplicate data entry and duplicate information requests
- consistent use of national coding standards
- compliance with cyber security and data protection requirements
- participation in system-wide intelligence platforms
- routine submission of agreed datasets
- digital capabilities supporting neighbourhood MDTs and integrated care delivery.

Digital infrastructure

Providers will be expected to demonstrate:

- modern and supported digital infrastructure
- secure network connectivity
- business continuity and disaster recovery arrangements
- cyber resilience and recovery plans
- workforce access to appropriate digital tools.

Clinical Systems and Integration

Providers will be expected to demonstrate:

- interoperable clinical systems
- shared access to care plans
- electronic referral management
- digital prescribing capability where appropriate
- integrated digital pathways supporting coordinated care.

Data quality

Providers will be expected to demonstrate:

- accurate clinical coding
- complete clinical records
- timely data submissions
- reduction in missing or duplicate records
- ongoing data quality improvement programmes.

Population health intelligence

Providers will be expected to demonstrate:

- routine use of risk stratification
- neighbourhood population dashboards
- identification of high-risk cohorts
- data-driven service planning
- outcome and inequality measurement.

Digital workforce capability

Providers will be expected to demonstrate:

- digital literacy programme
- training in data-driven decision making.
- adoption of AI and automation technologies where appropriate
- development of analytical capability within operational and clinical teams.

Performance against Digital Maturity Standards will be reviewed through routine contract management and annual assurance processes. Providers unable to demonstrate progress will be required to implement formal improvement plans with defined delivery milestones.

Data, interoperability and information sharing

From April 2027, all providers will be required to comply with agreed Kent and Medway standards for:

- interoperability
- data quality
- information governance
- information sharing
- cyber security.

Providers will be expected to:

- participate in system-wide dashboards and intelligence platforms
- share agreed datasets securely and consistently
- resolve data quality issues promptly
- support system performance management and commissioning intelligence
- use data to identify variation, inequalities and improvement opportunities.

Information will increasingly be used not only to support care delivery but also commissioning decisions, pathway redesign, resource allocation, prevention, evaluation and benefits realisation.



Artificial intelligence and automation

NHS Kent and Medway will actively support adoption of artificial intelligence, automation and ambient technologies where there is evidence of benefit to patients, staff or services.

Providers will be expected to identify and implement opportunities in:

- ambient clinical documentation
- clinical coding
- workflow automation
- administrative automation
- population risk stratification
- waiting list validation
- demand forecasting
- clinical decision support
- pathway optimisation
- call and recall systems.

All adoption must be clinically led and supported by robust governance, evaluation, clinical safety and accountability arrangements.

By the end of 2027/28, providers will be expected to demonstrate measurable productivity, workforce or quality benefits arising from AI implementation.

Research, evaluation and innovation

From April 2027, all major pathway redesign programmes, neighbourhood developments and digital investments will require formal evaluation frameworks.

Providers will be expected to demonstrate:

- baseline measures
- defined outcomes
- benefits realisation plans
- evaluation methodologies
- learning and dissemination arrangements
- evidence of continuous improvement.

No major transformation programme should proceed without clear evaluation criteria demonstrating how improvements in quality, outcomes, access, productivity, value for money or health inequalities will be measured. Research, innovation and evaluation will become routine commissioning requirements rather than standalone activities.

Contractual accountability

From April 2027, digital, data, intelligence and research requirements will be explicitly incorporated into provider contracts. Providers will be expected to demonstrate:

- adoption of agreed digital capabilities
- participation in system data and intelligence arrangements
- compliance with interoperability standards
- delivery of digital inclusion requirements
- achievement of digital maturity trajectories
- delivery of agreed benefits and outcomes
- compliance with cyber security and data quality standards
- participation in evaluation and benefits realisation frameworks.

Digital maturity, interoperability, cyber security, data quality, evaluation and benefits realisation will form part of routine contract management arrangements. NHS Kent and Medway will increasingly use contractual incentives, improvement plans, recovery arrangements and contractual consequences to accelerate delivery where required.

How success will be judged

Outcomes

Providers will demonstrate:

- improved population health intelligence
- earlier identification of high-risk populations
- improved pathway outcomes
- better targeting of prevention interventions
- improved commissioning intelligence.

Quality

Providers will demonstrate:

- improved data quality
- improved interoperability
- improved cyber security maturity
- improved outcome reporting
- reduced duplication
- improved information sharing.

Access

Providers will demonstrate:

- increased NHS App utilisation
- improved digital access
- faster communication with patients
- reduced administrative burden
- improved navigation through services.

Productivity

Providers will demonstrate:

- measurable benefits from automation
- reduced administrative workload
- improved clinical productivity
- better use of workforce capacity
- improved value for money.

Digital maturity

Providers will demonstrate:

- achievement of agreed Kent and Medway Digital Maturity Standards
- year-on-year improvement in digital maturity assessments
- reduction in reliance on paper-based processes
- increased utilisation of integrated digital pathways.

Interoperability

Providers will demonstrate:

- real-time sharing of agreed clinical information
- consistent use of shared records
- digital transfer of referrals and discharge information
- reduced duplication between organisations
- improved care coordination.

Health inequalities

Providers will demonstrate:

- reduced digital exclusion
- improved digital uptake within underserved groups
- better identification of high-risk population
- reduction in inequalities of access.

Research and innovation

Providers will demonstrate:

- evaluation of all major transformation programmes
- increased research participation
- routine benefits realisation reporting
- adoption of evidence-based innovation.

Patient experience

Providers will demonstrate:

- improved digital experience
- better communication
- greater access to information
- improved self-management support
- higher patient satisfaction.

By the end of 2027/28, NHS Kent and Medway expects digital, data, intelligence and research to be fully embedded within commissioning, operational delivery and clinical practice. Providers will be expected to demonstrate that technology and intelligence are delivering measurable improvements in outcomes, quality, productivity, patient experience and health inequalities, with digital capability regarded as a core component of service delivery rather than a supporting function.



14. Contract management, governance, assurance and provider board accountability

The 2027/28 commissioning intentions describe the strategic, clinical, operational and financial changes that NHS Kent and Medway expect to commission from April 2027 onwards. Successful delivery will require more than contractual agreement; it will require active leadership, governance and oversight from provider boards, executive teams, clinical leaders and system partners. The implementation of the 2027/28 commissioning intentions will therefore become a core component of organisational planning, contract management and board assurance across Kent and Medway.

The final commissioning intentions will be approved by the NHS Kent and Medway Board in September 2026 following completion of the summer engagement programme. Following approval, all commissioned providers will be expected to demonstrate how the commissioning intentions have informed the development of their organisational strategies, annual operating plans, quality strategies, workforce plans, financial recovery plans and transformation programmes for 2027/28.

From October 2026 onwards, providers will be expected to maintain a clear line of sight between the commissioning intentions, annual planning processes, contracting discussions and operational delivery arrangements. NHS Kent and Medway will increasingly assess organisations not simply on delivery of activity, but on their ability to implement the commissioning shifts, quality improvements, productivity opportunities and population health outcomes described throughout this document.

Provider board accountability

Provider boards remain accountable for organisational delivery within their statutory responsibilities and governance arrangements. NHS Kent and Medway will seek assurance through commissioning, contracting and performance arrangements that the commissioning priorities described within this document are being addressed. NHS Kent and Medway expects that provider boards formally consider the final commissioning intentions and determine their organisational response.

This response should describe how the provider intends to contribute to the delivery of the Four Layers of Care model, neighbourhood health, elective recovery, urgent and emergency care reform, mental health transformation, maternity improvement, digital maturity and financial sustainability. Provider boards will be expected to:

- formally review and discuss the final commissioning intentions
- approve an organisational response and delivery plan
- ensure annual operating plans are aligned to commissioning priorities
- ensure workforce plans support agreed service transformation
- ensure financial plans support commissioning intentions and contractual requirements
- ensure quality improvement plans reflect commissioning expectations
- monitor implementation through routine Board reporting
- review delivery of contractual trajectories and outcome measures
- maintain oversight of risks, recovery plans and mitigation arrangements

- receive regular assurance regarding delivery against agreed commissioning requirements
- hold executive teams accountable for implementation.

Boards should be able to demonstrate clear evidence that commissioning intentions have shaped organisational priorities and investment decisions. The expectation is that delivery of the commissioning intentions becomes a standing board responsibility rather than solely a contracting or operational activity.



Development of 2027/28 provider plans

All providers will be expected to explicitly demonstrate how the commissioning intentions have informed the construction of their 2027/28 plans. Provider plans should clearly describe how:

- services will support delivery of the Four Layers of Care model
- activity will shift towards prevention and neighbourhood health where appropriate
- quality and safety improvements will be delivered
- health inequalities will be reduced
- productivity and efficiency opportunities will be realised
- digital maturity and interoperability requirements will be achieved
- workforce requirements will support service redesign
- financial sustainability and recovery plans align with commissioning expectations
- contractual trajectories will be achieved.

NHS Kent and Medway will increasingly expect providers to demonstrate a direct relationship between commissioning requirements, annual plans, service delivery plans, workforce plans and performance management arrangements.

In developing their organisational plans, providers should demonstrate how patients, communities, staff, carers and wider stakeholders have informed service design and transformation priorities. Plans should clearly evidence how organisations will meet their statutory duties in relation to patient and public involvement, equality, health inequalities and reducing unwarranted variation in access, experience and outcomes. Organisations should be able to demonstrate how insight has influenced decision-making and how the impact of service changes will be monitored and evaluated.

Contract management committees

Contract management committees will become the principal mechanism through which NHS Kent and Medway assure delivery of the 2027/28 commissioning intentions.

The purpose of contract management committees will move beyond traditional contract monitoring. They will act as formal oversight forums responsible for assuring delivery of contractual obligations, transformation programmes and commissioning priorities. All major commissioned providers will be expected to participate in formal contract management committees throughout 2027/28.

Contract management committees will be responsible for:

- monitoring delivery against commissioning intentions
- monitoring delivery against annual operating plans
- reviewing contractual performance
- reviewing quality, safety and patient experience
- monitoring access and waiting time trajectories
- reviewing productivity and financial performance
- monitoring delivery of workforce plans
- reviewing digital maturity and interoperability requirements
- monitoring delivery of transformation programmes
- reviewing progress against health inequality objectives
- monitoring implementation of recovery plans
- escalating significant risks and concerns.

Contract management committees will increasingly focus upon outcomes, quality, productivity and transformation rather than activity alone. Performance reporting will increasingly include:

- quality indicators
- outcome measures
- population health measures
- health inequalities indicators
- digital maturity standards
- productivity trajectories
- workforce indicators
- financial performance
- patient experience measures
- transformation milestones.

Provider collaborative accountability

The acute collaborative and neighbourhood collaborative will be expected to play a central role in implementation. Future commissioning arrangements will increasingly expect providers to demonstrate both organisational performance and collective system performance. Provider collaboratives will therefore be expected to:

- deliver agreed pathway redesign
- reduce unwarranted variation
- implement common clinical standards
- improve productivity
- deliver shared outcome measures
- support activity shifts required by commissioning intentions
- deliver agreed transformation programmes
- support financial sustainability across the health economy.

Commissioners will increasingly assess providers on their contribution to collaborative delivery as well as individual organisational performance.

Escalation, recovery and intervention

Where providers fail to deliver agreed requirements, NHS Kent and Medway will operate a structured escalation and recovery framework. In collaboration with NHS England, this may include:

- enhanced monitoring arrangements
- additional reporting requirements
- executive-led recovery meetings
- formal recovery plans
- improvement notices
- independent assurance reviews
- enhanced quality oversight
- contractual recovery trajectories
- Board-to-Board escalation.

Persistent failure to deliver agreed quality, access, financial, workforce, digital or transformation requirements may result in contractual intervention and influence future commissioning and investment decisions. Quality, safety, outcomes and transformation will be subject to the same level of scrutiny and accountability as activity and finance.

Annual assurance and system accountability

Each year, NHS Kent and Medway will undertake a formal review of progress against the commissioning intentions. This review will consider:

- population health outcomes
- quality and safety performance
- access and waiting times
- financial sustainability
- workforce performance
- delivery of transformation programmes
- progress against health inequalities
- digital maturity and interoperability
- research and innovation
- patient and community experience.

Annual assurance discussions will inform commissioning decisions, contractual arrangements and future investment priorities.



15. Summary and conclusion

The 2027/28 commissioning intentions set out a fundamental shift in how NHS Kent and Medway will commission services from April 2027. They move commissioning beyond the purchase of activity and towards the improvement of outcomes, quality, patient experience, productivity, health inequalities and long-term sustainability.

The Commissioning Intentions recognise that Kent and Medway faces significant challenges. Demand continues to grow, the population is ageing, health inequalities remain substantial, mental health need is increasing, elective pressures persist and the health economy continues to face significant financial challenge. At the same time, residents, communities, staff and partners have consistently told us that services must become easier to access, more joined up, more preventative and more focused on improving outcomes rather than simply managing demand.

In response, NHS Kent and Medway has set out a commissioning framework built around the Four Layers of Care model. This framework seeks to progressively shift activity, resource and clinical effort towards prevention, neighbourhood health, primary care and multi-neighbourhood care, whilst ensuring acute services remain focused on specialist, complex and emergency care. Across primary care, elective care, urgent and emergency care, mental health, learning disability, autism and ADHD, maternity and women's health, and digital and intelligence, a consistent commissioning direction has been established based upon prevention, standardisation, integration, quality improvement and accountability.

A central theme throughout the 2027/28 commissioning intentions is that commissioning will increasingly focus on delivery and outcomes rather than intentions alone. Future contracting arrangements will place greater emphasis on measurable improvements in access, quality, productivity, patient experience and population health. Providers will increasingly be expected to demonstrate not only that services have been delivered but that those services have improved outcomes for the people of Kent and Medway.

The 2027/28 commissioning intentions also establish a new relationship between commissioners and providers. Greater collaboration will be expected through the acute collaborative and neighbourhood collaborative. Clinical management committees will oversee pathway delivery and transformation. Digital capability, population health intelligence, evaluation and research will become core components of service delivery rather than supporting activities. Quality, finance, performance, workforce and transformation will increasingly be managed together as part of a single commissioning framework.



The implications are clear:

- The commissioning intentions will become the foundation for annual planning, contracting and performance management across Kent and Medway.
- Provider Boards will be expected to own delivery.
- Executive teams will be expected to implement delivery.
- Contract management committees will be expected to assure delivery.
- Clinical management committees will be expected to oversee pathway performance.
- Provider collaboratives will be expected to support transformation and system-wide improvement.
- Future contracts will increasingly focus on outcomes, quality, productivity, inequalities and transformation rather than activity alone.
- Future investment decisions will increasingly favour providers able to demonstrate delivery, improvement and measurable impact against the priorities set out within the 2027/28 commissioning intentions.
- The 2027/28 commissioning intentions are intentionally ambitious. They recognise that the clinical, operational and financial challenges facing Kent and Medway cannot be addressed through incremental change. Sustainable improvement will require providers, commissioners, clinicians, local authorities, the voluntary sector and communities themselves to work differently and with greater collective accountability for outcomes.

The document also represents the continuation of a conversation rather than the conclusion of a planning process. Throughout summer 2026 these proposals will continue to be tested with residents, communities, providers, staff, local authorities and wider stakeholders. Feedback will be used to strengthen the final document before formal approval by the NHS Kent and Medway Board.

By April 2027, the expectation is that the 2027/28 commissioning intentions are no longer viewed as an NHS Kent and Medway document, but as the shared delivery framework for commissioners, provider Boards, executive teams, clinical leaders and system partners across Kent and Medway.

Success will ultimately be judged not by the number of contracts signed, meetings held or plans produced. It will be judged by whether people live longer, healthier lives; whether inequalities narrow; whether services become safer and more responsive; whether patients experience better care; whether resources are used more effectively; and whether the Kent and Medway health and care system becomes clinically and financially sustainable for future generations.



16. Next steps: provider commissioning letters, contractual negotiation and board accountability

To support the transition from strategic commissioning intentions to formal contractual arrangements, all providers will receive a detailed provider-specific commissioning intentions Letter no later than 30 September 2026. This letter will set out, in clear and unambiguous terms, the specific outcomes, standards, service requirements, productivity expectations, financial assumptions and transformation commitments that the NHS Kent and Medway Integrated Care Board expects each provider to deliver during 2027/28.

The commissioning intentions Letter will represent the formal expression of the ICB's expectations and will form the primary basis for the 2027/28 contractual negotiation process. While the commissioning intentions document establishes the overall strategic direction for the system, the provider-specific letters will translate these strategic intentions into detailed organisational requirements and contractual expectations.

It is essential that provider boards give full consideration to the contents of these letters and are satisfied that they understand the commitments being requested of their organisation. The ICB expects provider boards to review the requirements formally and ensure they are reflected within organisational planning processes, operational plans, workforce strategies, investment decisions and risk management arrangements.

The intention of this process is to establish clarity and transparency at the outset of the planning cycle. The ICB wishes to avoid situations where expectations are assumed, interpreted differently across organisations, or challenged for the first time during final contract negotiations. Early and explicit articulation of requirements will provide providers with the opportunity to assess deliverability, identify risks, and engage constructively in the development of final contractual arrangements.

Where a provider believes that it is unable to commit to any element of the commissioning intentions letter, the expectation is that this is identified and escalated at the earliest possible opportunity. Such discussions must be supported by robust evidence and should not be based solely upon organisational preference or historical approaches to service delivery. Providers will be expected to present a clear rationale supported by relevant operational, clinical, workforce, financial and performance data, together with any associated risk assessments.

In circumstances where a provider is unable to deliver a specific requirement, they will be expected to set out:

- The specific element of the commissioning requirement that cannot be delivered.
- The evidence base supporting that position.
- The risks associated with delivery.
- The actions already taken to mitigate those risks.
- Any alternative proposals that would achieve equivalent outcomes for patients and the wider health and care system.
- The timetable and conditions under which delivery could become achievable.

The ICB's expectation is that any inability to commit to a commissioning requirement should be exceptional rather than routine. The starting position for all organisations should be a commitment to deliver the agreed system priorities, recovery objectives and transformation ambitions. Providers will therefore be expected to demonstrate how they have explored all reasonable options to achieve delivery before concluding that a requirement cannot be met.

This approach is particularly important given the scale of recovery, reform and productivity improvement required across Kent and Medway. The 2027/28 contracting round is not simply a transactional exercise; it represents a key mechanism through which the system will deliver improved outcomes, reduced inequalities, enhanced productivity, financial sustainability and the implementation of the future operating model set out within these commissioning intentions.

The ICB will therefore expect formal board oversight and ownership of provider responses. Where providers are unable to commit to specific requirements, the Board-level position, supporting evidence and proposed mitigation will be expected to be clearly documented and available for discussion with the ICB during the contractual negotiation process. This will ensure that both organisations have a shared understanding of the risks, constraints and consequences associated with any departure from agreed commissioning intentions.

Ultimately, successful contractual agreement for 2027/28 will rely upon transparency, mutual accountability and a shared commitment to delivering the improvements required for the population of Kent and Medway. The commissioning intentions Letters and the subsequent negotiation process are intended to provide the discipline, clarity and accountability necessary to achieve that ambition.



CS59024 NHS Creative 2026

OVERVIEW ENGAGEMENT REPORT

WHAT MATTERS MOST: COMMISSIONING INTENTIONS

1. INTRODUCTION

This is an overview of what staff and the public believe should be prioritised across health and care services. An interim report was provided on 17 August and many of the messages about priorities remain, with variations in total amounts now that all research is complete. Responses to the commissioning intentions from voluntary and community organisations, members of the public and patient representatives add further detail and explanation of views. A full report on the findings including detailed demographic breakdowns is being prepared.

We have received a total of 3,343 responses to a survey which was conducted using three different approaches to ensure coverage across the communities of Kent and Medway – an ICB online survey, an independent high-street survey and an independent selected demographic sample survey. 533 of those who responded work in health and care and/or for an NHS organisation.

Method	Respondents	NHS/health/care workers
LAKE – demographic sample survey	1,098	76
EK360 – high-street survey	752	60
ICB - online survey	1,493	397
Total	**3,343**	**533**

In addition, we have received 33 responses to the draft commissioning intentions from provider organisations, partners, VCSEF organisations and members of the public.

The strongest overall message is that people want an NHS that is easier to access, better connected, more local where appropriate, more preventative and more responsive to individual circumstances.

The strongest priorities identified were:

- Easier access to GP appointments
- Shorter hospital waiting times
- Improving urgent and emergency care
- Better mental health support

When asked which areas they would most like the NHS to focus on improving over the coming year over 60 per cent of respondents told us that we should prioritise easier access to GPs.

There is also strong support for several elements of system development:

- 85 per cent support greater investment in preventing ill health.
- Over 90 per cent support urgent treatment centres focusing on urgent injuries and illnesses provided alternatives to A&E are strengthened.
- Over 70 per cent express some willingness to receive appropriate care closer to home.
- Nine in ten people are willing to have diagnostics such as scans and blood tests carried out at local centres away from major hospitals.
- Over 50 per cent want telephone, paper or face-to-face routes retained for people who need them.

However, the feedback introduces important conditions to all of this.

Respondents are not simply asking for services to be moved from hospitals into communities or from face-to-face to digital channels. They want those changes to be accompanied by sufficient workforce, capacity, continuity, communication, specialist support and clear ownership of the patient journey with open accountability and patient and public voice built into the changes.

2. STRATEGIC ALIGNMENT

- Commission the right services each year
- To ensure financial sustainability over three years
- Lead strategy and ensure commissioning levers deliver impact
- Develop into a high-performing commissioning organisation
- Renew our culture for long-term sustainability.

3. Demographics

Gender and age

The surveys heard from 2,114 females, 1,135 males with 64 preferring not to say. We were more likely to hear from older people when the total survey numbers were combined:

16-24	194
25-34	280
35-44	398
55-64	654
65-74	663

75+	564
Prefer not to say	72

Health status and caring responsibilities

39.6 per cent respondents identified as having a long-term physical or mental health condition/illness or a disability.

748 respondents, equivalent to 22.4 per cent of all 3,343 survey participants, were reported as having caring responsibilities or as being a carer.

Geography

Respondents reported from across each district in Kent and Medway. An estimation of total numbers across each district is as follows:

Ashford	223
Canterbury	323
Dartford	151
Dover	169
Folkestone and Hythe	206
Gravesham	177
Maidstone	279
Medway	433
Sevenoaks	153
Swale	251
Thanet	283
Tonbridge and Malling	215
Tunbridge Wells	303
None of the above	54

Ethnicity

Across the three surveys there were 3,028 White respondents (93 percent) and approximately 220 ethnic minority respondents (6.8 percent). A further 85 preferred not to say, and 10 had no recorded ethnicity answer.

4. Method collection

4.1 LAKE market research demographic sample survey

A demographically representative sample of 1,067 residents aged 16 and over was targeted for this research component. The final sample size of 1,098 means that the dataset has a maximum confidence level of +/-3 per cent (at a 95 per cent level of confidence).

All interviews were undertaken face to face with residents via door knocking.

Sampling was undertaken using Census Output Areas (COAs) as the primary sampling units. Within each authority area, COAs were ranked by the Index of Multiple Deprivation (IMD) to make sure that the target sample was representative by deprivation. COAs were then selected at random as sampling points but ensured a range of deprivation levels were included.

The number of sampling points selected was proportional to the interviewing target for each authority area. All addresses for each COA sampling point were made available to interviewers to approach for interview. Local authority level quotas were set to ensure the final sample reflected the Kent and Medway's population profile in terms of age, gender, working status and ethnicity (using Census 2021 data).

4.2 EK360 independent high street survey

Between the 23rd of July and the 11th of August, EK360 undertook a series of face-to-face engagement activities at locations within all districts of Kent and in Medway.

Engagement teams positioned themselves on high streets in urban areas or locations with high footfall in rural locations. The teams situated themselves in close proximity to each other to create a visual presence and proactively approached members of the public. Respondents were therefore a random selection of people who were in the location at the time and who agreed to stop and talk to the engagement teams.

Engagement teams used paper copies of the survey and completed the survey in conversation with members of the public. Data was entered into a secure web form for analysis. Engagement locations were:

- Deal town centre
- Dover town centre
- Tonbridge town centre
- Sheerness
- Sittingbourne
- Canterbury town centre
- Herne Bay

- Folkestone town centre
- New Romney
- West Malling
- Snodland
- Ashford town centre
- Tenterden
- Gravesend town centre
- Meopham
- Chatham high street
- Tunbridge Wells town centre
- Horsmonden
- Maidstone town centre
- Sevenoaks town centre
- Edenbridge
- Faversham high street
- Margate high street and Margate old town
- Dartford town centre
- Swanscombe
- Sandwich

4.3 ICB engagement approach and NHS channel performance

An online survey comprising more than 20 questions was promoted to Kent and Medway residents, and NHS staff across the system, through a coordinated mix of ICB channels.

A news release generated 885 views and secured coverage in *Healthcare Leader*. A *News for You* article received 1,500 views and generated 81 click-throughs to the survey. Organic (free) social posts reached a combined total of more than 28,000 individuals.

Promotion through multiple articles and reminders in the GP Update achieved a total of 2,099 views among primary care staff. Internal promotion on KAM generated more than 370 opens from ICB colleagues.

Wider stakeholder reach

To extend reach beyond NHS audiences, the survey was shared with:

- 201 parish councils
- 168 VCSE organisations
- 140 elected councillors at Kent and Medway councils
- 65 patient participation groups
- 28 Men's Sheds
- 25 large businesses
- 8 learning disability support organisations
- 2 chambers of commerce.

The communications and involvement toolkit was shared with communications teams at both Kent County Council and Medway Council, and communication colleagues at each of

the NHS provider trusts. All system partners including district councils were tagged in our social media posts.

Social media

The table below shows organic (non-paid) social media content published from 24 July to 28 August.

	Posts	**Reach** (total number of people who saw the post)	**Views** (total number of times our content appeared on someone's screen)
Facebook	10	10,629	17,656
Instagram	7	1,073	1,521
Next Door	3	16,446	Views not measured on this channel, but 20 comments received and logged.

Facebook posts: Tagged district councils, shared by local councils. Shared into local Facebook community groups.

Next Door – one post targeted communities in Medway, DGS and Folkestone.

Social media comments on our posts had similar themes: access to primary care, pressure on hospitals and how both relates to new housing being planned.

"There are too many people for the system to cope with, also a few years ago my Dr knew me, every time you see another Dr you either go through all your history or hope he has read your notes."

"Being able to actually see my GP!"

"Darent valley hospital needs help to keep up with the volume of new housing developments and people moving into the area. Staff do their best under difficult circumstances. Hospital capacity should reflect the population using it."

Paid advertising (stats as of the end of the campaign, 31 August)

Google Display Network

- Impressions: 1,740,043
- Clicks: 69, 657
- Click through rate: 4 per cent

Facebook

- Impressions: 182,143
- People reached: 72,171
- Clicks: 2,505
- Click through rate: 1.38 per cent

- Engagement: 68 likes, 19 comments

Spotify

- Impressions: 108,853
- People reached: 58,184
- Clicks: 427
- Click through rate: 0.39 per cent

Overall, the paid advertising has delivered more than 2 million impressions to people within our target audience, resulting in over 72,000 visitors to our survey webpage.

5. Findings

5.1 Prevention and health inequalities

Support is strong for spending more on prevention, but lower when respondents are asked to support transferring money from other NHS services. When asked whether the NHS should spend more on prevention 79 per cent said yes. When asked whether money should be moved from other sources around 60 per cent said yes with 24 per cent unsure.

Staff responses were more mixed – in the ICB survey there was a higher proportion selecting *"don't know"* This suggests that although staff broadly support prevention, they are more cautious about how that investment should be funded and may be aware of the practical implications of diverting resources from existing services.

We asked people about whether NHS funding should be allocated across all areas or targeted towards communities with greater health needs.

There is no overwhelming resistance to targeted funding. Across the three surveys, more than four in ten respondents supported giving additional resources to communities with worse health outcomes, and in the EK360 face-to-face survey a clear majority favoured the "equity" option.

Many people still instinctively favour equal spending. The LAKE and ICB surveys both found around half of respondents preferred spending the same everywhere.

The overall picture is therefore not "equal spending only", but rather acceptance that need should matter. Staff were even more supportive of a needs-based approach.

5.2 Elective, Maternity and Specialised Commissioning CMDT

Elective care

Over 40 per cent of those who answered the questions on elective choice selected travelling farther within Kent and Medway in return for earlier treatment.

A further 914 respondents (31.2 per cent) preferred treatment close to home even if that meant waiting longer, and 469 (16.0 per cent) said they could not travel farther and therefore needed local treatment.

There is substantial interest in offering earlier elective care elsewhere in Kent and Medway, but it should be an additional choice rather than the default pathway. Nearly half of respondents either preferred local care or reported being unable to travel farther.

Respondents are strongly supportive of simplifying referral and diagnostic pathways, but support becomes more conditional when proposals reduce face-to-face contact or traditional outpatient follow-up.

People appear highly willing to bypass an initial outpatient appointment and go directly to a diagnostic test where clinically appropriate.

There is very strong consensus that referral processes should be coordinated through a single, joined-up system rather than fragmented arrangements managed separately by individual services. Around 90 per cent agreed overall.

Maternity and neonatal care

Keeping mothers and babies safe is the leading priority. In all three reports, the leading priority was “Keeping mothers and babies safe”

LAKE: 371 respondents (33.8 per cent of those who answered the question).

EK360: 506 selections (572 respondents answered the question).

ICB report: 840 respondents (87 per cent of 966 respondents who answered the question).

Ensuring there are enough specialist staff during day and night and better support after birth also scored highly across respondents. Staff responses showed a similar concern with slightly more emphasis placed on continuity of care and postnatal support.

The EK360 researchers reported that many participants commented that safety of mothers and babies should be a given, that it should not be an option.

Fertility and specialised services

The strongest and most consistent message was that **treatments that worked well and fair access for everyone who meets the criteria** mattered most for future fertility services. Over 60 per cent of those who answered these questions ranked these as being the most important above shorter waiting times and good patient experience.

Commissioning recommendations:

- Make elective pathways faster and simpler while retaining safety, choice, fairness and access to specialist expertise.
- Use system-wide capacity where this improves waiting times, with an explicit equality and travel assessment.

- Any maternity configuration change should demonstrate sufficient specialist staffing, clinical expertise, safe escalation and the ability to respond to complications.
- Do not treat diagnosis, speed or location as the sole measure of quality; as fairness, effectiveness and experience are also important.

5.3 Urgent and Emergency Care, Discharge and Flow CMDT

Urgent and emergency care

Urgent and emergency care is a significant public priority: over 30 per cent selected it as one of their priorities for the next year. There is strong support for strengthening alternatives to A&E.

- Over 90 per cent support urgent treatment centres focusing on urgent injuries and illnesses provided alternatives to A&E are strengthened.

Qualitative responses told us that:

- Support for moving urgent care closer to home was conditional on clinically safe local alternatives being fully operational before services moved away from emergency departments.
- Respondents wanted transitions to include named accountability, safe handovers and clear communication with patients and families.
- Community services need enough workforce, infrastructure, funding and social-care capacity before taking on additional activity. People were concerned that existing hospital provision could be reduced before sustainable alternatives were established.
- “Closer to home” wasn’t considered the same as accessible. Travel time, public transport availability and affordability—particularly in rural and coastal communities—must inform service locations.
- Urgent-care pathways should include immediate mental-health assessment, addiction support, follow-up and safe handovers.
- Success shouldn’t be measured through reduced admissions alone. Respondents wanted monitoring of patient outcomes, service gaps, delayed escalation, repeat presentations and any additional burden placed on carers.

Overall: The evidence supports more local urgent treatment, but only where it provides a safe, accessible and properly resourced alternative—not simply a transfer of activity away from A&E.

Discharge and flow

Respondents have said the following are issues with discharge and flow:

- Late discharge decisions
- Delays with prescriptions and medicines
- Transport availability and family collection arrangements
- Lack of downstream capacity
- Social care pressures
- Poor coordination between teams
- Responsibility mustn't be transferred to unpaid carers without identifying and supporting them.
- Safe discharge and aftercare should be a core requirement, with timely discharge information, clear responsibility for follow-up and prompt referrals to onward support.
- "Supported referrals" were recommended: the receiving service should be contacted directly and confirm the next step with the patient, rather than leaving patients to navigate services themselves.
- Better integration is needed between hospitals, community services, social care, housing and VCSE organisations. Respondents warned that fragmented services allow people—particularly those with complex needs—to fall through gaps.

The feedback therefore describes discharge as both a capacity problem and a process problem. Respondents described late discharge decisions, delays with prescriptions and medicines, transport and family collection arrangements, lack of downstream capacity, social care pressures and poor coordination between teams.

For example:

"In my experience of four recent hospital stays in six months... discharging of patients, which is often left quite late, and prescriptions also delay patients getting home."

A staff respondent similarly called for patients to be *"safely and quickly discharged from hospital"* with rehabilitation and care packages in place rather than waiting in an acute bed.

Commissioning recommendations

- Strengthen alternatives to emergency departments alongside primary and community capacity.
- Start discharge planning earlier and improve coordination of medicines, transport and family/carer communication.
- Strengthen community and reablement capacity and the integration with social care.
- Treat urgent care, discharge and flow as one whole-system pathway rather than separate organisational problems.
- Redesigning the hospital front door without strengthening other services risks moving pressure rather than reducing it.

5.4 Mental Health, Learning Disability and Autism CMDT

Mental health

The strongest message from the public and staff response is prevention and early intervention rather than a system focused mainly on crisis response.

Provide help earlier, before people reach crisis. This was the leading mental-health improvement in the surveys, narrowly ahead of faster access to services.

Make advice and treatment faster to access. Respondents highlighted long waits, high referral thresholds and people receiving help only after their needs become severe.

Improve referral pathways and ongoing support. People wanted more referral options, fairer access and continued help rather than discharge after limited contact.

Make mainstream services more accessible to autistic people and people with ADHD. This includes staff understanding communication needs, making reasonable adjustments and offering clear, neurodivergent-friendly communication.

Strengthen support around the individual. Respondents valued support for carers and families, schools and colleges, talking therapies, loneliness and social isolation, and community services.

Autism and ADHD

Respondents do not want diagnosis to be the sole gateway to meaningful support.

Views were almost evenly divided between prioritising a quicker diagnosis and receiving needs-based help regardless of diagnosis, suggesting both are important and one shouldn't replace the other.

Around half of the total respondents prioritise practical help and support while people wait, even if diagnosis takes longer.

Learning disability and complex communication needs

Feedback highlights the need for more accessible ongoing medical support for people with learning disabilities, particularly where communication needs are complex.

Neurodiversity and mainstream services

Better NHS staff understanding of autism, PDA and ADHD, with appropriate staff training. Neurodivergent-friendly clinics and sensory awareness.

The feedback suggests that improving autism and ADHD services is not only about diagnosis; NHS services need to become more accessible and flexible for everyone.

Commissioning recommendations:

- Strengthen prevention, early intervention and community support before crisis.
- Provide meaningful support while people wait for Autism/ADHD assessment or diagnosis.
- Improve referral pathways and reduce administrative burden where possible.
- Build accessibility for learning disability and neurodivergent people into mainstream pathways, not only specialist services.

5.5 Primary, Community and Neighbourhood Care

Care closer to home: Over 70 per cent express some willingness to receive appropriate care closer to home.

Respondents are highly willing to consider home-based support using technology and professional input, emergency response teams visiting people at home, and diagnostics at local centres.

We asked people which factors would give them most confidence when receiving care away from hospital. Across the three surveys, the strongest common message is that confidence in receiving care away from hospital depends on:

1. rapid escalation and face-to-face help if a person deteriorates;
2. access to specialist advice;
3. being listened to and involved in decisions;
4. joined-up access to medical records;
5. confidence that care will be safe and clearly connected to hospital services.

Continuity with the same team, evening/weekend availability and a named contact were still valued, but were generally less prominent than safety, involvement and rapid clinical support.

Community pharmacy and dentistry

The survey findings all support high confidence in pharmacies for vaccinations, blood pressure checks, medicines advice, minor illness and healthy living support.

Across all three surveys, there is a **consistent and very strong public acceptance of community pharmacy delivering routine clinical and preventative services**, particularly:

- Blood pressure checks.
- Advice on prescribed medicines.
- Vaccinations.
- Minor illness treatment.
- Healthy living and smoking cessation advice.

Overall over 70 per cent were confident in receiving blood pressure checks and nearly 80 per cent confident in vaccinations and medicines advice.

The results all show caution in community pharmacy providing **sexual health services and especially substance misuse support** are less readily accepted in pharmacy settings than routine clinical care.

The single biggest dentistry concern is the availability of NHS dentists—specifically, being unable to find a practice accepting new NHS patients. It ranked first in every survey clearly ahead of affordability, urgent access and waiting times. Affordability is also an issue, but less important, and timely access—especially urgent care in pain and appointment waits—comes after that.

Staff comments revealed the extent to which even NHS employees often struggle to access NHS dentistry. Many respondents reported paying privately due to a lack of NHS provision. *"I have gone private for my family because NHS dentistry service was poor"*

Several respondents stated that they no longer attempted to access NHS dental services at all, while others described concerns about appointment availability, local access and the overall quality and sustainability of NHS dentistry.

Commissioning recommendations:

- Improve GP access and continuity while building neighbourhood capacity for prevention, long-term conditions, frailty, urgent care and appropriate care closer to home.
- Make sure there is always a non-digital option for those who need it.
- Ensure community pathways - services outside acute hospitals, including primary care, community services, rehabilitation/reablement, urgent response and pharmacy - are adequately staffed and connected to specialist and hospital services.
- Do not equate 'closer' with 'more accessible' without testing transport, affordability, disability and carer impacts. Respondents gave practical examples: one said: “The buses in my area have had route changes, I can no longer access the local hospital or even my GP service by bus. And “I have mobility problems.” Another highlighted “cost of travel, availability of public transport” and the need for better communication and appointment arrangements.

5.6 Digital

There is a clear message that digital **shouldn’t be the only route into care**. People support digital options, but want **telephone, face-to-face and paper routes retained**, particularly for those who need them.

Between 55 and 70 percent wanted phone, paper or face-to-face services retained. The main concern is **digital exclusion**. People said digital-only access could disadvantage older people, disabled people, those with sensory or learning difficulties, people lacking devices or reliable internet, those with limited digital confidence, and people facing language barriers. EK360 recorded **168 mentions** relating to internet access, equipment, skills and confidence.

6. Single biggest improvement

When given the option to tell us, in their own words, what would make the single biggest improvement to the NHS there were some common themes:

- **Access to GP services.** The most common theme related to access to GP services. Respondents frequently described difficulties obtaining appointments, long waits, barriers created by online systems and a lack of face-to-face consultations. Many felt that improving access to primary care would also help reduce pressure on other parts of the NHS, particularly urgent and emergency care. One respondent stated, *“Actually being able to see a GP"*, while another called for *"easy access to GP services within 48 hours"*.
- **Reducing waiting times.** Many respondents highlighted long waits for appointments, diagnostic tests, specialist referrals and treatment. Concerns were raised about delays affecting health outcomes, quality of life and anxiety levels. Respondents commonly called for faster diagnosis and treatment, with one commenting that the NHS should focus on *"cutting waiting in every area at every stage"*.
- **Urgent and emergency care.** Respondents frequently referred to the challenges facing urgent and emergency care services, particularly long waits in A&E departments, overcrowding and corridor care. Many linked these pressures to wider problems accessing GP and community services. There were also calls for additional urgent treatment centres and improved local emergency provision.
- **Capacity, workforce and local services.** Many comments reflected concerns that health services have not kept pace with population growth across Kent and Medway. Respondents called for more GPs, nurses and other healthcare professionals, as well as additional hospitals, health centres and diagnostic facilities. Several specifically referenced pressures on Medway Hospital and the impact of new housing developments on local services.
- **Better joined-up care and communication.** Respondents wanted health services to work together more effectively. Common suggestions included shared patient records, improved communication between organisations and better coordination between GPs, hospitals, community services and social care. Respondents also wanted clearer communication about appointments, referrals and waiting times. One respondent called for *"one centralised system whereby all medical professionals can access patient records"*.
- **Prevention, mental health and community support.** A smaller but significant group of respondents highlighted the importance of preventing ill health, improving mental health services and strengthening support within communities. Comments included calls for earlier intervention, support before crisis point, better social care and greater investment in community-based services to help people stay well and independent for longer.

7. VCSEF feedback

Feedback from 18 voluntary, community, social enterprise and faith organisations, alongside a Be One workshop involving 29 people from grassroots groups, showed broad support for the focus on prevention, neighbourhood health, integrated care and reducing inequalities. However, respondents said the sector must be recognised as an equal

strategic and delivery partner, with a formal role in governance, neighbourhood teams and pathway design—not simply consulted or used as additional support. As Medway Voluntary Action put it, “the sector largely appears as a supporting partner rather than a strategic delivery partner.”

A central message was the need to invest sustainably in prevention, early intervention and community capacity. VCSEF organisations said they already provide trusted, culturally appropriate support that helps people before they reach crisis, particularly those affected by poverty, poor housing, isolation, digital exclusion, addiction, neurodiversity and other complex needs. They called for longer-term and more accessible funding, formal referral routes and better integration across NHS, social care, housing and community services. Respondents stressed that “successful neighbourhood health models require communities to be active partners, not simply recipients of services” and warned that voluntary organisations can fill gaps in preventative provision but “need to be funded appropriately to do so.”

8. Cross cutting themes

Several themes from the feedback go beyond NHS services and could be useful.

Performance measures

Some respondents explicitly challenge an emphasis on targets and waiting-list performance. They describe patients being moved between services or waiting lists without necessarily experiencing better care.

The underlying message is:

Reducing a performance metric is not necessarily the same as improving the patient's experience or outcome.

Commissioning should consider measures of:

- patient outcomes
- patient experience
- continuity
- whole-pathway waiting time
- and whether patients feel someone has taken ownership.

Patient pathways

Respondents describe being passed between GPs, hospitals, specialists, community services, mental health services and other organisations.

Some specifically call for a named contact, particularly when someone is waiting a long time or their condition changes.

The suggestion is: Patients should know who owns their journey, even when multiple organisations are involved.

"Don't transfer activity without transferring capacity."

This is one of the strongest cross-cutting messages, particularly from staff.

Respondents support care closer to home but simultaneously describe pressure within:

- general practice
- community services
- pharmacies
- specialist services
- and social care.

The concern is that new responsibilities may simply be added to already stretched services, and it's suggested to "not transfer activity without transferring capacity, workforce and resource".

Local care is not automatically accessible care

There is strong support for care closer to home, but the equality feedback provides an important qualification. Here, "equality feedback" means respondents highlighted practical and personal factors that can make a service harder to use even when it is geographically closer — including poor public transport, parking, unfamiliar locations, mobility or sensory impairment, travel costs and reliance on a carer. One respondent described a partially sighted older relative being moved to a location that was difficult to reach from the car park, creating additional pressure for the family carer.

Moving a service can make access worse for some people if:

- public transport is poor
- parking is difficult
- the location is unfamiliar
- the person has mobility or sensory impairment
- the person cannot afford travel
- or they rely on a carer

Therefore: "closer" should not automatically be equated with "more accessible".

Social care is under-represented

Several respondents raise:

- integration with social care
- reablement
- respite
- dementia
- end-of-life care
- care for older people
- support after discharge.

One explicit concern is that there is too little mention of integration with social care.

This is important because the respondents view health and social care as one connected system, even where commissioning structures remain separate.

Communication and patient experience

The feedback repeatedly refers to:

- being listened to
- having enough time
- understanding what will happen
- receiving information while waiting
- clear explanations
- communication needs
- being able to contact somebody when circumstances change.

Communication therefore appears to be more than a patient-experience issue.

For some respondents, poor communication creates a barrier to safe and effective care.

Population growth and infrastructure

Some respondents link service pressure to:

- new housing
- population growth
- insufficient GP capacity
- lack of local facilities
- pressure on hospitals and dentists.

This suggests that some respondents see access problems as a capacity and infrastructure issue, rather than simply a problem of how existing services are organised.

This should be tested against population projections, estate plans and local capacity data.

Conclusion

Submissions from the public and surveys provide a strong but conditional mandate for transformation.

The public is willing to support significant change, but they want that change to feel like better care rather than simply different care.

The strongest test of the commissioning intentions should therefore be whether they deliver better access, better outcomes, better experience and greater equity, while ensuring that workforce, capacity and accessibility are designed into the model from the outset.

NHS
Kent and Medway



The four layers of care

The clinical model for healthcare services and what people in Kent and Medway can expect from each layer



Kent and Medway integrated model of care

Four layers of care: One seamless patient journey

Escalation: Increasing need

Recovery and return home

Layer four: Acute care

Specialist hospital-based care

- ✔ Emergency and major surgery
- ✔ Complex inpatient treatment
- ✔ Cancer, stroke and cardiac care

'Highly specialised care when I need it most'

Layer three: Multi-neighbourhood care

- ✔ Scaled specialist services
- ✔ Community diagnostics
- ✔ Virtual wards and hospital-at-home
- ✔ Specialist clinics and rehab services
- ✔ Rapid response teams

'Specialist care without needing a hospital visit'

Layer two: Single neighbourhood care

- ✔ Proactive and coordinated care
- ✔ Frailty and high-risk support
- ✔ MDT care planning
- ✔ Home based services
- ✔ Remote monitoring

'Supporting me before I become unwell'

Layer one: Primary care

- ✔ The foundation of care
- ✔ General practice and pharmacy
- ✔ Optometry and dentistry
- ✔ Preventative and chronic care

'Accessible, continuous care close to home'

Executive summary

Change is needed in the way healthcare is commissioned and delivered in Kent and Medway.

- Too many outcome and quality metrics are poor and inequitable with life expectancy 10 years lower in the most deprived locations versus the least.
- Access is limited in both elective and non-elective care with lengthening waiting times to be seen in the emergency department or for an outpatient's appointment. We hear repeatedly the effect difficulties accessing care has on people's experience of healthcare.
- Healthcare is reactive not proactive and too often delivered in an expensive inconvenient hospital setting.
- This has contributed to a £300m structural deficit across Kent and Medway, which is unsustainable.

The Kent and Medway 'four layers of care' model describes a single, coherent healthcare offer organised across four interdependent layers: Primary care, single neighbourhood care, multi-neighbourhood care, and acute hospital care. These layers operate not as separate services, but in a continuous model through which patients move as their needs change.

In the past, providers both large and small have operated as isolated units within the system rather than working collaboratively. This will change as providers work in two collaboratives and one alliance, with the ICB commissioning for better outcomes and experience.

Patients will experience a single joined-up system, rather than multiple disconnected services. Most care begins and continues within primary care, supported by continuity and accessibility.

As needs increase, care is strengthened through multidisciplinary support at neighbourhood level. Where greater intensity or specialist capability is required, services operate at multi-neighbourhood scale. Acute hospital care remains essential but is reserved for those with the highest level of clinical need, or where highly specialised staff, equipment or estates are required – with a consistent emphasis on returning people safely home at the earliest opportunity. A core principle of the model is the shift from reactive, episodic care toward proactive and anticipatory care, particularly for those at highest risk.

The four layers of care also supports a deliberate transfer of elective care out of hospital settings, ensuring services are delivered as close to home as possible while maintaining clinical safety and quality.



The case for change

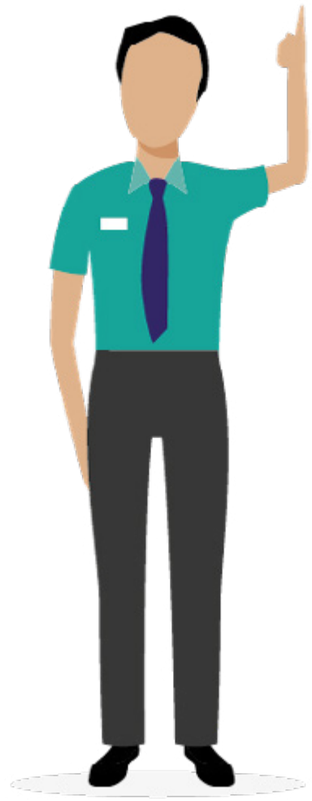
NHS Kent and Medway faces growing demand from an ageing population with increasing levels of frailty, long-term conditions and mental health need, alongside persistent health inequalities, workforce pressures and significant financial challenges. Variation in quality, safety, access and outcomes remains too great, while current models of care are often reactive, fragmented and focused on responding to illness rather than preventing it.

Residents, communities and staff have told us they want healthcare that is easier to access, better coordinated and delivered as close to home as possible. They want earlier support, greater continuity of care and services that help people remain independent and in their own homes for as long as possible, avoiding unnecessary hospital attendances and admissions wherever safe to do so.

This aligns directly with the NHS 10 Year Health Plan and Neighbourhood Health Framework, which call for a fundamental shift from hospital to community, analogue to digital and sickness to prevention.

The Kent and Medway four layers of care model provides the framework for delivering this change. By progressively moving activity and resource from higher-cost, reactive services into primary care, single neighbourhood care and multi-neighbourhood care, we can provide more proactive support, prevent deterioration, improve outcomes and reduce avoidable hospital use. Acute services remain essential but will increasingly focus on specialist, complex and emergency care that can only be delivered in hospital settings.

Through this approach, NHS Kent and Medway aims to improve safety, quality and patient outcomes, reduce health inequalities, strengthen workforce and provider sustainability, and create a clinically and financially sustainable health and care system for the future.



Layer 1: Primary care - the foundation of care

Primary care forms the foundation of the integrated model. It is the first point of contact for most patients, the setting in which the majority of clinical care is delivered, and the ongoing clinical home for registered populations. Delivered through general practice, community pharmacy, optometry and dentistry and supported by a wider multidisciplinary team, it provides accessible, continuous and coordinated care.

Patients experience this layer as the most familiar and consistently available part of the system. It is where new health concerns are assessed, long-term conditions are managed and preventative care is delivered. Access is designed to be flexible, combining telephone, online and face-to-face routes, with urgent needs addressed promptly and planned care arranged to support continuity.

In an environment of growing demand and workforce pressures, general practice is evolving through smarter triage systems, digital access and multidisciplinary teams to ensure patients receive the right care, from the right professional, at the right time. While the route into care may be changing, continuity remains a defining feature of effective primary care. Long-term relationships between patients and clinicians foster trust and a detailed understanding of medical, social and personal circumstances, supporting proactive intervention, personalised care and seamless coordination with wider services.

Future universal offer in layer one

At layer one, residents will benefit from a consistent, universal offer across general practice, community pharmacy, dentistry and optometry, providing accessible, proactive and coordinated care close to home. General practice will deliver core and locally enhanced services through multidisciplinary teams, including GPs, nurses, advanced clinical practitioners, pharmacists and allied health professionals, with a strong focus on prevention, improved access and systematic management of long-term conditions. Community pharmacy will play an expanded role in delivering accessible, preventive and clinically effective care, helping people stay well and independent while reducing pressure on general practice and hospitals. Dentistry and optometry services will be available and accessible to all communities regardless of residency or registration status, ensuring equitable access to essential primary care services.

The ICB will commission and deliver

- **Modern General Practice**, including digital triage, multidisciplinary team-based care and a more diverse workforce.
- **Improved access standards**, with 90 per cent of urgent cases seen on the same day within general practice.
- **An expanded community pharmacy offer**, supporting management of same-day need, long-term conditions, prevention and vaccination programmes.
- **Independent prescribing for cardiovascular disease**, enabling community pharmacists to manage hypertension and lipid reduction closer to home and at times convenient for patients.
- **Improved access to dental care under general anaesthesia**, ensuring no patient waits longer than 18 weeks through partnership with the Acute Provider Collaborative.

Together, these changes will strengthen primary care, improve access, support prevention and long-term condition management, and provide more care closer to home.





Layer two: Single Neighbourhood Care – proactive and coordinated care for defined populations

Layer two is made up of 45 distinct geographic regions covering populations of roughly 30,000 to 50,000 each. It represents a shift from reactive, episodic care to a more structured and proactive model.

The ICB will risk stratify our population to identify cohorts of patients who will benefit from proactive intervention. Over time, this will improve their health outcomes and the quality of the care they receive.

In 26/27, the primary focus is the frailest five per cent of the population (PNG 10/11 plus). Physical health is often the cause of this extreme frailty, but for some it is a mental health need that must be proactively addressed. This group were prioritised as the evidence shows poor patient outcomes and experience through unnecessary hospital admission and loss of independence.

The ICB will commission a bundle of proactive care elements designed to reduce the likelihood of physical or mental deterioration that would previously require a hospital attendance and admission.

1. Comprehensive geriatric assessment to understand a patient's health needs.
2. Structured medication review to make sure medications and doses are optimised.
3. Respect form to make sure a patient's wishes are understood and followed.

The second targeted cohort, planned for 27/28, are those identified through population health analyses as 'rising risk'. Patients with diabetes or cardiovascular disease who without proactive management are likely to deteriorate, having poorer health outcomes and escalating cost to the healthcare system. In future, patients will receive regular review, coordinated multidisciplinary input and structured care planning that anticipates need rather than responding only when problems occur.

In parallel, layer two supports the movement of selected elective care out of acute hospitals, enabling more services to be delivered within a community settings. Some of the diagnostics currently found in layer four can be moved to layer two, this can support diagnosis and management closer to home.

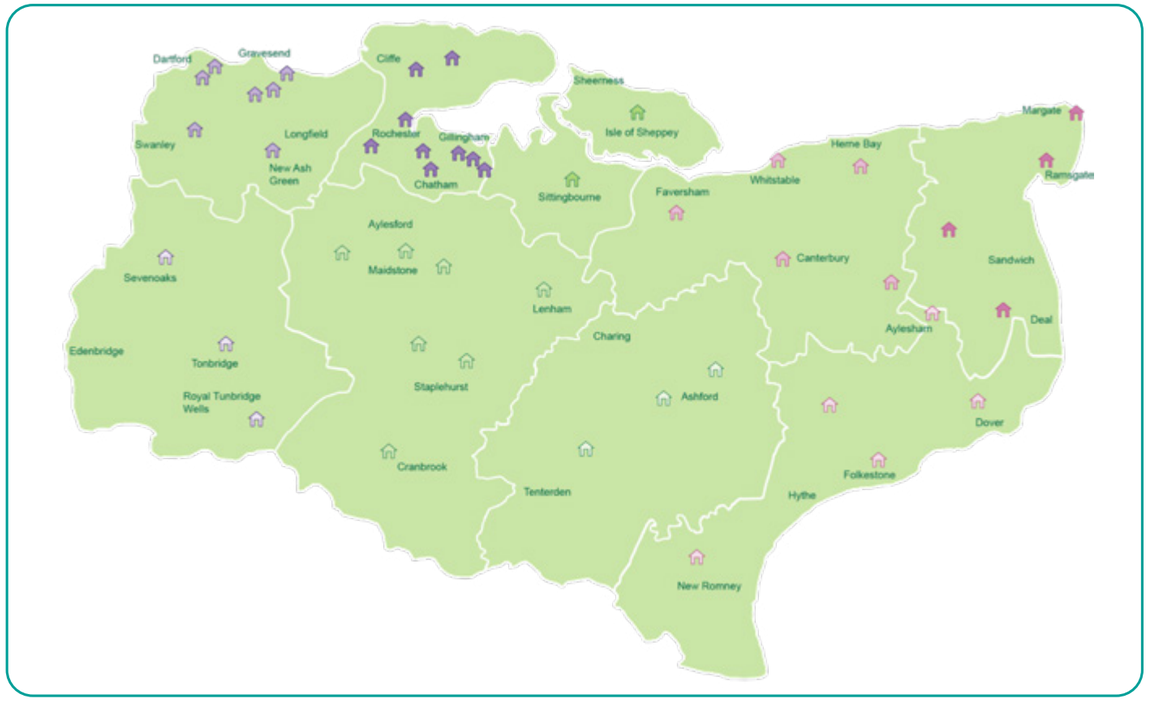
Future universal offer in layer two

At layer two, residents will receive proactive, neighbourhood-based care focused initially on people living with frailty and long-term conditions, with additional population groups included over time. Care will be delivered closer to home through coordinated multidisciplinary teams, reducing the need for hospital attendance and supporting earlier intervention. Residents will benefit from extended access to general practice appointments during evenings and weekends, alongside greater availability of diagnostics and outpatient services within neighbourhood settings. Services that have traditionally only been available in hospital, such as specialist diabetes support, will increasingly be delivered locally, improving convenience and access while supporting better health outcomes.

The ICB will commission and deliver

- **Specialist frailty multidisciplinary teams (MDTs)** to proactively manage the complex needs of the five per cent most frail residents identified through primary care records.
- **Proactive population health interventions** for additional cohorts, beginning with people living with diabetes and cardiovascular disease.
- **Extended access to general practice**, including evening and weekend appointments.
- **Neighbourhood-based diagnostics and outpatient services**, bringing appropriate services currently delivered in hospital settings closer to patients' homes.
- **Specialist community-based clinics**, including services such as diabetes nurse specialists and GPs with specialist interests, delivered at neighbourhood level where appropriate.

Together, these developments will provide more proactive, preventative and personalised care, helping residents manage their health conditions effectively while reducing the need for hospital-based care.



Layer three: Multi-neighbourhood care – scaled services serving larger localities

Multi-neighbourhood care operates across populations of approximately 250,000 people, bringing together several of the single neighbourhoods to provide layer three care. There are nine in Kent and Medway.

Care commissioned in this layer typically requires a greater level of healthcare resource, coordination or specialist capability than can be delivered within a single neighbourhood.

Layer three offers both an elective and a non-elective alternative to hospital care that is more convenient, closer to home and lower cost than layer four.

Non-elective care

This layer supports patients during periods of acute deterioration, recovery following illness and transition from hospital back into the community. Care will be delivered in the patient's home or community setting, avoiding hospital admission where clinically appropriate and supporting recovery in a more familiar environment.

Multi-disciplinary teams including geriatricians, GPs, advanced clinical practitioners (ACPs), nursing staff and the voluntary sector will work together to deliver hospital level care in a patient's own home. These multidisciplinary teams (MDTs) are supported in their work through wearable technologies, community virtual wards, shared care records and access to specialist input through advice and guidance or same day emergency care (SDEC) in layer four.

Layer three will also provide extended GP access through same-day hubs, supported by diagnostics and a MDT providing urgent treatment.

For some conditions such as stroke, where part of the recovery pathway is a period of specialist rehabilitation before continuing recovery at home, these beds will be part of the offer in layer three.

Elective care

Care which has traditionally been delivered in a hospital setting can often be done in layer three. Many outpatient clinics only require simple diagnostics or treatments so do not need to be in an acute hospital but can be delivered closer to home in layer three.

Examples of care that will move out of layer four into layer three are:

- Outpatient activity in cardiology, orthopaedics and gynaecology. The data shows this group have some of the longest waits to be seen and the poorest outcomes while waiting.
- Diagnostics can also be placed at layer three with MRI, CT, X-ray and ultrasound placed closer to home.
- Certain treatments, biologics for autoimmune conditions, rheumatology treatments and others, should no longer require a hospital trip.



Universal offer in layer three

At the multi-neighbourhood level, residents will receive a consistent, scaled offer that brings some urgent treatment and elective care closer to home. Services will include same-day access hubs, rapid community response services, community diagnostics and community virtual wards, enabling more people to receive specialist and acute-level care in community settings. Residents will also benefit from access to outpatient services that have traditionally been delivered in hospitals, alongside coordinated rehabilitation, reablement and recovery support to help them regain independence following illness or hospital care. This model will provide more integrated care pathways across neighbourhoods, ensuring patients receive the right care, in the right place, at the right time.



The ICB will commission and deliver

- **Community-based outpatient services** across each of the nine multi-neighbourhood areas, initially covering cardiology, orthopaedics and gynaecology, with further specialties added over time.
- **Redesigned community urgent treatment centres (UTCs)**, transforming the current 12 community UTCs into enhanced same day GP access hubs to increase access to urgent care.
- **Specialist frailty multidisciplinary teams** in each multi-neighbourhood area, providing responsive, hospital-level care for frail residents within their own homes.
- **A redesigned virtual ward model**, rationalising the current nine services into two consistent models: Community Virtual Wards supporting frailty and Acute Virtual Wards supporting early discharge from hospital.
- **Enhanced community diagnostic services**, including expansion of diagnostic capacity across all nine multi-neighbourhood areas.
- **Advanced community treatment services**, including delivery of some therapies traditionally provided in hospital settings.

Together, these changes will create a stronger community-based care model that delivers more specialist, urgent and recovery services closer to home, improves patient experience and outcomes, and reduces reliance on hospital-based care.

Layer four: Acute hospital care

Acute hospital care provides the most specialised and resource-intensive component of the system, including emergency care, inpatient treatment and complex procedures. It is designed for those with the highest level of clinical need where there are interdependencies between specialised services or where specialist equipment or estates are required.

Patients enter this layer when hospital-level care is required and cannot be safely delivered within community settings. Within the four layers of care model, this represents a targeted escalation rather than the default pathway.

Care within the acute setting is recovery focused and time limited. There is a strong emphasis on delivering the necessary intervention efficiently and initiating discharge planning at the earliest possible stage. Acute care operates as part of a continuous pathway, with clear links to the multi-neighbourhood and single neighbourhood layers that provide ongoing care following discharge and supports recovery.

In Kent and Medway, our four acute hospital trusts will be more efficient and improve patient outcomes if they work together through the Acute Provider Collaborative. Better sharing of staff, estates and patients will reduce inequalities, increase access and reduce costs to the system.

Universal offer in layer four

At layer four, residents will receive access to the most specialised hospital-based services for urgent, complex and life-threatening conditions. This includes emergency department care, major surgery, complex inpatient and outpatient treatment, and specialist pathways such as stroke, cardiac and critical care services. Care will be delivered through consultant-led multidisciplinary teams supported by advanced diagnostics and specialist facilities. While this layer will continue to provide high-quality acute care when needed, there will be a stronger focus on making sure patients move seamlessly through the system, with diagnostics, assessment, discharge planning and follow-up care organised more efficiently and with greater consistency across Kent and Medway.



The ICB will commission and deliver

- **A single patient tracker list across Kent and Medway,** enabling patients to be offered the next available appointment or operation regardless of provider, rather than waiting solely for treatment at their local hospital.
- **A Single Point of Triage (SPOT)** for the 10 highest-volume specialties, making sure patients are assessed to consistent standards across all trusts and, wherever appropriate, managed within layers one to three rather than referred into acute hospital services.
- **Implementation of Getting It Right First Time (GIRFT) 'Straight to Test' pathways** across all trusts, allowing patients to undergo relevant diagnostic tests before their first outpatient appointment to reduce delays and improve productivity.
- **A redesigned discharge support model**, including a review of rehabilitation capacity, care packages and care home provision to ensure patients are discharged as soon as they are clinically ready.
- **A 'home first' approach to therapy and assessment activities**, with physiotherapy, occupational therapy and council assessments delivered in community settings, wherever appropriate.
- **A single Kent and Medway urgent care hub**, combining the single point of access, clinical advisory service and 999 validation functions into a coordinated 24/7 service supporting timely access to the right level of care.

Together, these changes will improve access to specialist hospital services, reduce waiting times and unnecessary variation, support faster discharge from hospital, and make sure acute care is focused on those residents who need it most while enabling more care to be delivered in community settings.

Conclusion

The Kent and Medway four layers of care represents a fundamental transformation of how health and care is delivered, experienced and sustained across our system. Over the next three years, we will move decisively from a model built around organisations and episodes of illness to one built around people, neighbourhoods and outcomes.

By 2029, residents should experience a genuinely integrated health and care system in which access is simpler, care is delivered closer to home, and support is increasingly proactive rather than reactive. The majority of care will be provided within layers one to three, supported by strong neighbourhood teams, expanded community diagnostics, digital technology, and a multidisciplinary workforce. Layer four acute hospital services will remain a vital component of the system but will be focused on those patients whose needs genuinely require acute, specialist or highly complex care.

This transformation will be underpinned by a new provider architecture. The Neighbourhood Collaborative, bringing together primary care, community and mental health providers, will be responsible for delivering integrated services across layers one to three. The Acute Provider Collaborative will lead the delivery of specialist and hospital-based care within layer four. Together, through the Kent and Medway Provider Alliance, providers will share accountability for population outcomes, patient experience, workforce sustainability and financial performance, moving beyond organisational boundaries to operate as a single coordinated system.

Our ambition is that within three years:

- unplanned hospital admissions will reduce through earlier intervention and proactive management of frailty, mental health needs and long-term conditions
- significantly more outpatient, diagnostic and treatment activity will be delivered in community settings
- waiting times for urgent, elective and diagnostic care will improve through greater collaboration and more efficient use of capacity
- patients will report better experiences of care coordination, continuity and access
- health inequalities will begin to narrow through targeted population health interventions and equitable access to services
- the system will be placed on a more sustainable financial footing through the transfer of care to lower-cost, higher-value settings and improved productivity across providers.

Success will not be measured solely by activity or performance targets, but by the outcomes that matter most to residents: Living longer in good health, maintaining independence, receiving care closer to home, and having confidence that services will be available when needed. Progress will be monitored through a clear outcomes framework, informed by population health intelligence, patient experience and regular engagement with residents, communities and frontline staff.

The four layers of care provides the blueprint for achieving the ambitions of the NHS 10-Year Health Plan in Kent and Medway. By working together as one layered health and care system, we have the opportunity to improve outcomes, reduce inequalities, strengthen our workforce and secure long-term sustainability. Our vision is clear: A system that delivers the best possible care, in the best possible place, for every resident of Kent and Medway, every time they need it.





July 2026

Report to	Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Kent and Medway Strategic Commissioning Performance Report (SCPR) – NHS Oversight Framework 2026/27
Key question	The Board is asked to note the changes in the NHS Oversight Framework for 2026/27, noting the absence of a full release of benchmarking data from NHSE.
Executive Lead	Chris Neill, Chief Commissioning Officer
Author	Geraint Griffiths-Dale, Director of Performance and Regulation Clare White, Head of Performance and Regulation Ian Roberts, Head of Performance Analytics

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☒ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☒ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

The Board is asked to:

1. **NOTE** the changes in the NHS Oversight Framework for 2026/27 noting the absence of a full release of benchmarking data from NHSE.

Executive summary:

NHS Kent and Medway Integrated Care Board is presented with an update on the NHS Oversight Framework 2026/27 and its implications for the Strategic Commissioning Performance Report (SCPR).

This update highlights key national changes, including the reintroduction of ICB segmentation, revised scoring methodologies, updated and new oversight metrics, future

league table reporting for ICBs, and the emerging approach to ICB capability assessments.

These changes will affect how Kent and Medway ICB's performance is measured, benchmarked and reported.

Note: This report has been published before the 2026/27 data has been uploaded onto Model Health System. The assessments are therefore based on the published data earlier in August and benchmarked against nationally published data to give indicative scoring using draft methodology. Methodology for local estimated scores will be reviewed following final publication of national metric scores and technical guidance to ensure alignment.

Proposed next steps:

The following actions will be taken to progress development of the SCPR and strengthen the ICB's performance assurance arrangements:

- Development of a corporate approach to commissioning MDT reporting against action plans to address performance areas of focus
- Refresh of reported ICB key strategic actions in line with 2026/27 business plan
- Refresh of ICB metrics in line with the publication of the 2026/27 NHS Oversight Framework (Quarter 1 anticipated to be reported nationally from September 2026).

Governance pathway to date:

Integrated Quality and Performance Group	2 September 2026	
Kent and Medway ICB Executive Committee	9 September 2026	

Contact for further information	Geraint Griffiths-Dale, geraint.griffiths@nhs.net Clare White, clare.white2@nhs.net Ian Roberts, ianroberts@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

COMPLIANCE NOTES:

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?

☐ Yes ☒ No

If yes, please confirm how the conflict has been managed.

FOI status

Is this report disclosable under FOI?

☒ Yes ☐ No

If no, please specify why:

Financial implications

Are there financial implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Legal implications

Are there legal implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Quality and safety implications

Are there quality or safety implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Patient and public engagement

Are there patient and public engagement implications associated with this report?

☐ Yes ☒ No

If yes, please describe. If no, please specify why:

STRATEGIC COMMISSIONING PERFORMANCE REPORT

Update on NHS Oversight Framework 2026/27

1. INTRODUCTION

NHS Kent and Medway Integrated Care Board is presented with an update on the NHS Oversight Framework (NOF) 2026/27, including a summary of changes from 2025/26 NOF, evolution of metrics and impact on Strategic Commissioning Performance Reporting.

The NHS Oversight Framework for 2026/27 was published in June 2026, updating the 2025/26 Framework to provide clarity around accountability, reflect the maturing NHS operating model and align with the priorities in the NHS Medium-Term Planning Framework and 10-Year Health Plan.

The key changes made to the framework for 2026/27 are:

- alignment of the segmentation approach for ICBs and providers. ICBs were not segmented in 2025/26 due to a recognition of structural changes taking place
- updates to the oversight metrics: aligned to the Medium-Term Planning Framework and feedback from the service
- refinement of the delivery segmentation methodology, moving from a quartile-based approach to statistical thresholds, to make tracking of improvement easier
- a clearer oversight response model: linking delivery segmentation, organisational capability, and ongoing monitoring to engagement, support, incentives, and consequences.

Over 2026/27, NHS England will work with the service to develop an approach to ICB capability assessments. This will include looking at the ICB's role as a strategic commissioner, including for primary care services, and its alignment with the strategy for neighbourhood health.

2. STRATEGIC ALIGNMENT

The update to the NHS Oversight Framework (NOF) for 2026/27 retains the core architecture of the 2025/26 NOF whilst strengthening the links between oversight, accountability, the 10-Year Health Plan, and the Medium-Term Planning Framework.

The SCPR, once fully developed, will summarise into one report how well the ICB is delivering its strategic commissioning role and objectives. The SCPR is intended to introduce ICB-level key performance indicators aligned to strategic priorities, giving a clear balanced view of performance across all strategic commissioning areas and highlight risks to delivery and mitigating actions.

3. NHS Oversight Framework 2026/27

Roles and Responsibilities

The NOF 2026/27 clarifies the roles and responsibilities of ICB's, Providers and NHS England (NHSE) as:

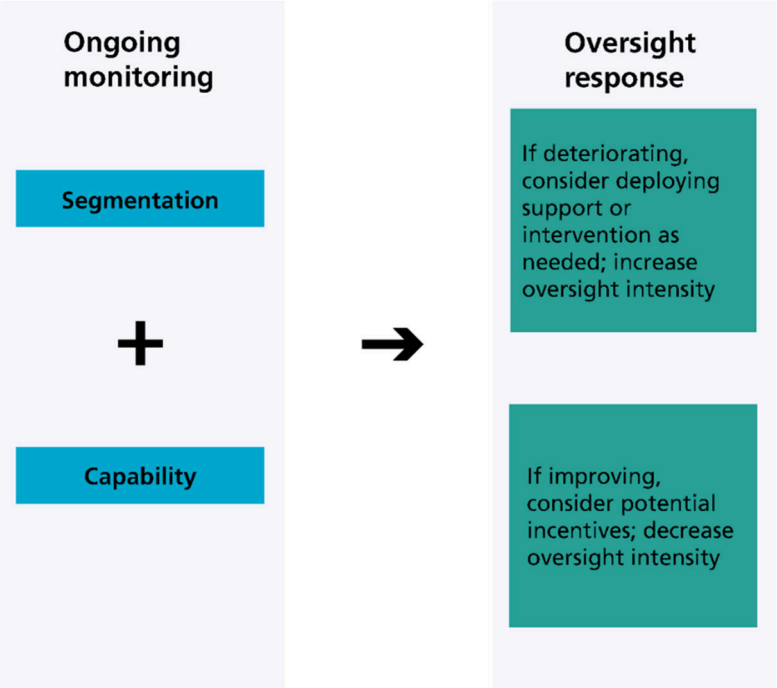
NHSE National Teams	NHSE Regional Teams	ICBs	Providers
• setting overarching oversight policy • ensuring consistency of implementation, including moderation of capability assessments • calculation of oversight segments • agreeing the use of support and intervention, including diagnostics, where this requires national resources • co-ordinating cross-boundary risks and issues that require a national view	• leading day-to-day oversight of provider and ICB delivery • making assessments of NHS organisational capability • calibration of support and intervention based on analysis of regional risk profile • escalating major issues where these constitute sufficient risk or complexity • undertaking and co-ordinating annual assessments of ICB performance and capability • enacting the use of enforcement powers in line with guidance and governance	• contract-managing and assuring commissioned services (including those commissioned on behalf of NHSE) and using contractual levers to address non-delivery • self-assessing capability and performance • operating a 'no surprises' approach and escalating potentially significant issues where these constitute sufficient risk or complexity	• ensuring high-quality and effective care through effective quality governance, including learning and improvement following patient safety incidents • setting strategic direction, ensuring the executive has appropriate capacity and capability to monitor and manage quality of care and operational delivery • using prudent and effective controls to lead the organisation • promoting and adhering to the organisation's values • meeting all statutory and regulatory obligations • self-assessing capability and performance • maintaining a 'no surprises' approach with NHSE

The NOF applies to ICBs and providers as statutory NHS entities. Other providers of NHS services are overseen through contractual and regulatory arrangements:

- **Independent providers of NHS services –** ICBs are expected to ensure the quality and performance of these services through contract management and, where necessary, taking action and escalating concerns to the relevant regions. NHSE continues to oversee certain independent providers under the independent providers risk assessment framework (IPRAF).
- **Primary care providers** – ICBs are responsible for primary care commissioning and population health. Consideration of how effectively an ICB is commissioning, assuring, and overseeing services, including primary care, in their strategic commissioning role forms part of ongoing ICB oversight, including annual assessments and future capability assessments.
- **Provider collaboratives, groups and clustered ICBs** – these groups are formed from legally distinct organisations and so are subject to this framework as distinct entities.

Oversight Approach

NHSE's oversight approach uses a combination of **delivery monitoring (segmentation),** which is used to identify whether support or intervention is needed; and **capability monitoring** (likely from 2027/28), which is used to determine how capable an organisation is to manage its support needs. These are used to inform NHSE's **oversight response**:



In addition to the oversight approach, where real-time intelligence or operational information indicates that an organisation's delivery or quality may decline rapidly, NHSE regional teams may undertake performance management activities to ensure improvement.

ICB Segmentation

Organisations are measured against the metrics set out in the NOF. The metrics are split into 7 domains. Each individual scoring metric is scored on a range of 1.00 (Best) to 4.00 (Worst), which are then used to calculate average **domain scores** and overall **organisational delivery scores.**

Organisational delivery scores are benchmarked nationally using defined rules to translate the score into a segment of 1,2,3 or 4:

Determining the unadjusted segment

In 2025/26, a quartile-based model was used to translate average metric scores into segments. Actual segmentation data for 2025/26 has been used to determine appropriate fixed thresholds for segmentation in 2026/27.

The mean average from 2025/26 (2.34) has been used to determine the threshold between segment 2 and 3, and the standard deviation (how much values typically vary from the mean average) to determine the thresholds for segments 1 and 4.

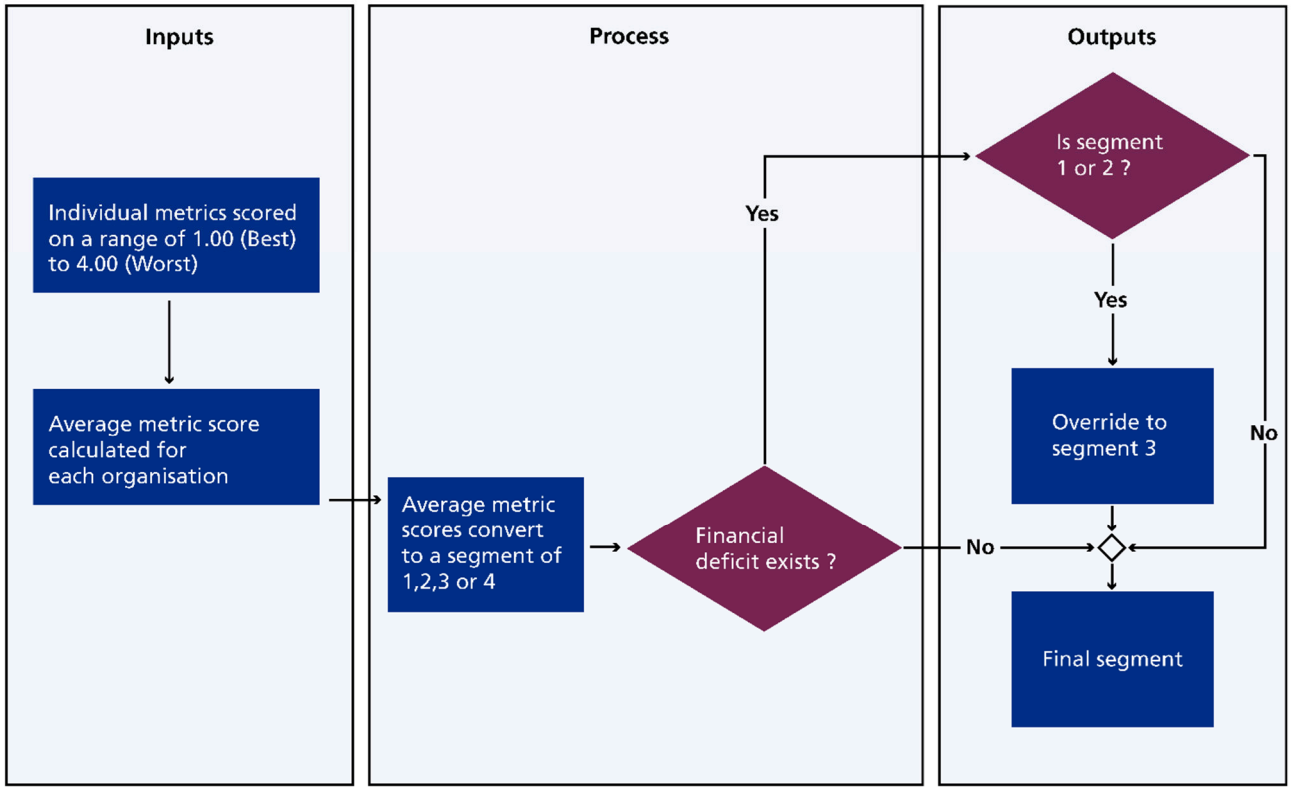
As these thresholds have been set using 2025/26 data, they may need to be revised if 2026/27 performance shows a substantial difference:

Segment	Average metric score
1	Below 1.94
2	1.94 to 2.33
3	2.34 to 2.77
4	Above 2.77

Additionally, contextual (non-scoring) metrics (largely covered by the improving health and reducing inequality domain) are used to reflect medium-term goals and outcomes. These also inform NHS England's oversight relationship with an organisation.

There are other metrics within the NOF for which the ICB has input, but which do not form part of the ICB's overall ICB scoring (e.g. Bank and Agency usage).

A financial deficit override is in place for organisations within the segmentation methodology, i.e. an organisation cannot be higher than segment 3 if it has an organisation-level financial deficit (including planned and agreed deficits).



The organisational delivery scores, accounting for the financial override, are used to categorise organisations into one of four segments, 1-4:

Segment 1 - The organisation performs highly across most areas, and any challenges have a narrow focus.

Segment 2 – The organisation performs better than average across most areas but may have some areas of challenge to address.

Segment 3 – The organisation performs below average across multiple areas and may require more co-ordinated responses, or the organisation's delivery segment has been overridden due to finance concerns.

Segment 4 - The organisation performs significantly below average in a range of areas and is likely to require a co-ordinated response and potential intervention.

Scoring and Contextual Metrics

Metrics are divided into 7 domains, and each organisation is scored against all non-contextual metrics for which it supplies data. Each metric results in a score ranging from 1.00 (Best possible score) to 4.00 (lowest possible score) in line with one of four broad models:

Model one: Target and spread – A target value is identified and any organisation meeting that value scores 1.00. Organisations not meeting the target are evenly ranked to two decimal places from 2.00 (Closest to the target without hitting it) to 4.00 (Furthest from the target)

Model two: Banded score – Specific criteria are set which relate to defined scores e.g. a value between X% and Y% will score 1.00, etc.

Model three: Floor and spread - A lowest acceptable value is identified and any organisation failing to meet that value scores 4.00. Organisations exceeding the floor are evenly ranked to two decimal places from 3.00 (Closest to the floor without hitting it) to 1.00 (Furthest from the floor).

Model four: Even spread – The highest performing organisation scores 1.00 and the lowest performing organisation scores 4.00. All other organisations are evenly ranked to two decimal places in between based on relative performance.

*One ICB metric (% of clinical trials set up within 90 days), has a Target, Floor and spread model, with both a target value (scoring 1.00 if met) and a lowest acceptable value (scoring 4.00 if not met), with organisations evenly ranked between, to determine scores of 2.00 and 3.00.

Of the 43 ICB-level metrics included in NOF 2026/27, 6 are contextual, with the remaining 37 metrics using the following scoring models:

Scoring					Non- scoring
Target & Spread	Banded Score	Floor & Spread	Even Spread	Target, Floor & Spread	Contextual Metrics
9	16	0	10	2	6

The most up to date locally assessed position against each metric is provided in Appendix 1.

See Appendix 2 for full list of metrics in each scoring category, alongside provisional MDT alignment and level of granularity available from nationally published sources.

To support prioritisation discussions, an analysis of the current ICB position (where available) against targets or thresholds for metrics using Target (& Floor) & Spread, and Banded Score methodologies is provided below. It is suggested that, where ICB performance is close to target thresholds, or where performance is at risk of dropping below a threshold, then actions could be focussed on achieving or maintaining these segment positions to most impact the overall ICB position.

League Tables

NHS League Tables were introduced for all NHS Trusts and Foundation Trusts in September 2025. They are based on NOF segmentation data and provide two distinct lenses:

- **Individual metric rankings**: Allowing all organisations who submit data for a specific metric to be compared directly for that measure
- **Aggregated metric rankings**: Allowing an overview of each organisation compared with others of the same broad type

Aggregated metric rankings (colloquially referred to as “League tables”) are calculated in two phases:

- First each organisation of the same type is ranked against its peers in divisions by segment i.e. all segment one trusts, following by all segments two trusts, etc
- The organisations are ranked within their segment division based on their average metric score

In simple terms the “top” trust in the league table is the segment one trust with the lowest average metric score and the “bottom” trust is the segment four trust with the highest average metric score

From 2026/27, ICBs will also become subject to individual and aggregated metric rankings.

ICB Capability Assessments

Capability assessments provide NHS England with a structured view of an organisation’s leadership, governance and ability to deliver sustained improvement. They consider how effectively boards set direction, manage risk, use data and insight, engage with partners and translate plans into delivery.

The capability assessment will form the basis of the statutory annual assessment that NHS England is required to undertake each year.

For 2025/26, ICB annual assessment was conducted in line with the ICB annual assessment guidance for 2025/26.

It is not yet known how ICB capability assessments will be scored, or the weighting of metric-derived organisational delivery scores compared to capability assessments in

determining NHSE's oversight response for ICBs. During 2026/27, NHS England will work with ICBs to develop an approach to ICB capability assessments. This will include looking at the ICB's role as a strategic commissioner, including for primary care services, and its alignment with the strategy for neighbourhood health.

From 2027/28, it is anticipated that formal ICB capability assessments will be incorporated into the annual assessment, alongside a delivery score derived from the ICB's average segment in the preceding year.

In the meantime, the 2025/26 annual assessment will be used to provide a qualitative view of ICB leadership, governance and strategic commissioning readiness, to inform NHSE's oversight response, in conjunction with other considerations from ongoing monitoring.

It is expected that capability assessments will focus on how well ICBs:

- Understand their local context including population health needs, what drives outcomes, and what the system currently delivers.
- Develop long-term population health strategy including how effectively the ICB describes future strategy, linked to defined outcomes.
- Manage delivery and resource allocation including allocating resources, shaping the market, and contracting for defined outcomes - recognising and rewarding those ICBs that commission population health delivery models.
- Evaluate impact including how effectively the ICB determines whether it achieved defined objectives, can understand what may need to change next time.

In addition, they are likely to be assessed on how capably they are implementing key aspects of the 10 Year Health Plan, their effectiveness as a system leader, and how well they are leading a well-run organisation, with effective governance, decision making and a high performing board.

Aligned with the Provider Capability process, NHS England expects to rate ICBs on the outcome of their assessment (Green, Amber/Green, Amber/Red, or Red).

4. NHS Oversight Framework Metric Evolution

There are 43 ICB-level metrics in the 2026/27 NOF, with 27 metrics retained from NOF 2025/26, 6 metrics which have evolved to align with emerging direction or policy, and 10 new metrics:

Retained metrics: 27	
• Annual change in the size of the waiting list • % of all cancers diagnosed at stage 1 or 2 • % of patients to describe booking a general practice appointment as easy • Acute bed days per 100,000 people (Occupied bed days per 100,000 head of population) • Average number of days from discharge ready date and actual discharge date • % of inappropriate out of area placement adult acute mental health bed days • % of patients who receive all 8 diabetes care processes • % of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance • % of hypertension patients treated to target • % of patients with a preferred general practice professional reporting they were able to get an appointment with that professional • Number of neonatal deaths and stillbirths per 1,000 total births • % of children (aged 0 – 9) prescribed antibiotics in the last 12 months • Sickness absence rate • NHS staff survey engagement theme sub-score	• Planned surplus/deficit • Variance year-to-date to financial plan • *Combined finance score (combination of above 2 finance metrics – not counted in metric total)* • Implied productivity level (year-to-date compared to previous year) • NHS Talking Therapies reliable recovery rate • Cervical screening coverage for females aged 25-64 within the target period • Bowel screening coverage in the last 30 months aged 60-74 • Breast screening coverage in the last 36 months for females aged 53-70 • % of pregnant women who quit smoking (Banded estimate score) • % of patients supported by obesity programmes (Proportion of people taking up lifestyle/behavioural programmes to reduce obesity) • Deprivation and ethnicity gap in pre-term births score • Deprivation gap in early cancer diagnosis gap • % of annual health checks completed for patients with a learning disability or who are autistic • % of SMI patients with a full physical health check

Evolved metrics: 6
• Growth in number of urgent dental appointments provided versus target (changed to Dental UDAs as a % of contracted) • Change in the number of inpatients who are autistic or have a learning disability (changed to Percentage of people with a learning disability and autistic people in mental health hospital with the longest lengths of stay) • GP leaver rate (changed to GP Headcount per capita – *NB: metric is a measure of FTE per 100k total weighted population*) • MMR2 vaccine uptake rate (Methodology updated to align with emerging direction or policy) • Deprivation gap in myocardial infarction admissions (changed to Deprivation gap in lipid management) • Deprivation gap in stroke admissions (changed to Deprivation gap in hypertension management)

New metrics: 10
• Under 75s cancer mortality rate • Under 75s cardiovascular disease mortality rate • % of clinically urgent appointments that happen on the same day • 12-month adult admission rate for people with a learning disability or who are autistic • % of people with 3 or more emergency admissions in the last 90 days of life • % of clinical trials set up within 90 days • Level of growth in community care contacts • % of acute adult mental health admissions with no contact with community mental health services in the previous year • Over 65s bed days per 100,000 head of population • % of complaints open beyond 6 months

Removed metrics: 3
• Percentage of continuing healthcare referrals completed in 28 days • NHS staff survey education and training theme score - "we are always learning" section score • Time spent in good health, before people develop their first significant long term health condition The four system-level contextual metrics (yes/no indicators of system performance) were not included in the published Oversight Framework or Technical Specification for 2026/27, although some have been retained as scoring metrics (e.g. SMI physical health checks) and mentioned above.

5. Impact on Strategic Commissioning Performance Report

Change in Metrics

Where metrics have been added to the NHS Oversight Framework (NOF) for this year, these have been provisionally aligned to commissioning MDTs. This provisional alignment has been shared with MDTs, alongside a list of previously aligned metrics being removed from the NOF, to facilitate discussions around alignment review, prioritisation, ongoing monitoring and action planning which will continue through September 2026.

Change in Metric Methodology

The change in metric methodology from the NHS Oversight Framework in 2025/26 to the framework for 2026/27 will impact on the reported RAG position for some metrics carrying over into the new reporting year.

Additionally, on 1 April 2026, changes were made to some ICB footprints through a series of mergers and one boundary change, resulting in the number of ICBs reducing from 42 to 36. As a result of this change, the national and peer benchmark comparators will change for all metrics with data reporting periods from April 2026 onwards. While some datasets have retroactively applied the new ICB footprints to existing data, this has not been the case for all metrics and, therefore, comparison of benchmarked positions across a time period will not be possible.

NHSE has advised that the People and Culture metric relating to Staff Survey engagement scores will not be scored for ICBs this year as a result of ICB restructuring.

For SCPR reporting national ranking will evolve over the next 18 months as data sources are updated and ICBs formally merge. Where the data period of a metric is after April 2026, the rank provided will be against the new footprints (first stage - 36 ICBs) and new ICB peers. Older metric data will continue to use historic footprints. This will be highlighted in the report.

Change in Local Government Structure

The Government has announced its decision on the future structure of local government in Kent and Medway, which will see all existing councils abolished and replaced by 4 unitary councils (Option 4B) from 1 April 2028.

To support commissioning decision making, service planning and targeted spending at local levels, data ideally would be available at unitary authority level. It does not appear at this stage that current PCN or multi-neighbourhood areas align to the agreed unitary authority footprints.

The Performance and Regulation team will continue to explore where it is possible to map metric performance and outcomes at this level and incorporate this into future reporting.

6. Local Assessment of NOF 2026/27 ICB Metrics

A local assessment of the new National Oversight Framework (NOF) 2026/27 metrics has been undertaken, using the draft technical specification and applying the methodology to available nationally published data, to determine an indicative score for each metric, domain, and overall average score.

There are seven unscored metrics due to a lack of national baseline at present. Methodology for local estimated scores will be reviewed following final publication of national metric scores and technical guidance to ensure alignment.

Based on local assessment of available metrics, the following key performance areas are highlighted:

Primary Community and Neighbourhood Care

- The proportion of patients able to see their preferred GP professional reduced to 63.0% in July 2026, compared with 87.4% in December 2025, and ICB performance for GP access has been in the lowest quartile in the last nine out of ten waves of the Health Insight Survey. Actions are being progressed through the 2026/27 GP contract implementation, modern general practice access, care navigation, digital and telephony improvement, and practice/PCN-level access improvement plans. The Single Neighbourhood Health model, commissioning intentions and NAPC response will be used to strengthen consistency of GP access at neighbourhood and multi-neighbourhood level, with targeted improvement where need and opportunity are greatest.
- The ICB is currently ranked in the lowest quartile nationally for the number of GPs (Full-Time Equivalent) per weighted population. A 24-month improvement response is being mobilised, including a universal core offer, targeted support for highest-risk practices and localities, supervision and leadership support, digital and telephony recovery, estates quick wins and primary-secondary care interface improvement.

Population Health, Prevention and Reducing Inequality

- Local PCN and practice-level analysis shows wide variation in delivery of all eight diabetes care processes, variation in identification, coding, medicines optimisation, recall and follow-up for patients with GP-recorded cardiovascular disease. Improvement will focus on systematic recall, data quality, targeted support to lower-performing practices and PCNs, and use of population health intelligence to identify patients missing one or more diabetes care processes, and prioritisation of higher-risk CVD patient cohorts through population health management.
  This will be aligned to the wider commissioning intentions focus on reducing unwarranted variation in prevention and long-term condition management across neighbourhoods.
- Measles, Mumps and Rubella (MMR) uptake remains poor, with the latest published Q4 2025/26 position at 82.9%, below the level needed to provide population protection and reduce outbreak risk. Performance is affected by variation in call/recall, data quality, parental confidence, access to convenient vaccination opportunities and lower uptake in some underserved communities.

Actions include targeted practice and PCN catch-up activity, data cleansing, strengthened call/recall, focused outreach in lower-uptake communities and continued joint work with the NHS England Screening and Immunisation Team. The winter vaccination plan will use timely uptake and population-health data to direct oversight and improvement, with outreach providers and vaccine ambassadors supporting confidence and access in areas of lower uptake.

Finance

- At Month 4, the ICB is reporting an in-month deficit of £4.2m, in line with plan, resulting in a year-to-date deficit of £16.9m. The required Cost Improvement Plan (CIP) of £49.7m has now been posted in Month 4 to the relevant budgets which allows for close monitoring of savings delivery overseen by the Financial Recovery Group (FRG). Various cost pressures are emerging and are driving adverse year-to-date variances in several areas. These areas will be subject to close monitoring, with active interventions implemented where feasible to contain expenditure and mitigate further risk.

Elective Care

- The elective Referral to Treatment (RTT) waiting list is growing. It has been identified that a key driver of this growth is acute trust under-delivery of the activity required to reduce the waiting list size in line with plans. This is being addressed through contract management escalation.

Performance information and provisional scores have been shared with commissioning multi-disciplinary teams (CMDTs) to support prioritisation discussions for areas of focus. Following publication of the Quarter 1 results, exception reports will be produced for all metrics, and a robust ICB contracting performance management approach will be developed, driven by CMDTs. Action plan development will focus on prioritised metrics in the first instance, to identify and articulate areas where current plans are not delivering expected improvements, or where further actions are required. The Performance and Regulation Team will work with MDTs to develop a corporate approach for reporting against action plans to address performance areas of focus, including mitigating actions, trajectories and expected impact.

Kent and Medway most up-to-date local assessment of NOF (2026/27) ICB Metrics
(published data, which is not yet reported on Model Health System)

Domain	Sub-domain	No of Metrics	No of Scoring Metrics	Total Score	Average Score		
Population health, prevention and reducing inequality	Population Health	2	0	-	-	3.13	*1 cannot be scored at this time
	Preventing ill health	8	5	14.90	2.98		
	Reducing inequality	4	4	13.24	3.31		
Allocating Resources		8	5	12.14	2.43	2.43	*1 cannot be scored at this time
Experience of Care	Experience	3	2	6.00	3.00	2.64	*1 cannot be scored at this time
	Patient Flow	3	2	4.57	2.29		
Effectiveness of Care	Outcomes	3	2	4.00	2.00	2.56	*3 cannot be scored at this time
	Managing LTCs	5	3	8.81	2.94		
Patient Safety		2	2	4.17	2.09	2.09	
Finance, productivity and innovation		4	2	3.00	1.50	1.50	*1 cannot be scored at this time
People		2	2	6.20	3.10	3.10	
		44	29	77.03	2.66	2.66	

Kent and Medway most up-to-date local assessment of NOF (2026/27) ICB Metrics

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

NHS
Kent and Medway

Population health, prevention and reducing inequality

- 4 out of 10 scoring metrics in the highest 2 quartiles (all in quartile 2)
- 2 contextual Popuation Health metrics (nationally benchmarked in quartiles 2 and 3)
- 4 metrics in the lowest quartile nationally
  - MMRV (measles, mumps, rubella and varicella) uptake rate
  - Percentage of eligible people supported by obesity prevention programmes
  - Deprivation and ethnicity gap in pre-term births
  - Deprivation gap in lipid management

Indicative Domain Score 3.13

Allocating resources

- 3 out of 6 scoring metrics in the highest 2 quartiles with 1 TBD
- 2 contextual metrics (one benchmarked in quartile 3, one TBD)
- No metrics are assessed as being in the lowest quartile nationally

Indicative Domain Score 2.43

Experience of care

- 2 out of 5 scoring metrics in the highest 2 quartiles (quartile 2), with 1 TBD
- One contextual metric (nationally benchmarked in quartile 1)
- One metric in the lowest quartile nationally
- Percentage of patients rating their experience of GP access is easy

Indicative Domain Score 2.64

Overall Average	2.66
Indicative unadjusted segment	3

Effectiveness of care

- 2 out of 8 scoring metrics in the highest 2 quartiles
- 4 metrics in the lowest quartile nationally
  - Percentage of patients who receive all 8 diabetes care processes
  - Percentage of patients with GP recorded hypertension whose blood pressure is managed to NICE guidance
  - Percentage of patients with GP recorded cardiovascular disease whose cholesterol is managed to NICE guidance
  - Percentage of people aged 14+ on the QOF Learning Disability Register with an annual health check and health action plan

Indicative Domain Score 2.56

Patient safety

- 2 out of 2 scoring metrics in the highest 2 quartiles (in quartile 2)

Indicative Domain Score 2.09

Finance, productivity and innovation

- National benchmarking not available for locally reported finance metrics
- One productivity contextual metric nationally benchmarked in quartile 2
- One innovation metric with score TBD

Indicative Domain Score 1.50

People

- 1 out of 2 scoring metrics in the highest 2 quartiles (all in quartile 2)
- 1 metric in the lowest quartile nationally
  - Number of general practitioners per 100k head of weighted population

Indicative Domain Score 3.10

NB: Indicative domain score calculated using locally assessed metrics that were able to be scored. All metrics calculated in this report are indicative only, based on currently available nationally published data, calculated in line with developing NHSE technical specifications. Methodology for local estimated scores will be reviewed following publication of national metric scores to ensure alignment.

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7. KEY RISKS, MITIGATIONS, AND CONTROLS

None to note.

8. OTHER CONSIDERATIONS

No other considerations to state.

9. REQUIRED OUTCOMES AND NEXT STEPS

The Board is asked to:

- **NOTE** the changes in the NHS Oversight Framework for 2026/27 and the impact on future SCPR reporting, noting the absence of a full release of benchmarking data from NHSE.

The following next steps should be noted:

- Development of a corporate approach to commissioning MDT reporting against action plans to address performance areas of focus
- Refresh of reported ICB key strategic actions in line with 2026/27 business plan
- Refresh of ICB metrics in line with the publication of the 2026/27 NHS Oversight Framework (Quarter 1 anticipated to be reported nationally from September 2026).

10. SUPPORTING DOCUMENTATION

Slide pack attached.

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Kent and Medway ICB
Strategic Commissioning Performance Report

August 2026 (September Committees)

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Executive Summary

Summary Overview

This iteration of the ICB's Strategic Commissioning and Performance Report (SCPR) includes the ICB position against both Statutory and key strategic ICB actions from national guidance, and the Q4 2025/26 performance against the NHS Oversight Framework (NOF) ICB-level metrics, aligned to Commissioning Multi-Disciplinary Teams (CMDTs), with a local assessment provided based on more recent published data for metrics included in the newly published NOF 2026/27.

A summary of changes from the 2025/26 NOF, evolution of metrics and impact on Strategic Commissioning Performance Reporting has also been included.

Highlights

NHS Oversight Framework 2025/26

- In Q4 2025/26 of 43 Contextual metrics the ICB is RAG rated either Red or Amber/Red for 31 metrics (72.1%). This represents a deterioration compared with Q3, where 27 metrics (62.8%) were in the lower quartiles.
- 12 metrics (27.9%) are rated Green or Green/Amber, down from 15 metrics (34.9%) in Q3.
- ICB RAG is based on comparative benchmarking. All domains contain metrics in the lower quartiles, but the weakest areas in the published Q4 position are:
  - Access – 3 of 4 metrics in Red or Amber/Red
  - Effectiveness and experience of care – 8 of 9 metrics in Red or Amber/Red
  - There is also significant pressure in Patient safety, where 3 of 3 benchmarked metrics are in the lower quartiles.
- A summary narrative has been provided outlining actions being taken to address lower quartile and deteriorating metrics.

Provisional Scoring against NHS Oversight Framework 2026/27

- Local assessment of currently available nationally published data has been undertaken to provide an indication of how the ICB may score using the 2026/27 NOF methodology. Scores have been calculated in line with developing NHSE technical specifications, which are still subject to change, and some metric data sources are not published nationally. Methodology for local estimated scores will be reviewed following publication of national metric scores to ensure alignment.
- It is not possible to directly compare between 2025/26 and 2026/27 performance against each other, due to changing methodology in individual metric calculation, the change in methodology provides a robust framework to measure improvement and the inclusion of fixed targets supports identification of areas for focussed commissioning activity.

Regulatory Compliance

NHS Oversight Framework 2026/27 Update

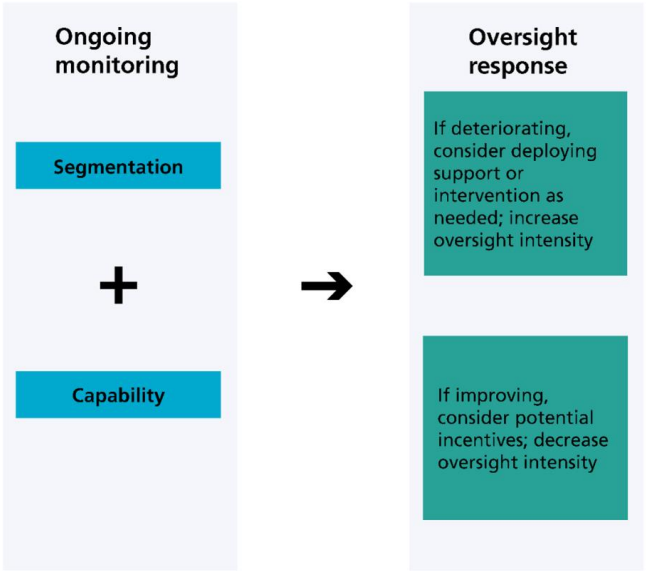
The NHS Oversight Framework for 2026/27 was published in June 2026, updating the 2025/26 Framework to provide clarity around accountability, reflect the maturing NHS operating model and align with the priorities in the NHS Medium-Term Planning Framework and 10-Year Health Plan.

The key changes made to the framework for 2026/27 are:

- alignment of the segmentation approach for ICBs and providers. ICBs were not segmented in 2025/26 due to a recognition of structural changes taking place.
- updates to the oversight metrics: aligned to the Medium-Term Planning Framework and feedback from the service
- refinement of the delivery segmentation methodology, moving from a quartile-based approach to statistical thresholds, to make tracking of improvement easier
- a clearer oversight response model: linking delivery segmentation, organisational capability, and ongoing monitoring to engagement, support, incentives, and consequences.

Oversight Approach

NHSE's oversight approach uses a combination of **delivery monitoring (segmentation),** which is used to identify whether support or intervention is needed; and **capability monitoring** (likely from 2027/28), which is used to determine how capable an organisation is to manage its support needs. These are used to inform NHSE's **oversight response:**



ICB Segmentation

Organisations are measured against the metrics set out in the NOF. The metrics are split into 7 domains. Each individual scoring metric is scored on a range of 1.00 (Best) to 4.00 (Worst), which are then used to calculate average **domain scores** and overall **organisational delivery scores.**

Organisational delivery scores are benchmarked nationally using defined rules to translate the score into a segment of 1,2,3 or 4. A financial deficit override is in place for organisations within the segmentation methodology, i.e. an organisation cannot be higher than segment 3 if it has an organisation-level financial deficit (including planned and agreed deficits).

NHS Oversight Framework 2026/27 Update

Scoring and Contextual Metrics

Metrics are divided into 7 domains, and each organisation is scored against all non-contextual metrics for which it supplies data. Each metric results in a score ranging from 1.00 (Best possible score) to 4.00 (lowest possible score) in line with one of four broad models:

- **Target and spread –** A target value is identified and any organisation meeting that value scores 1.00. Organisations not meeting the target are evenly ranked to two decimal places from 2.00 (Closest to the target without hitting it) to 4.00 (Furthest from the target)
- **Banded score** – Specific criteria are set which relate to defined scores e.g. a value between X% and Y% will score 1.00, etc
- **Floor and spread** - A lowest acceptable value is identified and any organisation failing to meet that value scores 4.00. Organisations exceeding the floor are evenly ranked to two decimal places from 3.00 (Closest to the floor without hitting it) to 1.00 (Furthest from the floor)
- **Even spread** – The highest performing organisation scores 1.00 and the lowest performing organisation scores 4.00. All other organisations are evenly ranked to two decimal places in between based on relative performance
- Of the 43 ICB-level metrics included in NOF 2026/27, 6 are contextual, with the remaining 37 metrics using the following scoring models:

Scoring					Non- scoring
Target & Spread	Banded Score	Floor & Spread	Even Spread	Target, Floor & Spread	Contextual Metrics
9	16	0	10	2	6

- The mean average from 2025/26 (2.34) has been used to determine the threshold between segment 2 and 3, and the standard deviation (how much values typically vary from the mean average) to determine the thresholds for segments 1 and 4.
- As these thresholds have been set using 2025/26 data, they may need to be revised if 2026/27 performance shows a substantial difference:

Segment	Average Metric Score
1	Below 1.94
2	1.94 to 2.33
3	2.34 to 2.77
4	Above 2.77

NHS Oversight Framework (2025/26)
ICB Contextual metrics

Kent and Medway Q4 Position
(as published on Model Health System)

2.1 NHS Oversight Framework (Q4 2025/26) ICB Contextual Metrics Overview

	RAG		Nat. Rank	Peer Rank
Annual change in the size of the waiting list (Monthly)	A/R		25/42	3/6
Percentage of all cancers diagnosed at stage 1 or 2 (Band Score)* (Monthly)	G/A		20/42	4/6
Growth in number of urgent dental appointments provided versus target (Monthly)	A/R		23/36	4/6
Percentage of patients to describe booking a general practice appointment as easy (Monthly)	R		38/42	6/6
Acute bed days per 100,000 people (Quarterly)	G		9/42	1/6
Change in the number of inpatients who are autistic or have a learning disability** (Quarterly)	R		22/36	3/6
Average number of days from discharge ready date and actual discharge date (Monthly)	R		32/42	4/6
Percentage of continuing healthcare referrals completed in 28 days (Quarterly)	R		41/42	6/6
Percentage of inappropriate out of area placement adult acute mental health bed days (Quarterly)	A/R		24/42	4/6
Percentage of patients who receive all 8 diabetes care processes (Quarterly)	R		38/42	5/6
Percentage of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance (Quarterly)	R		40/42	6/6
Percentage of hypertension patients treated to target (Quarterly)	R		41/42	6/6
Percentage of patients with a preferred general practice professional reporting they were able to get an appointment with that professional (Monthly)	A/R		29/42	4/6
NHS Staff Survey – raising concerns sub-score (Annually)	R		39/41	6/6
Number of neonatal deaths and stillbirths per 1,000 total births (banded score) (Annually)	A/R		11/42	5/6
Percentage of children (aged 0 – 9) prescribed antibiotics in the last 12 months (Monthly)	R		17/36	3/6
Sickness absence rate (Quarterly)	A/R		24/42	3/6
NHS staff survey engagement theme sub-score (Annually)	R		41/42	6/6
NHS staff survey education and training theme score - “we are always learning” section score (Annually)	A/R		30/42	4/6
GP leaver rate (Quarterly)	A/R		26/42	4/6
Planned surplus/deficit (Monthly)	G		7/42	1/6
Variance year-to-date to financial plan (Monthly)	R		42/42	6/6
Combined finance score ()	A/R			
Implied productivity level (year-to-date compared to previous year) (Monthly)	G/A		12/42	3/6

		RAG		Nat. Rank	Peer Rank
Improving Health and Reducing Inequalities	Time spent in good health, before people develop their first significant long term health condition (Annually)	A/R		31/42	5/6
	NHS Talking Therapies reliable recovery rate (Monthly)	A/R		22/42	4/6
	Cervical screening coverage for females aged 25-64 within the target period (Monthly)	G/A		21/42	2/4
	Bowel screening coverage in the last 30 months aged 60-74 (Monthly)	A/R		23/42	6/6
	Breast screening coverage in the last 36 months for females aged 53-70 (Monthly)	G/A		27/42	3/6
	Percentage of pregnant women who quit smoking (Banded estimate score) (Monthly)	A/R		25/42	3/6
	Percentage of patients supported by obesity programmes (Proportion of people taking up lifestyle/behavioural programmes to reduce obesity) -Banded score (Quarterly)	A/R		36/42	5/6
	MMR vaccine uptake rate - Percentage of children to receive two doses of MMR vaccine before their 5th birthday (Quarterly)	R		33/42	6/6
	Deprivation and ethnicity gap in pre-term births score (composite scored band) (Quarterly)	A/R		33/42	4/6
	Deprivation gap in early cancer diagnosis (Quarterly)	G/A		18/42	3/6
	Deprivation gap in myocardial infarction admissions (rolling annual) (Monthly)	G		10/42	1/6
	Deprivation gap in stroke admissions (rolling annual) (Monthly)	G/A		10/30	2/4
	Percentage of annual health checks completed for patients with a learning disability or who are autistic (Banded score) (Monthly)	A/R		24/42	2/6
System Performance for ICBs	Has the system been in the lowest quartile for 4 hour UEC performance for each of the last three months? (Quarterly)	G		32	4
	Has the system been in the lowest quartile for 18-week performance for each month of the last quarter? (Quarterly)	G		42	6
	Has the system been in the lowest quartile for 62-day performance for each month of the last quarter? (Quarterly)	G		25	4
	Is the system in the lowest quartile for overall primary care patient satisfaction? (Quarterly)	R		41	6
	Is the system’s proportion of annual physical health checks for those with severe mental illness completed in the last year below 60%? (Quarterly)	R		12	2
	Is the system projecting an annual deficit of over 2.5% or a deficit below 2.5% that is over 1% off plan? (Quarterly)	G		13	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

This report is based on the Model Health System published figure as at 24/06/2026

Kent and Medway Q4 Position (as published on Model Health System)

No.	Domain	Domain Sub-Group	Metric	MDT	MDT Priority	ICB Lead	Data Frequency	Latest Data Period	Q4 Performance	Q3 Performance	Q4 vs Q3 Performance Movement	National Quartile	National Average	National Rank	Peer Rank
1	Access	Elective care	Annual change in the size of the waiting list	Electives Diagnostics & Cancer	Yes	Deputy CE and CCO	Monthly	Mar-2026	-2.03%	-1.57%	Improved	A/R	-3.86%	25/42	3/6
2		Cancer Care	Percentage of all cancers diagnosed at stage 1 or 2 (Band Score)*	Electives Diagnostics & Cancer	Yes	Deputy CE and CCO	Monthly	Mar-2026	1.51%	1.51%	No Change	G/A	1.49%	20/42	4/6
3		Primary care	Growth in number of urgent dental appointments provided versus target	Primary Community & Neighbourhood		Deputy CE and CCO	Monthly	Sep-2025	90.68%	90.68%	No Change	A/R	91.16%	23/36	4/6
4			Percentage of patients to describe booking a general practice appointment as easy	Primary Community & Neighbourhood	Yes	Deputy CE and CCO	Monthly	Mar-2026	68.00%	67.60%	Improved	R	75.00%	38/42	6/6
5	Effectiveness and experience of care	Discharges	Acute bed days per 100,000 people	UEC & Flow	Yes	Deputy CE and CCO	Quarterly	Q4 2025/26	80.56	129.15	Improved	G	91.23	9/42	1/6
6		Inpatients (Mental Health)	Change in the number of inpatients who are autistic or have a learning disability**	Mental Health & Learning Disabilities	TBC	Deputy CE and CCO	Quarterly	Q4 2025/26	4	4	No Change	R	N/A	22/36	3/6
7		Discharges	Average number of days from discharge ready date and actual discharge date	UEC & Flow	Yes	Deputy CE and CCO	Monthly	Mar-2026	1.13	1.22	Improved	R	0.88	32/42	4/6
8		Community Health Services	Percentage of continuing healthcare referrals completed in 28 days	TBC		Deputy CE and CCO	Quarterly	Q4 2025/26	26.00%	48.56%	Deteriorated	R	80.45%	41/42	6/6
9		Inpatients (Mental Health)	Percentage of inappropriate out of area placement adult acute mental health bed days	Mental Health & Learning Disabilities	TBC	Deputy CE and CCO	Quarterly	Q4 2025/26	2.00%	3.94%	Improved	A/R	1.50%	24/42	4/6
10		Effectiveness	Percentage of patients who receive all 8 diabetes care processes	Primary Community & Neighbourhood	Yes	Deputy CE and CCO	Quarterly	Q3 2025/26	35.29%	49.80%	Deteriorated	R	41.30%	38/42	5/6
11		Prevention	Percentage of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Primary Community & Neighbourhood	Yes	Deputy CE and CCO	Quarterly	Q3 2025/26	45.66%	43.12%	Improved	R	50.94%	40/42	6/6
12			Percentage of hypertension patients treated to target	Primary Community & Neighbourhood	Yes	Deputy CE and CCO	Quarterly	Q3 2025/26	65.39%	64.64%	Improved	R	69.3%	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	Primary Community & Neighbourhood		Deputy CE and CCO	Monthly	Mar-2026	76.4%	87.4%	Deteriorated	A/R	80.0%	29/42	4/6
14	Patient safety	Patient safety	NHS Staff Survey – raising concerns sub-score	Culture & Wellbeing		JCPCO	Annually	2024	5.72	5.72	No Change	R	6.45	39/41	6/6
15			Number of neonatal deaths and stillbirths per 1,000 total births (banded score)	TBC		Deputy CE and CCO	Annually	2024	3.00	3.00	No Change	A/R	N/A	11/42	5/6
16		Primary care	Percentage of children (aged 0 – 9) prescribed antibiotics in the last 12 months	Medicines Optimisation		CMOO	Monthly	Mar-2026	25.9%	26.1%	Improved	R	27.3%	17/36	3/6
17	People and workforce	People and workforce	Sickness absence rate	Operational HR		JCPCO	Quarterly	Q3 2025/26	4.56%	3.18%	Deteriorated	A/R	4.27%	24/42	3/6
18			NHS staff survey engagement theme sub-score	Culture & Wellbeing		JCPCO	Annually	2024	6.03	6.03	No Change	R	6.63	41/42	6/6
19			NHS staff survey education and training theme score - "we are always learning" section score	Culture & Wellbeing		JCPCO	Annually	2024	4.90	4.90	No Change	A/R	5.17	30/42	4/6
20		Primary care	GP leaver rate	Primary Community & Neighbourhood		Deputy CE and CCO	Quarterly	Q4 2025/26	7.18%	4.62%	Deteriorated	A/R	6.93%	26/42	4/6
21	Finance and productivity	Finance	Planned surplus/deficit	Finanacial Strategy		CFO	Monthly	Q4 2025/26	0.26%	0.26%	No Change	G	0.00%	7/42	1/6
22			Variance year-to-date to financial plan	Financial Performance		CFO	Monthly	Q4 2025/26	-1.30	-0.67	Deteriorated	R	0.00	42/42	6/6
23			Combined finance score	Financial Performance		CFO		Q4 2025/26	3.00	2.00	Deteriorated	A/R	0.00%		
24		Productivity	Implied productivity level (year-to-date compared to previous year)	Financial Performance		CFO	Monthly	Q4 2025/26	3.90%	3.60%	Improved	G/A	2.70%	12/42	3/6

This report is based on the Model Health System published figure as at 24/06/2026

Kent and Medway Q4 Position (as published on Model Health System)

No.	Domain	Domain Sub-Group	Metric	MDT	MDT Priority	ICB Lead	Data Frequency	Latest Data Period	Q4 Performance	Q3 Performance	Q4 vs Q3 Performance Movement	National Quartile	National Average	National Rank	Peer Rank
25	Improving health and reducing inequality	Improving population health	Time spent in good health, before people develop their first significant long term health condition	Prevention		Director of Strategic Change and Population Health	Annually	Mar-2026	48.83	48.83	No Change	A/R	49.25	31/42	5/6
40			NHS Talking Therapies reliable recovery rate	Mental Health & Learning Disabilities		Director System Commissioning and Operational Planning	Monthly	Mar-2026	49%	45%	Improved	A/R	0.49	22/42	4/6
26a		Primary prevention	Cervical screening coverage for females aged 25-64 within the target period	Primary Community & Neighbourhood		Deputy CE and CCO	Monthly	Jun-2025	71.70%	71.70%	No Change	G/A	71.66%	21/42	2/4
26b			Bowel screening coverage in the last 30 months aged 60-74	Primary Community & Neighbourhood		Deputy CE and CCO	Monthly	Mar-2024	72.96%	72.96%	No Change	A/R	73.02%	23/42	6/6
26c			Breast screening coverage in the last 36 months for females aged 53-70	Primary Community & Neighbourhood		Deputy CE and CCO	Monthly	Mar-2024	74.10%	74.10%	No Change	G/A	73.07%	27/42	3/6
27			Percentage of pregnant women who quit smoking (Banded estimate score)	Primary Community & Neighbourhood		Deputy CE and CCO	Monthly	Jun-2025	2.25	2.25	No Change	A/R	2.00	25/42	3/6
28			Percentage of patients supported by obesity programmes (Proportion of people taking up lifestyle/behavioural programmes to reduce obesity) - Banded score	Primary Community & Neighbourhood		Deputy CE and CCO	Quarterly	Q4 2025/26	3.10	3.17	Improved	A/R	2.43	36/42	5/6
29			MMR vaccine uptake rate - Percentage of children to receive two doses of MMR vaccine before their 5th birthday	Primary Community & Neighbourhood		Deputy CE and CCO	Quarterly	Dec-2025	83.70%	83.70%	No Change	R	87.0%	33/42	6/6
30		Inequalities	Deprivation and ethnicity gap in pre-term births score (composite scored band)	TBC		CMOO	Quarterly	Q4 2025/26	3	3	No Change	A/R	2	33/42	4/6
31			Deprivation gap in early cancer diagnosis	Electives Diagnostics & Cancer	Yes	CMOO	Quarterly	Q4 2025/26	6.05%	6.05%	No Change	G/A	6.67%	18/42	3/6
32a			Deprivation gap in myocardial infarction admissions (rolling annual)	Electives Diagnostics & Cancer	Yes	CMOO	Monthly	Mar-2026	22.80%	24.44%	Improved	G	25.54%	10/42	1/6
32b			Deprivation gap in stroke admissions (rolling annual)	Electives Diagnostics & Cancer	Yes	CMOO	Monthly	Mar-2026	21.40%	15.73%	Deteriorated	G/A	26.35%	10/30	2/4
33			Percentage of annual health checks completed for patients with a learning disability or who are autistic (Banded score)	Mental Health & Learning Disabilities	TBC	Deputy CE and CCO	Monthly	Q4 2025/26	3	2	Deteriorated	A/R	N/A	24/42	2/6
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?**	**UEC & Flow**	**Yes**	Deputy CE and CCO	Quarterly	Q4 2025/26			No Change	N/A	N/A	32	4
35		**Elective care**	**Has the system been in the lowest quartile for 18-week performance for each month of the last quarter?**	**Electives Diagnostics & Cancer**	**Yes**	Deputy CE and CCO	Quarterly	Q4 2025/26			No Change	N/A	N/A	42	6
36		**Cancer Care**	**Has the system been in the lowest quartile for 62-day performance for each month of the last quarter?**	**Electives Diagnostics & Cancer**	**Yes**	Deputy CE and CCO	Quarterly	Q4 2025/26			No Change	N/A	N/A	25	4
37		**Primary care**	**Is the system in the lowest quartile for overall primary care patient satisfaction?**	**Primary Community & Neighbourhood**		Deputy CE and CCO	Quarterly	Q4 2025/26			Improved	N/A	N/A	41	6
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%?**	**Mental Health & Learning Disabilities**	**TBC**	Deputy CE and CCO	Quarterly	Q4 2025/26			No Change	N/A	N/A	12	2
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?**	**Financial Recovery**		CFO	Quarterly	Q4 2025/26			No Change	N/A	N/A	13	4

* Fixed national England target expected at or below 27%

This report is based on the Model Health System published figure as at 24/06/2026

NHS Oversight Framework (2026/27)
ICB Level 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 of NOF (2026/27) ICB Metrics

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

Kent and Medway

Domain	Sub-domain	No of Metrics	No of Scoring Metrics	Total Score	Average Score		
Population health, prevention and reducing inequality	Population Health	2	0	-	-	3.13	*1 cannot be scored at this time
	Preventing ill health	8	5	14.90	2.98		
	Reducing inequality	4	4	13.24	3.31		
Allocating Resources		8	5	12.14	2.43	2.43	*1 cannot be scored at this time
Experience of Care	Experience	3	2	6.00	3.00	2.64	*1 cannot be scored at this time
	Patient Flow	3	2	4.57	2.29		
Effectiveness of Care	Outcomes	3	2	4.00	2.00	2.56	*3 cannot be scored at this time
	Managing LTCs	5	3	8.81	2.94		
Patient Safety		2	2	4.17	2.09	2.09	
Finance, productivity and innovation		4	2	3.00	1.50	1.50	*1 cannot be scored at this time
People		2	2	6.20	3.10	3.10	
		44	29	77.03	2.66	2.66	

NB: Indicative domain score calculated using locally assessed metrics that were able to be scored. All metrics calculated in this report are indicative only, based on currently available nationally published data, calculated in line with developing NHSE technical specifications. Methodology for local estimated scores will be reviewed following publication of national metric scores to ensure alignment.

Kent and Medway most up-to-date local assessment of NOF (2026/27) ICB Metrics

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

Population health, prevention and reducing inequality

- 4 out of 10 scoring metrics in the highest 2 quartiles (all in quartile 2)
- 2 contextual Popuation Health metrics (nationally benchmarked in quartiles 2 and 3)
- 4 metrics in the lowest quartile nationally
  - MMRV (measles, mumps, rubella and varicella) uptake rate
  - Percentage of eligible people supported by obesity prevention programmes
  - Deprivation and ethnicity gap in pre-term births
  - Deprivation gap in lipid management

Indicative Domain Score 3.13

Allocating resources

- 3 out of 6 scoring metrics in the highest 2 quartiles with 1 TBD
- 2 contextual metrics (one benchmarked in quartile 3, one TBD)
- No metrics are assessed as being in the lowest quartile nationally

Indicative Domain Score 2.43

Experience of care

- 2 out of 5 scoring metrics in the highest 2 quartiles (quartile 2), with 1 TBD
- One contextual metric (nationally benchmarked in quartile 1)
- One metric in the lowest quartile nationally
- Percentage of patients rating their experience of GP access is easy

Indicative Domain Score 2.64

Overall Average	2.66
Indicative unadjusted segment	3

Effectiveness of care

- 2 out of 8 scoring metrics in the highest 2 quartiles
- 4 metrics in the lowest quartile nationally
  - Percentage of patients who receive all 8 diabetes care processes
  - Percentage of patients with GP recorded hypertension whose blood pressure is managed to NICE guidance
  - Percentage of patients with GP recorded cardiovascular disease whose cholesterol is managed to NICE guidance
  - Percentage of people aged 14+ on the QOF Learning Disability Register with an annual health check and health action plan

Indicative Domain Score 2.56

Patient safety

- 2 out of 2 scoring metrics in the highest 2 quartiles (in quartile 2)

Indicative Domain Score 2.09

Finance, productivity and innovation

- National benchmarking not available for locally reported finance metrics
- One productivity contextual metric nationally benchmarked in quartile 2
- One innovation metric with score TBD

Indicative Domain Score 1.50

People

- 1 out of 2 scoring metrics in the highest 2 quartiles (all in quartile 2)
- 1 metric in the lowest quartile nationally
  - Number of general practitioners per 100k head of weighted population

Indicative Domain Score 3.10

NB: Indicative domain score calculated using locally assessed metrics that were able to be scored. All metrics calculated in this report are indicative only, based on currently available nationally published data, calculated in line with developing NHSE technical specifications. Methodology for local estimated scores will be reviewed following publication of national metric scores to ensure alignment.

Kent and Medway most up-to-date local assessment of NOF (2026/27) ICB Metrics

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

Domain	Domain Sub-Group	Metric	Commissioning MDT	Data Frequency	Latest Data Period	Latest Performance	Target	National Quartile	National Average	National Rank	Peer Rank	Indicative Score	Scoring Methodology	Distance from Target
Population health, prevention and reducing inequality	Population Health	Under 75s cancer mortality rate	Elective Diagnostics and Cancer	Annually	2024	117.58		3	115.85	23/42	4/6	N/A	Contextual	
		Under 75s cardiovascular disease mortality rate	Elective Diagnostics and Cancer	Annually	2024	68.24		2	68.85	21/42	4/6	N/A	Contextual	
	Preventing ill health	Cervical screening rate	Primary Community and Neighbourhood	Quarterly	To March 2026*	71.70	80.00	2	71.66	21/42	4/6	2.98	Target and spread	8.30
		Bowel screening rate	Primary Community and Neighbourhood	Annually	2024	74.10	76.00	3	74.14	22/42	4/6	2.79	Target, floor, and spread	1.90
		Breast screening rate	Primary Community and Neighbourhood	Annually	2024/25	74.10	80.00	2	73.07	15/42	4/6	2.68	Target and spread	5.90
		MMRV (measles, mumps, rubella and varicella) uptake rate	Primary Community and Neighbourhood	Quarterly	Q4 2025/26	82.90	95.00	4	87.35	35/42	6/6	4.00	Banded score	12.10
		Percentage of eligible people supported by obesity prevention programmes	Elective Diagnostics and Cancer	Quarterly	Q4 2025/26	3.10		4	0.00%	36/42	2/6	0.00	Even spread	
		Sub-metric: Eligible Referrals to lifestyle/behavioural weight management programmes (rate per 100,000 people living with obesity)	Elective Diagnostics and Cancer	Quarterly	Q4 2025/26	181.30		4	255.95	35/42	1/6	N/A	N/A - Sub-metric	
		Sub-metric: The number of people who have started the NHS Diabetes Prevention Programme (rate per 1,000)	Elective Diagnostics and Cancer	Quarterly	Q4 2025/26	12.77		3	25.00	12.77/42	3/6	N/A	N/A - Sub-metric	
		Percentage of pregnant women who quit smoking	Executive Committee	Quarterly	Oct-25	31.80		2	30.90	18/33	3/6	2.46	Even spread	
	Reducing inequality	Deprivation gap in early cancer diagnosis	Elective Diagnostics and Cancer	Annually	2024/25	6.05		2	6.67	18/42	3/6	3.00	Banded score	
		Deprivation and ethnicity gap in pre-term births	Executive Committee	Quarterly	Q4 2025/26	3.00		4	2.00	33/42	4/6	3.00	Banded score	
		Deprivation gap in lipid management	Primary Community and Neighbourhood	Quarterly	Dec-25	-12.65%	0%	4	-7.29%	38/42	6/6	3.78	Banded score	12.65%
		Deprivation gap in hypertension management	Primary Community and Neighbourhood	Quarterly	Dec-25	-9.47%	0%	3	-7.65%	31/42	4/6	3.46	Banded score	9.47%

NB: All metrics calculated in this report are indicative only, based on currently available nationally published data, calculated in line with developing NHSE technical specifications. Methodology for local estimated scores will be reviewed following publication of national metric scores to ensure alignment.

Kent and Medway most up-to-date local assessment of NOF (2026/27) ICB Metrics

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

Domain	Domain Sub-Group	Metric	Commissioning MDT	Data Frequency	Latest Data Period	Latest Performance	Target	National Quartile	National Average	National Rank	Peer Rank	Indicative Score	Scoring Methodology	Distance from Target
Allocating Resources	Elective Care	Percentage change in overall waiting list size vs previous year	Elective Diagnostics and Cancer	Monthly	Jun-2026	0.67		3	-1.33	22/36	3/6	3.00	Even spread	
	Community Care	Level of growth in community care contacts	Primary Community and Neighbourhood	Quarterly (aggregated)	TBD	TBD		TBD	TBD	TBD	TBD	TBD	Banded score	
	Cancer Care	Percentage of cancers diagnosed at stage 1 or 2	Elective Diagnostics and Cancer	Monthly	Mar-26	1.51%		2	1.49%	20/42	4/6	2.00	Banded score	Increase staging completeness by 2.7% (currently 77.3%)
	Mental Health Care	Percentage of acute adult mental health admissions with no contact with community mental health services in the previous year	Mental Health Learning Disabilities and Autism	Monthly	May-26	6.00%		2	10.00%	5/36	1/6	2.00	Banded score	-1.00%
	Urgent Care	Occupied bed days per 100,000 head of population	UEC and Flow	Quarterly	Q4 2025/26	80.56		1	91.23	9/42	1/6	2.00	Banded score	3.74
	Primary Care	Percentage of clinically urgent appointments that happen on the same day	Primary Community and Neighbourhood	Monthly	Jun-26	76.50%	90%	3	77.3%	21/36	3/6	3.14	Target and spread	13.50%
	Dental Care	Units of dental activity delivered as a percentage of commissioned	Primary Community and Neighbourhood	Quarterly	Not currently published	TBD		TBD	TBD	TBD	TBD	TBD	Contextual	
	Learning disabilities and people who are autistic	Percentage of people with a learning disability and autistic people in a mental health hospital with the longest length of stay	Mental Health Learning Disabilities and Autism	Monthly	Jun-26	52.00%		3	43.50%	27/36	5/6	N/A	Contextual	
Experience of Care	Experience	Percentage of patients rating their experience of GP access as easy	Primary Community and Neighbourhood	Monthly	Jul-26 (Wave 26)	69.10%		4	75.65%	33/36	5/6	4.00	Banded score	Lowest for 9 out of last 10 waves Minimum of 3 months sustained performance above lowest quartile to change score
		Percentage of people with a preferred general practice professional able to see or speak with that professional	Primary Community and Neighbourhood	Monthly	Jul-26 (Wave 26)	63.00%		3	64.50%	26/36	3/6	2.00	Banded score	Worsening position No highest quartile performance for last 7 waves. Lowest quartile performance in wave 25.
		Percentage of all complaints received open beyond six months without a response	Executive Committee	TBD	None	TBD	0%	TBD	TBD	TBD	TBD	TBD	Target and spread	TBD - data not currently published
	Patient Flow	12-month adult admission rate for people with a learning disability and autistic people in mental health hospital	Mental Health Learning Disabilities and Autism	Monthly	Jul-26	5 per million		1	35 per million	1/36	1/6	N/A	Contextual	
		Percentage of ICB commissioned adult inappropriate out of area placement bed days as a proportion of all ICB commissioned bed days	Mental Health Learning Disabilities and Autism	Quarterly	Jun-26	Acute MH: 1% MHLDA acute / rehab: 13%		2		13/36	3/6	2.00	Banded score	Reduce MHLDA OAP by 8%
		Average number of days between discharge ready date and actual discharge date	UEC and Flow	Monthly	Jun-26	1.09		3	0.94	27/36	6/6	2.57	Even spread	

NB: All metrics calculated in this report are indicative only, based on currently available nationally published data, calculated in line with developing NHSE technical specifications. Methodology for local estimated scores will be reviewed following publication of national metric scores to ensure alignment.

Kent and Medway most up-to-date local assessment of NOF (2026/27) ICB Metrics

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

Kent and Medw

Domain	Domain Sub-Group	Metric	Commissioning MDT	Data Frequency	Latest Data Period	Latest Performance	Target	National Quartile	National Average	National Rank	Peer Rank	Indicative Score	Scoring Methodology	Distance from Target
Effectiveness of Care	Outcomes	Percentage of NHS Talking Therapies patients completing a course of treatment and achieving reliable recovery	Mental Health Learning Disabilities and Autism	Monthly	Mar-26	49.00%		3	49.00%	22/42	4/6	3.00	Banded score	To Band 2 - 1% To Band 1 - 3%
		Percentage of people with 3 or more emergency admissions in the last 90 days of life	UEC and Flow	Annually	2024	4.57		1	6.55	3/42	1/6	1.00	Banded score	
		Over 65s bed days per 100,000 head of population	UEC and Flow	TBD	TBD	TBD		TBD	TBD	TBD	TBD	TBD	Even spread	TBD - data not currently published
	Managing Long Term Conditions	Percentage of patients who receive all eight diabetes care processes	Primary Community and Neighbourhood	Quarterly	Q4 25/26	49.81%		4	56.70%	38/42	5/6	3.81	Even spread	
		Percentage of patients with GP recorded cardiovascular disease, whose cholesterol is managed to NICE guidance	Primary Community and Neighbourhood	Quarterly	Q3 25/26	45.65% (raw value)	0%	4	50.94%	40/42 (NOF 25/26 calculation)	6/6	TBD	Target and spread	TBD - baseline March 26
		Percentage of patients with GP recorded hypertension whose blood pressure is managed to NICE guidance	Primary Community and Neighbourhood	Quarterly	Q3 25/26	65.39% (raw value)	0%	4	69.34%	41/42 (NOF 25/26 calculation)	6/6	TBD	Target and spread	TBD - baseline March 26
		Patients on the GP severe mental illness register receiving a full physical health check	Mental Health Learning Disabilities and Autism	Quarterly	Q4 25/26	59.00%	68%	2	65.00%	33/42	5/6	3.00	Banded score	To Band 2 - 1% To Band 1 - 9%
		Percentage of people aged 14+ on the QOF Learning Disability Register with an annual health check and health action plan.	Mental Health Learning Disabilities and Autism	Monthly	Jun-26	11.15%		4	13.44%	31/36 (raw % value)	4/6	2.00	Banded score	Above previous year: Jul - 18.6% Aug - 23.9%
Patient Safety	Safe Practice	Percentage of children aged 0-9 years prescribed antibiotics in primary care	Executive Committee	Monthly	May-26	26.04%	<25%	2	27.46%	14/36	1/6	2.17	Target and spread	1.04%
	Safe Outcomes	Number of neonatal deaths and stillbirths per 1,000 total births	Executive Committee	Annually	2024	4.55		2	4.77	12/42	4/6	2	Banded score	Currently 5.03% below average (4.77) - close to Band 3
Finance, productivity and innovation	Finance	Planned surplus/deficit	Executive Committee	Monthly	July-26	-0.94%				TBD		2.00	Banded score	Below surplus or deficit
		Variance to plan year-to-date	Executive Committee	Monthly	July-26	0.00%				TBD		1.00	Banded score	Remain on plan or better
	Productivity	Implied productivity growth	Executive Committee	Quarterly	Q4 2025/26	3.90%		2	2.70%	12/42	3/6	N/A	Contextual	
	Innovation	Percentage of clinical trials set up within 90 days	Executive Committee	Monthly	Jul-26	*72.22% (assumes ICB value = aggregated providers)*	95%			TBD		TBD	Target, floor, and spread	22.78%
People	People and Culture	Sickness absence rate	Executive Committee	Monthly	Apr-26	3.12%		2	3.60%	15/36	2/6	2.20	Even spread	
	Workforce	Number of general practitioners per 100k head of weighted population	Primary Community and Neighbourhood	Quarterly	Jun-26	49.58		4	60.93	36/36	6/6	4.00	Even spread	

NHS Oversight Framework (2025/26)
ICB Contextual metrics

Areas of focus: 2025/26 NHS Oversight Framework

Narrative update for highlighted areas showing deterioration in NHS Oversight Framework (NOF) nationally benchmarked (RAG) position between Q3 and Q4 2025/26, as reported on Model Health System (MHS) and where ICB performance sits in the bottom quartile (Red).

3.0 Areas of focus: 2025/26 NHS Oversight Framework

Narrative update for highlighted areas showing deterioration in NHS Oversight Framework (NOF) nationally benchmarked (RAG) position between Q3 and Q4 2025/26, as reported on Model Health System (MHS) and where ICB performance sits in the bottom quartile (Red).

Deteriorated Metrics

MDT	Metric Name	PUBLISHED							LOCAL			MDT Lead Commentary
		MHS Q3 2025/26			MHS Q4 2025/26				Latest Published			
		Latest period	Actual	RAG	Latest period	Actual	Move-ment	RAG	Latest period	Actual	RAG	
MHLDA	% of annual health checks completed for patients with a learning disability or who are autistic	Q3 25/26	Band 2	G/A	Q4 25/26	Band 3	↓	A/R	Jun-26	Band 2	G/A	Metric calculated as a banded score, combining whether the target was met last year and comparison to the same period in the previous year. Band 2 performance indicates the ICB achieved the target last year, but the latest performance year to date is below that of the same period last year. ICB continues to exceed national target (75%). 25/26 completion rate 77.58% (reduction from 24/25 (79.4%)). Number of dynamic factors that contribute to variation involving the patients themselves, GP Practice procedures, and data recording. Annual Health Check provision is an enhanced service, many GPs will leave the completion of these checks until Q4. The ICB is working with GP practices to change this culture, and actions include monthly Champions meetings with PCNs, operationally driven by a Core Group with representation from all PCN levels; and a Learning Disability Annual Health Check awards scheme, with 21 practices having been awarded to date.
Primary Community and Neighbourhood	% of patients with a preferred GP professional reporting they were able to get an appointment with that professional	Dec-25	87.4%	G	Mar-26	76.4%	↓	A/R	Jul-26	63.0%	A/R	Latest local position remains challenged, with the proportion of patients able to see their preferred GP professional reducing to 63.0% in July 2026, compared with 87.4% in December 2025. The deterioration reflects the combined impact of workforce pressure, appointment model variation, continuity challenges and local differences in demand and clinical capacity. Actions are being progressed through the 2026/27 GP contract implementation, modern general practice access, care navigation, digital and telephony improvement, and practice/PCN-level access improvement plans. The NAPC under-doctoring review and GP Patient Survey outputs will be used to target practical support to localities and practices with the greatest mismatch between population need, workforce capacity and patient experience. Progress will be monitored through access dashboards, GP contract oversight, PCN delivery conversations and neighbourhood health reporting

To Note: Recent publication of NOF 2026/27, including change in metrics and scoring methodology; alongside changes to national ICB Geography and peer comparators will impact comparison for Q1 (publication anticipated on MHS late August 2026).

3.0 Areas of focus: 2025/26 NHS Oversight Framework

Narrative update for highlighted areas showing deterioration in NHS Oversight Framework (NOF) nationally benchmarked (RAG) position between Q3 and Q4 2025/26, as reported on Model Health System (MHS) and where ICB performance sits in the bottom quartile (Red).

Deteriorated Metrics

MDT	Metric Name	PUBLISHED							LOCAL			MDT Lead Commentary
		MHS Q3 2025/26			MHS Q4 2025/26				Latest Published			
		Latest period	Actual	RAG	Latest period	Actual	Move-ment	RAG	Latest period	Actual	RAG	
Primary Community and Neighbourhood	GP leaver rate	Q3 25/26	4.62%	G	Q4 25/26	7.18%	↓	A/R	Mar-26	7.18%	A/R	This metric is being replaced in the 2026/27 NOF with the number of general practitioners per 100k weighted population; the ICB is currently ranked 36/36 nationally. GP leaver rate deteriorated from 4.62% to 7.18% in Q4 2025/26, moving from Green to Amber/Red and highlighting workforce fragility. The NAPC review confirms that under-doctoring is structural, geographically uneven and driven by complexity, deprivation, workload, supervision requirements, interface pressures and local recruitment and retention risk. A 24-month improvement response is being mobilised, including a universal core offer, targeted support for highest-risk practices and localities, supervision and leadership support, digital and telephony recovery, estates quick wins and primary-secondary care interface improvement. Workforce risks and mitigations will be tracked through primary care contracting, workforce planning, GPIT steering arrangements, neighbourhood oversight and delivery of the general practice improvement plan
Elective Diagnostics and Cancer	% of patients supported by obesity programmes	Q3 25/26	3.17	G/A	Q4 25/26	3.10	↓	A/R	Q4 25/26	3.10	A/R	Metric calculated as a banded score, combining metrics for referrals to Digital Weight Management services and the number of people starting the Diabetes Prevention Programme. The ICB is currently 35 / 42 nationally for eligible referrals to lifestyle/behavioural weight management programmes (181.3 per 100k people living with obesity) and 25 / 42 for people starting the Diabetes Prevention Programme (12.77 per 1,000 pop)
Unaligned	Sickness absence rate	Q2 25/26	3.18%	G/A	Q3 25/26	4.56%	↓	A/R	Apr-26	3.12%	G/A	This metric is calculated quarterly, as an aggregate of monthly figures. ICB sickness absence saw a rise in October and November 25 and has been consistently below 4% since December 2025, remaining within the ICB's usual variation to June 2026.. The latest unpublished ICB position for the month of June July 2026 is 3.164.33%, above the 4% target. . Sickness absence continues to be primarily driven by a small number of long-term absence cases, with mental health-related absence accounting for approximately 50% of all cases and linked to organisational change. The People Team are providing targeted support to managers through regular case reviews, coaching and advice, wellbeing conversations and early intervention approaches.

3.0 Areas of focus: 2025/26 NHS Oversight Framework

Narrative update for highlighted areas showing deterioration in NHS Oversight Framework (NOF) nationally benchmarked (RAG) position between Q3 and Q4 2025/26, as reported on Model Health System (MHS) and where ICB performance sits in the bottom quartile (Red).

Bottom Quartile Metrics

		PUBLISHED							LOCAL			MDT Lead Commentary
		MHS Q3 2025/26			MHS Q4 2025/26				Latest Published			
MDT	Metric Name	Latest period	Actual	RAG	Latest period	Actual	Move-ment	RAG	Latest period	Actual	RAG	
MHLDA	Change in the number of inpatients who are autistic or have a learning disability	Q3 25/26	Band 4	R 🔴	Q4 25/26	Band 4	-	A/R 🔴	Apr-26	0.00%	G 🟢	This metric is being replaced in the 2026/27 NOF with 12-month adult admission rate for people with a learning disability and autistic people in mental health hospital (contextual metric). ICB Current performance is 47% (May 2026) (ranked 14/36). Performance is impacted by longstanding issues with access to appropriate accommodation in the Southeast, and support to providers with the requisite skills and experience to meet the most complex needs. There is a specific strategic group set up, chaired by KCC, to address the system level challenges for this patient group including modelling the financial impact.
Primary Community and Neighbourhood	% of patients to describe booking a general practice appointment as easy	Dec-25	67.60%	R 🔴	Mar-26	68.00%	-	R 🔴	Jul-26	69.10%	R 🔴	Performance remains Red and below national average, although the latest local position shows improvement from 67.6% in December 2025 to 69.1% in July 2026. The GP Patient Survey continues to show significant variation. Improvement actions are aligned to modern general practice access, digital and telephony improvement, care navigation, online consultation, demand and capacity review, and targeted support to practices and PCNs with lower access indicators. The Single Neighbourhood Health model, commissioning intentions and NAPC response will be used to strengthen consistency at neighbourhood and multi-neighbourhood level, with targeted improvement where need and opportunity are greatest. Progress will continue to be tracked through patient experience measures, access dashboards, GP contract oversight and neighbourhood improvement reviews.
Primary Community and Neighbourhood	% of patients who receive all 8 diabetes care processes	Q2 25/26	49.80%	R 🔴	Q3 25/26	35.29%	-	R 🔴	Q4 25/26	49.81%	R 🔴	Latest published position improved to 49.81% in Q4 2025/26, returning close to the Q2 position, but remains Red and below the England comparator level. Local practice-level analysis shows very wide variation in delivery of all eight diabetes care processes, with performance ranging from 5.2% to 83.3% and a local median of 51.5%. Improvement will focus on systematic recall, data quality, targeted support to lower-performing practices and PCNs, and use of population health intelligence to identify patients missing one or more care processes. The commissioning intentions and neighbourhood model will support a more consistent long-term condition offer, with improvement focused where need, deprivation and unwarranted variation are greatest. Delivery will be monitored through primary care quality reporting, PCN delivery conversations, neighbourhood outcomes dashboards and long-term condition improvement plans

3.0 Areas of focus: 2025/26 NHS Oversight Framework

Narrative update for highlighted areas showing deterioration in NHS Oversight Framework (NOF) nationally benchmarked (RAG) position between Q3 and Q4 2025/26, as reported on Model Health System (MHS) and where ICB performance sits in the bottom quartile (Red).

Bottom Quartile Metrics

MDT	Metric Name	PUBLISHED							LOCAL			MDT Lead Commentary
		MHS Q3 2025/26			MHS Q4 2025/26				Latest Published			
		Latest period	Actual	RAG	Latest period	Actual	Move-ment	RAG	Latest period	Actual	RAG	
Primary Community and Neighbourhood	% of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance	Q2 25/26	43.12%	R	Q3 25/26	45.66%	-	R	Q3 25/26	45.66%	R	Performance has improved from 43.12% to 45.66% but remains Red and below the level required to demonstrate consistent cholesterol management to NICE guidance. The position reflects variation in identification, coding, medicines optimisation, recall and follow-up for patients with GP-recorded cardiovascular disease. Actions are being strengthened through targeted case finding, lipid optimisation, pharmacy and medicines optimisation support, practice-level data quality review and prioritisation of higher-risk cohorts through population health management. This will be aligned to the wider commissioning intentions focus on reducing unwarranted variation in prevention and long-term condition management across neighbourhoods. Progress will be tracked through CVD prevention reporting, medicines optimisation oversight, PCN-level long-term condition reviews and neighbourhood outcomes dashboards.
Primary Community and Neighbourhood	% of hypertension patients treated to target	Q2 25/26	64.64%	R	Q3 25/26	65.39%	-	R	Q3 25/26	65.39%	R	Hypertension treated-to-target performance has shown marginal improvement from 64.64% to 65.39% but remains Red and below benchmark. Variation remains significant across practices and neighbourhoods, with drivers including case finding, monitoring, medicines optimisation, follow-up frequency and accurate recording of blood pressure control. Actions include systematic recall, targeted support for practices with lower performance, community pharmacy and medicines optimisation pathways, and use of population health intelligence to identify high-risk and undertreated cohorts. The indicator will be addressed through the 2027/28 commissioning intentions, Single Neighbourhood Health delivery and neighbourhood prevention plans, with a focus on reducing unwarranted variation and health inequalities. Progress will be monitored through primary care quality dashboards, PCN delivery reviews, medicines optimisation reporting and CVD prevention governance
Primary Community and Neighbourhood	MMR vaccine uptake rate - % of children to receive two doses of MMR vaccine before their 5th birthday	Dec-25	83.70%	R	Mar-26	83.70%	-	R	Q4 25/26	82.90%	R	MMR uptake remains Red, with the latest published Q4 2025/26 position at 82.9%, below the level needed to provide population protection and reduce outbreak risk. Performance is affected by variation in call/recall, data quality, parental confidence, access to convenient vaccination opportunities and lower uptake in some underserved communities. Actions include targeted practice and PCN catch-up activity, data cleansing, strengthened call/recall, focused outreach in lower-uptake communities and continued joint work with the NHS England Screening and Immunisation Team. The winter vaccination plan will use timely uptake and population-health data to direct oversight and improvement, with outreach providers and vaccine ambassadors supporting confidence and access in areas of lower uptake. Delivery will be monitored through immunisation performance reporting, primary care contracting routes, Screening and Immunisation Team oversight and neighbourhood health improvement arrangements

3.0 Areas of focus: 2025/26 NHS Oversight Framework

Narrative update for highlighted areas showing deterioration in NHS Oversight Framework (NOF) nationally benchmarked (RAG) position between Q3 and Q4 2025/26, as reported on Model Health System (MHS) and where ICB performance sits in the bottom quartile (Red).

Bottom Quartile Metrics

MDT	Metric Name	PUBLISHED							LOCAL			MDT Lead Commentary
		MHS Q3 2025/26			MHS Q4 2025/26				Latest Published			
		Latest period	Actual	RAG	Latest period	Actual	Move-ment	RAG	Latest period	Actual	RAG	
UEC and Flow	Average number of days from discharge ready date to actual discharge date	Dec-25	1.22	R	Mar-26	1.13	–	R	Jun-26	1.09	A/R	Actions being undertaken to resolve the increase in the average number of days between a patient being declared discharge ready and their actual discharge. Partners have agreed a targeted programme of improvement focused on discharge flow and intermediate care capacity. Actions include strengthening daily review and escalation processes for patients with a discharge-ready status, increasing utilisation and capacity across discharge pathways, and working with local authority and provider partners to address shortages in domiciliary care, rehabilitation and care home placements. In parallel, providers are improving hospital discharge processes through earlier discharge planning, timely therapy assessments, proactive use of Care Transfer Hubs, and streamlined discharge documentation and medicines management. These actions aim to reduce avoidable delays, increase acute bed availability, and improve patient flow across the urgent and emergency care system. Regional support from DAG and an extension of the Medway support offer from NHS-E via HIP. Continued work to resolve the MTW DQ issues (currently excluded from national reporting).
Unaligned	% of healthcare referrals completed within 28 days	Q3 25/26	48.56%	R	Q4 25/26	26.00%	-	R	Q4 25/26	26.00%	R	This metric has been removed from NOF reporting for 2026/27
Unaligned	NHS Staff Survey – raising concerns sub-score	2024	5.72	R	2024	5.72	–	R				The ICB did not participate in the 2025 NHS Staff Survey, instead ran internal monthly pulse surveys to gather colleague feedback during the change programme period. Following the final pulse survey in April 2026, it was agreed to transition to the national quarterly People Pulse Survey and rejoin the NHS Staff Survey from 2026, ensuring staff voice continues to inform organisational priorities and local improvement plans. The April 2026 Pulse Survey indicates that trust, collaboration and psychological safety within teams remain important strengths to build upon. The survey also suggests there is further work to do to strengthen organisational confidence and advocacy following a period of significant change, ensuring colleagues feel positive about their experience and would recommend the organisation as a place to work. An interim six-month Organisational Development Plan was approved in April 2026, focused on five priority areas: leadership and culture; operating model and ways of working; strategic commissioning capability; people experience and wellbeing; and change and transition capability. During this period, the ICB has also introduced its New Ways of Working framework, supported managers through dedicated guidance, strengthened equality, diversity and inclusion development across the organisation, and completed a governance reset to provide clearer accountability and oversight. The OD Plan has provided a foundation for the development of a new three-year People Strategy. Following Executive Committee approval early September, the strategy will enter a phase of staff engagement and co-creation, ahead of its planned launch in the later part of 2026.

3.0 Areas of focus: 2025/26 NHS Oversight Framework

Narrative update for highlighted areas showing deterioration in NHS Oversight Framework (NOF) nationally benchmarked (RAG) position between Q3 and Q4 2025/26, as reported on Model Health System (MHS) and where ICB performance sits in the bottom quartile (Red).

Bottom Quartile Metrics

		PUBLISHED							LOCAL			
		MHS Q3 2025/26			MHS Q4 2025/26				Latest Published			
MDT	Metric Name	Latest period	Actual	RAG	Latest period	Actual	Move-ment	RAG	Latest period	Actual	RAG	MDT Lead Commentary
Unaligned	% of children (aged 0 – 9) prescribed antibiotics in the last 12 months	Q3 25/26	21.6%	R	Q4 25/26	25.9%	–	R	May-26	26.04 %	G/A	Data on antibiotic prescribing is taken from Model Health System based on analysis produced by PrescQIPP to inform and support NHS professionals in the UK making commissioning decisions about primary care and to assist health and social care practitioners and others to improve the quality of medicines related care to patients. All ICBs are currently RAG rated Red on Model Health System for this metric. The ICB has met the national fixed target of 27% since August 2025 and regional reporting benchmarks the ICB in Quartile 2 nationally (Regional Quality Oversight Report) for Q4 2025/26. From Q1 26/27, the NOF metric scoring will be updated nationally - Where an organisation has a value of 25% or lower, they score 1.00. Remaining organisations are evenly ranked from 2.00 - 4.00 based on performance ranked low to high (Lower is better)
Unaligned	NHS Staff Survey engagement theme sub-score	2024	6.03	R	2024	6.03	-	R				Annual Metric. ICB did not take part in 2025 Staff Survey. Monthly Pulse survey in place during this period (moving to quarterly from April 26). This metric has been removed from ICB reporting for 2026/27.
Unaligned	Variance year-to-date to financial plan	Q3 25/26	-0.67%	R	Q4 25/26	-1.30%	–	R	May-26	0.26%	G/A	*From ICB Finance Report Month 4* At Month 4, the ICB is reporting an in-month deficit of £4.2m, in line with plan, resulting in a year-to-date deficit of £16.9m. The required Cost Improvement Plan (CIP) of £49.7m has now been posted in Month 4 to the relevant budgets which allows for close monitoring of savings delivery overseen by the Financial Recovery Group (FRG). Various cost pressures are emerging and are driving adverse year-to-date variances in several areas: • Out of Sector acute services; • All Age Continuing Care; • Discharge to Assess; • ADHD activity and expenditure; • Prescribing, particularly No Cheaper Stock Obtainable (NCSO) drugs; • Contract Finance, noting that these areas present a Month 3 position given the national reporting timetable These areas will be subject to close monitoring, with active interventions implemented where feasible to contain expenditure and mitigate further risk.

3.0 Areas of focus: 2025/26 NHS Oversight Framework

Narrative update for highlighted areas showing deterioration in NHS Oversight Framework (NOF) nationally benchmarked (RAG) position between Q3 and Q4 2025/26, as reported on Model Health System (MHS) and where ICB performance sits in the bottom quartile (Red).

System Metrics (contextual)

MDT	Metric Name	PUBLISHED							LOCAL			MDT Lead Commentary
		MHS Q3 2025/26			MHS Q4 2025/26				Latest Published			
		Latest period	Actual	RAG	Latest period	Actual	Move-ment	RAG	Latest period	Actual	RAG	
MHLDA	Is the system's proportion of annual physical health checks for SMI completed in the last year below 60%?	Q3 25/26	Yes	R	Q4 25/26	Yes	–	R	Q4 25/26	Yes (59%)	R	Q4 2025/26 performance 59% (1% below target) - shortfall of 168 people. Over 1,200 checks completed by KMMH Community Mental Health Teams - not included in national reporting, despite EMIS reporting being included in KMMH contract SDIP. Issue has been escalated through contract management arrangements. KMMHT has purchased software to allow EMIS reporting, however, there is a concern that capacity issues will delay installation by another six months.

System Metrics (contextual)

MDT	Metric Name	PUBLISHED							LOCAL			MDT Lead Commentary
		MHS Q3 2025/26			MHS Q4 2025/26				Latest Published			
		Latest period	Actual	RAG	Latest period	Actual	Move-ment	RAG	Latest period	Actual	RAG	
Elective Diagnostics and Cancer	Annual Change in the size of the waiting list	Dec-25	-1.57%	A/R	Mar-26	-2.03%	–	A/R	Jun-26	0.67%	A/R	The elective RTT list is growing, we have identified that providers in month 1 and 2 are not completing the levels of activity that are required to reduce the waiting list size in line with there plans. We are formally escalating this through the provider contract meetings
MHLDA	NHS Talking Therapies – Reliable Recovery Rate	Dec-25	45.00%	A/R	Mar-26	49.00%	–	A/R	Mar-26	49.00%	A/R	Performance continues to sit slightly below national ambition (50%). Reflective of significant service mobilisation following transition to a single-provider model in April 24. Recovery performance is improving following service mobilisation and is currently exceeding the agreed trajectory. Performance broadly in line with NHSE planning trajectory,- 48.6% in Month 1 (target 48.9%) and 49.4% in Month 2 (target 48.8%). Provider programme of actions including: • Full rollout of an enhanced clinical assessment and treatment model. • Strengthening clinical supervision and quality assurance arrangements • Improving referral appropriateness and pathway management. • Reducing variation in treatment delivery and clinical outcomes across teams. • Enhancing data quality, reporting and performance oversight. • Optimising workforce capacity and skill mix to support improved patient outcomes. Delivery monitored through contract and performance management arrangements. Expect continued month-on-month improvement towards national recovery ambitions as actions become fully embedded.

Appendix 1 - 2026/27 NOF ICB-level metric scoring methodologies

Provisional MDT	Domain area	Subject area	Metric	Scoring methodology	Level of Granularity
Elective Diagnostics and Cancer	Allocating resources	Cancer care	% of cancers diagnosed at stage 1 or 2	Banded score	ICB
		Elective care	% change in overall waiting list size vs previous year	Even spread	Provider
	Population health, prevention and reducing inequality	Population health	Under 75s cancer mortality rate	Contextual	MSOA
			Under 75s cardiovascular disease mortality rate	Contextual	MSOA
		Preventing ill health	% of eligible people supported by obesity prevention programmes	Even spread	ICB
		Reducing inequality	Deprivation gap in early cancer diagnosis	Even spread	ICB
Executive Committee	Experience of care	Experience	% of complaints open beyond 6 months	Target and spread	ICB
	Finance productivity and innovation	Finance	Planned surplus or deficit	Banded score	ICB
			Variance to plan year-to-date	Banded score	ICB
		Innovation	% of clinical trials set up within 90 days	Target, floor, and spread	Provider
		Productivity	Implied productivity growth	Contextual	ICB
	Patient safety	Safe outcomes	Number of neonatal deaths and stillbirths per 1,000 total births	Banded score	Local Authority
		Safe practice	Percentage of children aged 9 and under prescribed antibiotics	Target and spread	Practice
	People and workforce	People and culture	NHS staff survey engagement theme score	Even spread	ICB
			Sickness absence rate	Even spread	ICB
	Population health, prevention and reducing inequality	Preventing ill health	% of pregnant women who quit smoking	Even spread	ICB
		Reducing inequality	Deprivation and ethnicity gap in pre-term births	Banded score	ICB
MHLDA	Allocating resources	Mental health care	% of acute adult mental health admissions with no contact with community mental health services in the previous year	Banded score	Provider
	Effectiveness of care	Managing long term conditions	% of patients over 14 years old on GP learning disability registers to receive a full physical health check and action plan in the last 12 months	Banded score	Practice
			% of patients on GP severe mental illness registers to receive a full physical health check in the last 12 months	Banded score	Practice
	Access to services	Learning disabilities and autistic people	Percentage of people with a learning disability and autistic people in mental health hospital with the longest length of stay	Contextual	ICB
	Effectiveness of care	Outcomes	% of NHS Talking Therapies patients completing a course of treatment and achieving reliable recovery	Banded score	Provider
	Experience of care	Patient flow	% of ICB commissioned adult inappropriate out of area placement bed days as a proportion of all ICB commissioned bed days	Banded score	ICB
			12 month adult admission rate for people with a learning disability and autistic people	Contextual	ICB
Primary Community and Neighbourhood	Allocating resources	Community care	Level of growth in community care contacts	Banded score	Provider
		Dental care	Units of dental activity delivered as a % of commissioned	Contextual	ICB
		Primary care	% of clinically urgent appointments that happen on the same day	Target and spread	Practice
	Effectiveness of care	Managing long term conditions	% of patients who receive all 8 diabetes care processes	Even spread	Practice
			Number of patients with GP recorded cardiovascular disease whose cholesterol is managed to NICE guidance	Target and spread	Practice
			Number of patients with GP recorded hypertension whose blood pressure is managed to NICE guidance	Target and spread	Practice
	Experience of care	Experience	% of patients rating their experience of GP access as easy	Banded score	ICB
			% of patients with a preferred general practice professional able to see or speak with that professional	Banded score	Practice
	People and workforce	Workforce	GP headcount per capita	Even spread	Practice
	Population health, prevention and reducing inequality	Preventing ill health	Bowel screening rate	Target, floor, and spread	Practice
			Breast screening rate	Target and spread	Practice
			Cervical screening rate	Target and spread	Practice
			MMRV (measles, mumps, rubella and varicella) uptake rate	Banded score	Practice
		Reducing inequality	Deprivation gap in lipid management	Target and spread	Practice
			Deprivation gap in hypertension management	Target and spread	Practice
UEC and Flow	Allocating resources	Urgent care	Occupied bed days per 100,000 head of population	Banded score	ICB
	Effectiveness of care	Outcomes	% of people with 3 or more emergency admissions in the last 90 days of life	Banded score	ICB
			Over 65s bed days per 100,000 head of population	Even spread	ICB
	Experience of care	Patient flow	Average number of days between discharge ready and actual discharge date	Even spread	Provider

Appendix 2 - 2026/27 NOF metric change detailed summary (All metrics, including Provider-Level)

Retained metrics: 51

- 28 day cancer performance
- 62 day cancer performance
- 6 week diagnostic performance
- 52 week performance
- 18 week performance
- 18 week performance vs target
- 4 hour UEC performance
- 12 hour UEC performance
- C2 mean response time
- % of cancers diagnosed early
- Annual change in waiting list size
- Occupied bed days per 100k head of population
- 30 day readmission rate band
- % of LDA patients with a physical health check and action plan
- % of SMI patients with a full physical health check
- % of patients who receive all eight diabetes care processes
- Number of patients with CVD with cholesterol managed to guidance
- Patients with hypertension with BP managed to guidance
- % of NHS Talking Therapies patients achieving reliable recovery
- Deprivation and ethnicity gap in pre-term births
- Deprivation gap in early cancer diagnosis
- SHMI
- % of patients rating their experience of GP access as easy
- % of GP patients able to see their preferred health professional
- Community mental health survey satisfaction rate
- Inpatient survey satisfaction rate
- NHS staff survey advocacy rate
- Adult inappropriate OAP bed days as a % of all bed days
- Average discharge delay
- Planned surplus/deficit
- Variance to plan year-to-date
- Implied productivity growth
- Relative cost difference
- 24hr urgent crisis response
- Staff survey raising concerns score
- % of inpatients to acquire a new grade 3 or 4 pressure ulcer
- Extended perinatal mortality rate
- MRSA, C-Diff and Ecoli rates
- Rate of restrictive interventions
- % of under 9s prescribed antibiotics
- NETS satisfaction rate
- Staff survey engagement score
- Sickness absence rate
- % of people supported by obesity prevention programmes
- Inpatient smoking quit attempt rate
- % of pregnant smokers to quit
- Bowel, cervical and breast screening rate

Evolved metrics*: 11

- % of CYP mental health patients waiting over 104 weeks for contact
- Dental UDAs as a % of contracted
- Percentage of people with LDA in mental health hospital with the longest lengths of stay
- % of incidents managed via hear or see and treat
- Rate of women with a planned induction that are delayed
- Mean length of stay for adult acute and PICU patients
- Mean length of stay for older adult acute discharges
- GP headcount per capita
- MMR(V) uptake rate
- Deprivation gap in lipid and hypertension management

Removed metrics: 8

- Community mental health access rate
- Percentage of people with suspected autism waiting more than 13 weeks for contact
- Percentage of continuing healthcare referrals completed in 28 days
- Urgent community response 2-hour performance
- CQC safe inspection score (if awarded within the preceding 2 years)
- NHS staff survey education and training theme score
- Average number of years people live in healthy life
- Under 18s elective waiting list growth

New metrics: 24

- % of patients waiting less than 18 weeks for community care
- % of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages)
- Mean 999 call response time
- Level of growth in community care contacts
- % of acute mental health admissions with no contact with community mental health services in the previous year
- % of urgent GP appointments seen within 24 hours
- 14 day readmission rate
- % of acute adult discharges followed up within 72 hours
- % of people with 3 or more emergency admissions in the last 90 days of life
- Over 65s bed days per 100k head of population
- % of complaints open beyond six months
- Number of patients cared for in corridors
- % of intermediate care beds occupied by patients without criteria to reside
- 12-month adult admission rate for people with a learning disability and autistic people
- % of clinical trials set up within 90 days
- Data Quality Maturity Index
- Breadth and depth of clinical audit outliers
- % of safety incidents causing harm
- Rate of inpatient falls that cause harm
- Healthcare Worker Flu Vaccination Rate
- NHS staff standards score
- Temporary staffing cost as a % of total pay bill
- Under 75s cancer mortality rate
- Under 75s cardiovascular disease mortality rate

*Evolved metrics are those where a 25/26 metric has been updated to align with emerging direction or policy

Appendix 3

NHS Oversight Framework (2025/26)
ICB Contextual metrics

2026/27 NHS Oversight Framework Metric Summaries

Local Assessment Metrics by Domain

Under 75s cancer mortality rate

Population Health Prevention and reducing inequality

Metric	Under 75s cancer mortality rate		
Domain	Population Health Prevention and reducing inequality		
Domain Subgroup	Population health		
MDT	Electives Diagnostics & Cancer	**MDT Priority**	
ICB Commissioning Lead	K&M Cancer Alliance Director	**Clinical Lead**	
In NOF 2026/27?			

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	117.58	Latest Data (Local)	2024
National Rank	23/42	RAG Rating	A/R

Insight (based on most up-to date published data)			
Gap to next quartile	To improve to quartile 2	-6.48	New metric for 2026/27 NOF
	To improve to median	-1.73	

Data available at Middle-layer Super Output Area (MSOA) level to support MDT discussion.

Under 75s cardiovascular disease mortality rate

Metric	Under 75s cardiovascular disease mortality rate		
Domain	Population Health Prevention and reducing inequality		
Domain Subgroup	Population Health		
MDT	Electives Diagnostics & Cancer	**MDT Priority**	TBC
ICB Commissioning Lead	TBC	**Clinical Lead**	TBC
In NOF 2026/27?	Yes		

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	68.24%	Latest Data (Local)	2024
National Rank	21/42	RAG Rating	G/A

Insight (based on most up-to date published data)			
Gap to next quartile	To improve to quartile 1	-4.86	New metric for 2026/27 NOF
	To improve to median	-	

Data available at Middle-layer Super Output Area (MSOA) level to support MDT discussion.

*Indicative RAG based on Quartile – NHSE RAG methodology to be determined

Cervical screening coverage for females aged 25-64 within the target period

Metric	Cervical screening coverage for females aged 25-64 within the target period		
Domain	Population Health Prevention and reducing inequality		
Domain Subgroup	Preventing ill health		
MDT	Primary, Community and Neighbourhood	**MDT Priority**	No
ICB Commissioning Lead	K&M Cancer Alliance Director	**Clinical Lead**	
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided by NHSE in advance of ICB Annual Assessment)			
Current Performance (National)	71.70%	Latest Data (National)	March 2026
National Rank*	21/42	RAG Rating	G/A
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	71.70%	Latest Data (Local)	March 2026
National Rank	21/42	RAG Rating	G/A

Insight (based on most up-to date published data)

Gap to next quartile	To improve to quartile 1	1.48%	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	-		71.70%	71.70%	71.70%	71.70%
	To improve to target	8.30%					

Neighbourhood Level Data

Neighbourhood	Numerator	Denominator	Value	To target (80%)	To improve to next quartile	To improve to median	Add. Patients to target (80%)	Add. patients to next quartile	Add. patients to median
Dartford, Gravesham & Swanley	51,680	74,585	69.29%	10.71%	3.89%	2.37%	7,988	2,901	1,768
Canterbury, Coastal & Faversham	35,835	51,090	70.14%	9.86%	3.04%	1.52%	5,037	1,553	776
Folkestone, Hythe & Dover	30,150	42,395	71.12%	8.88%	2.06%	0.54%	3,766	875	230
Thanet & Deal	35,240	49,465	71.24%	8.76%	1.94%	0.42%	4,332	958	207
Ashford & Rural	27,050	37,390	72.35%	7.65%	0.83%	-	2,862	312	-
Medway	59,430	81,935	72.53%	7.47%	0.65%	-	6,118	530	-
Sittingbourne & Sheppey	19,155	26,275	72.90%	7.10%	0.28%	-	1,865	73	-
Sevenoaks, Tonbridge and Tunbridge Wells	46,030	61,925	74.33%	5.67%	-	-	3,510	-	-
Maidstone, Malling and The Weald	52,585	70,285	74.82%	5.18%	-	-	3,643	-	-

Bowel screening coverage in the last 30 months aged 60-74

Metric	screening coverage in the last 30 months aged 60-74		
Domain	Population Health Prevention and reducing inequality		
Domain Subgroup	Preventing ill health		
MDT	Primary Community & Neighbourhood	**MDT Priority**	No
ICB Commissioning Lead	K&M Cancer Alliance Director	**Clinical Lead**	
In NOF 2026/27?			

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	72.96%	Latest Data (National)	Mar-24
National Rank	23/42	RAG Rating	A/R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	74.10%	Latest Data (Local)	Mar-25
National Rank	22/42	RAG Rating	A/R

Insight (based on most up-to date published data)

			2025/26	Q1	Q2	Q3	Q4
Gap to next quartile	To improve to quartile 2	0.10%		74.36%	72.96%	72.96%	72.96%
	To improve to median	0.05%					

Neighbourhood Level Data

Neighbourhood	Numerator	Denominator	Value	To improve to quartile 3	To improve to median	Add. patients to q3	Add. patients to median
Dartford, Gravesham & Swanley	735	941	78.11%	-3.91%	-3.96%	-29	-29
Medway	753	908	82.93%	-8.73%	-8.78%	-66	-66
Sittingbourne & Sheppey	248	291	85.22%	-	-11.07%	0	-27
Ashford & Rural	359	418	85.89%	-	-11.74%	0	-42
Folkestone, Hythe & Dover	368	426	86.38%	-	-12.23%	0	-45
Maidstone, Malling and The Weald	672	776	86.60%	-	-12.45%	0	-84
Canterbury, Coastal & Faversham	400	461	86.77%	-	-12.62%	0	-50
Sevenoaks, Tonbridge and Tunbridge Wells	570	646	88.24%	-	-	0	0
Thanet & Deal	420	475	88.42%	-	-	0	0
NHS Kent and Medway ICB Total	**4,525**	**5,342**	**74.10%**	**0.00**	**0.00**	**5**	**2**

Most up-to-date performance position based on the local assessment of published data

Breast screening coverage in the last 36 months for females aged 53-70

Population Health Prevention and reducing inequality

Metric	Breast screening coverage in the last 36 months for females aged 53-70		
Domain	Population Health Prevention and reducing inequality		
Domain Subgroup	Preventing ill health		
MDT	Primary, Community and Neighbourhood	**MDT Priority**	No
ICB Commissioning Lead	K&M Cancer Alliance Director	**Clinical Lead**	
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	74.10%	Latest Data (National)	Mar-25
National Rank*	23/42	RAG Rating	G/A
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	74.1%	Latest Data (Local)	Mar-25
National Rank	23/42	RAG Rating	G/A

Insight (based on most up-to date published data)

			2025/26	Q1	Q2	Q3	Q4
Gap to next quartile	To improve to Target	5.90%%		71.56%	71.56%	74.10%	74.10%
	To improve to quartile 1	1.02%					
	To improve to median	-					

Neighbourhood Level Data

Neighbourhood	Numerator	Denominator	Value	To improve to next quartile	To improve to median	To improve to target (80%)	Add. patients to next quartile	Add. patients to median	Add. Patients to target (80%)
Sittingbourne & Sheppey	6,245	11,390	54.83%	20.29%	18.24%	25.17%	2,311	2,078	2,867
Dartford, Gravesham & Swanley	16,590	27,090	61.24%	13.88%	11.83%	18.76%	3,760	3,205	5,082
Medway	20,585	31,835	64.66%	10.46%	8.41%	15.34%	3,329	2,677	4,883
Ashford & Rural	10,160	15,685	64.78%	10.34%	8.29%	15.22%	1,623	1,301	2,388
Thanet & Deal	17,425	25,835	67.45%	7.67%	5.62%	12.55%	1,982	1,453	3,243
Sevenoaks, Tonbridge and Tunbridge Wells	17,685	25,970	68.10%	7.02%	4.97%	11.90%	1,824	1,291	3,091
Folkestone, Hythe & Dover	14,265	20,805	68.57%	6.55%	4.50%	11.43%	1,364	937	2,379
Canterbury, Coastal & Faversham	16,465	23,520	70.00%	5.12%	3.07%	10.00%	1,203	721	2,351
Maidstone, Malling and The Weald	21,220	29,995	70.75%	4.37%	2.32%	9.25%	1,312	697	2,776

ren to receive two doses of MMR vaccine before their 5th birthday

Population Health Prevention and reducing inequality

Metric	Percentage of children to receive two doses of MMR vaccine before their 5th birthday		
Domain	Population Health Prevention and reducing inequality		
Domain Subgroup	Preventing ill health		
MDT	Primary Community & Neighbourhood	**MDT Priority**	No
ICB Commissioning Lead	Director of Primary and Community Care (Sukh Singh)	**Clinical Lead**	Primary Care (Ash Peshen)
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Hospital)			
Current Performance (National)	83.70%	Latest Data (National)	Q4 2025/26
National Rank*	33/42	RAG Rating	R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	82.90%	Latest Data (Local)	Q4 2025/26
National Rank	33/42	RAG Rating	R

Insight (based on most up-to date published data)

Gap to next quartile	To improve to quartile 3	1.29%
	To improve to median	3.30%
	To improve to target	12.10%

2025/26	Q1	Q2	Q3	Q4
	85.10%	83.80%	83.70%	83.70%

Neighbourhood Level Data

Multi-Neighbourhood	Numerator	Denominator	Value	To improve to Q3	To improve to median	To improve to target	Add. patients to Q3	Add. patients to median	Add. patients to target
Dartford, Gravesham & Swanley	633	849	74.56%	9.64%	12.84%	20.44%	82	109	174
Thanet & Deal	339	415	81.69%	2.51%	5.71%	13.31%	10	24	55
Medway	736	869	84.70%	-	2.70%	10.30%	-	24	90
Folkestone, Hythe & Dover	363	428	84.81%	-	2.59%	10.19%	-	11	44
Sevenoaks, Tonbridge and Tunbridge Wells	477	553	86.26%	-	1.14%	8.74%	-	6	48
Sittingbourne & Sheppey	275	318	86.48%	-	0.92%	8.52%	-	3	27
Ashford & Rural	314	363	86.50%	-	0.90%	8.50%	-	3	31
Maidstone, Malling and The Weald	710	816	87.01%	-	0.39%	7.99%	-	3	65
Canterbury, Coastal & Faversham	460	517	88.97%	-	-	6.03%	-	-	31
Unaligned	14	84	16.67%	67.53%	70.73%	78.33%	57	59	66
NHS Kent and Medway ICB Total	**4,321**	**5,212**	**82.90%**	**1.30%**	**4.50%**	**12.10%**	**183**	**565**	**0**

rogrammes (proportion of people taking up lifestyle/behavioural programmes to reduce obesity)

NHS Kent and Medw

Population Health Prevention and reducing inequality

Metric	Percentage of patients supported by obesity programmes (Proportion of people taking up lifestyle/behavioural programmes to reduce obesity) - Banded score		
Domain	Population Health Prevention and reducing inequality		
Domain Subgroup	Preventing ill health		
MDT	Primary, Community and Neighbourhood	**MDT Priority**	No
ICB Commissioning Lead	Director of Strategic Change and Population Health	**Clinical Lead**	
In NOF 2026/27?	Yes	Both obesity metrics combined into a single score	

Q4 NHS Oversight Framework Performance (as provided by NHSE in advance of ICB Annual Assessment)			
Current Performance (National)	3.10	Latest Data (National)	Q4 2025/26
National Rank	36/42	RAG Rating	A/R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	3.10	Latest Data (Local)	Q4 2025/26
National Rank	36/42	RAG Rating	A/R

Insight (based on most up-to date published data)		
Gap to next quartile	To improve to quartile 2 Banded score	Banded score assessing 2 measures – see below

Metric	Q1	Q2	Q3	Q4
Obesity metric 1: Referrals to Digital Weight Management services per 100k people living with obesity	182.82	206.95	135.80	181.30
Obesity metric 2: Number of people starting the Diabetes Prevention Programme per 1k head of population	13.24	13.00	11.35	12.77

Percentage of pregnant women who quit smoking (banded estimate score)

Metric	Percentage of pregnant women who quit smoking (banded estimate score)		
Domain	Population Health Prevention and reducing inequality		
Domain Subgroup	Preventing ill health		
MDT	Primary, Community and Neighbourhood	**MDT Priority**	No
ICB Commissioning Lead	Director of Strategy and Planning (Dominic Cox)	**Clinical Lead**	
In NOF 2026/27?			

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	2.25	Latest Data (National)	Q4 Annual Assessment Data
National Rank		RAG Rating	A/R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	31.80	Latest Data (Local)	Oct-25
National Rank	18/33	RAG Rating	G/A

Insight (based on most up-to date published data)								
Gap to next quartile	To improve to quartile 2	Banded score	Trend (Actual)	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	Banded score			23.89%	24.27%	29.40%	24.27%

Most up-to-date performance position based on the local assessment of published data

Deprivation gap in early cancer diagnosis

Metric	Deprivation gap in early cancer diagnosis		
Domain	Population Health Prevention and reducing inequality		
Domain Subgroup	Reducing inequality		
MDT	Electives, Diagnostics and Cancer	**MDT Priority**	Yes
ICB Commissioning Lead	K&M Cancer Alliance Director	**Clinical Lead**	
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	6.05	Latest Data (National)	Q4 2025/26
National Rank*	18/42	RAG Rating	G/A
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	6.05	Latest Data (Local)	Q4 2025/26
National Rank	18/42	RAG Rating	G/A

Insight (based on most up-to date published data)							
Gap to next quartile	To improve to quartile 1	-1.26	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	-		8.18	6.25	6.05	6.05

Most up-to-date performance position based on the local assessment of published data

Deprivation and ethnicity gap in pre-term births score

Population Health Prevention and reducing inequality

Metric	Pre-term births by deprivation and ethnicity compared with the national average		
Domain	Population Health & Inequality		
Domain Subgroup	Reducing inequality		
MDT	TBD	**MDT Priority**	No
ICB Commissioning Lead	Director of Strategy and Planning (Dominic Cox)	**Clinical Lead**	Director of Population Health Insights and Strategic Improvement (Malti Varshney)
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Hospital)			
Current Performance (National)	3.00	Latest Data (National)	Q4 2025/26
National Rank*	33/42	RAG Rating	A/R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	3.00	Latest Data (Local)	Q4 2025/26
National Rank	33/42	RAG Rating	R

Insight (based on most up-to date published data)							
Gap to next quartile	To improve to quartile 3	N/A Banded Score	2025/26	Q1	Q2	Q3	Q4
	To improve to median	N/A Banded Score		One higher than average	One lower than average	One higher than average	One higher than average

Most up-to-date performance position based on the local assessment of published data

Deprivation gap in lipid management

Metric	Deprivation gap in lipid management		
Domain	Population Health Prevention and reducing inequality		
Domain Subgroup	Reducing inequality		
MDT	Primary Community and Neighbourhood	**MDT Priority**	
ICB Commissioning Lead	Director of Primary and Community Care (Sukh Singh)	**Clinical Lead**	Primary Care (Ash Peshen)
In NOF 2026/27?			

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	-12.65%	Latest Data (Local)	Dec-25
National Rank	38/42	RAG Rating	R

Insight (based on most up-to date published data)		
Gap to next quartile	To improve to target (0%) 12.65%	New metric for 2026/27 NOF

Most up-to-date performance position based on the local assessment of published data

Deprivation gap in hypertension management

Metric	Deprivation gap in hypertension management		
Domain	Population Health Prevention and reducing inequality		
Domain Subgroup	Reducing inequality		
MDT	Primary Community and Neighbourhood	**MDT Priority**	
ICB Commissioning Lead	Director of Primary and Community Care (Sukh Singh)	**Clinical Lead**	Primary Care (Ash Peshen)
In NOF 2026/27?			

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	-9.47%	Latest Data (Local)	Dec-25
National Rank	38/42	RAG Rating	A/R

Insight (based on most up-to date published data)		
Gap to next quartile	To improve to target (0%) 9.47%	New metric for 2026/27 NOF

Most up-to-date performance position based on the local assessment of published data

Percentage change in overall waiting list size vs previous year

Metric	Percentage change in overall waiting list size vs previous year		
Domain	Allocating Resources		
Domain Subgroup	Elective care		
MDT	Electives, Diagnostics and Cancer	**MDT Priority**	Yes
ICB Commissioning Lead	Director of Elective Care	**Clinical Lead**	
In NOF 2026/27?			

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	-2.03%	Latest Data (National)	Mar-2026
National Rank	25/42	RAG Rating	A/R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	0.67%	Latest Data (Local)	Jun-2026
National Rank	22/36	RAG Rating	A/R

Insight (based on most up-to date published data)

Gap to next quartile	To improve to quartile 2	-2.64%	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	-2.00%		-1.34%	-2.79%	-1.57%	-2.03%

Acute Provider Level Data

Provider	Total WL at end Jun-25	Total WL at end Jun-26	Change %	To improve to quartile 2	To improve to median
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	47,980	50,743	5.76%	-7.7%	-7.1%
MEDWAY NHS FOUNDATION TRUST	80,689	82,363	2.07%	-4.0%	-3.4%
DARTFORD AND GRAVESHAM NHS TRUST	32,577	30,461	-6.50%	-	-
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	39,993	34,986	-12.52%	-	-
NHS Kent and Medway System Total	**201,239**	**198,553**	-1.33%	-0.6%	-

The provider breakdown is not directly comparable to the ICB total. The ICB total comprises commissioned activity at all providers, whereas the provider detail is the total position for the local acute providers. A breakdown of ICB commissioned activity by provider is not currently available.

Change in percentage of all cancers diagnosed at stage 1 or 2

Metric	Percentage of all cancers diagnoses at stage 1 or 2		
Domain	Allocating Resources		
Domain Subgroup	Cancer Care		
MDT	Electives, Diagnostics and Cancer	**MDT Priority**	Yes
ICB Commissioning Lead	K&M Cancer Alliance Director	**Clinical Lead**	
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	1.51%	Latest Data (National)	March 2026
National Rank*	20/42	RAG Rating	G/A
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	1.51%	Latest Data (Local)	March 2026
National Rank	20/42	RAG Rating	G/A

Insight (based on most up-to date published data)							
Gap to next quartile	To improve to quartile 1	0.59%	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	-		1.55%	0.85%	1.51%	1.51%

Most up-to-date performance position based on the local assessment of published data

sions with no contact with community mental health services in the previous year

Allocating Resources

Metric	Percentage of acute adult mental health admissions with no contact with community mental health services in the previous year		
Domain	Allocating Resources		
Domain Subgroup	Mental Health Care		
MDT	Electives, Diagnostics and Cancer	**MDT Priority**	Yes
ICB Commissioning Lead	K&M Cancer Alliance Director	**Clinical Lead**	
In NOF 2026/27?	Yes		

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	6.00%	Latest Data (Local)	May 2026
National Rank	5/36	RAG Rating	G/A

Insight (based on most up-to date published data)		
Gap to next quartile	To improve to quartile 1 -1.00% To improve to median -	New metric for 2026/27 NOF

Most up-to-date performance position based on the local assessment of published data

Occupied bed days per 100,000 head of population

Allocating Resources

Metric	Acute bed days per 100,000 people		
Domain	Allocating Resources		
Domain Subgroup	Urgent Care		
MDT	UEC and Flow	**MDT Priority**	Yes
ICB Commissioning Lead	Director of UEC and Flow	**Clinical Lead**	Clinical Director for UEC and Flow
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	80.59	Latest Data (National)	Q4 2025/26
National Rank	9/42	RAG Rating	G
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	80.59	Latest Data (Local)	Q4 25/26
National Rank	9/42	RAG Rating	G

Insight (based on most up-to date published data)							
Gap to next quartile	To improve to next quartile	n/a	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	n/a		128.7	125.6	129.2	80.6

Percentage of clinically urgent appointments that take place on the same day

Metric	Percentage of clinically urgent appointments that take place on the same day		
Domain			
Domain Subgroup	Primary Care		
MDT		**MDT Priority**	
ICB Commissioning Lead		**Clinical Lead**	
In NOF 2026/27?			

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	76.50%	Latest Data (Local)	Jun-26
National Rank	21/36	RAG Rating	A/R

Insight (based on most up-to date published data)		
Gap to next quartile	To improve to target 3.50% To improve to median 0.80%	New metric for 2026/27 NOF

Neighbourhood Level Data

Neighbourhood	Same day appointments	Total appointments	Value	To improve to Target	To improve to median	Add. patients to Target	Add. patients to median
Thanet & Deal	12,009	16,722	71.82%	8.18%	5.48%	2,103	1,409
Medway	19,197	25,700	74.70%	5.30%	2.60%	1,288	632
Dartford, Gravesham & Swanley	18,426	24,293	75.85%	4.15%	1.45%	558	195
Folkestone, Hythe & Dover	10,206	13,431	75.99%	4.01%	1.31%	327	107
Sittingbourne & Sheppey	6,230	8,158	76.37%	3.63%	0.93%	598	154
Canterbury, Coastal & Faversham	12,679	16,471	76.98%	3.02%	0.32%	654	70
Sevenoaks, Tonbridge and Tunbridge Wells	17,009	21,636	78.61%	1.39%	0.00%	232	0
Maidstone, Malling and The Weald	13,527	16,750	80.76%	0.00%	0.00%	0	0
Ashford & Rural	10,670	12,321	86.60%	0.00%	0.00%	0	0
NHS Kent and Medway ICB Total	**119,953**	**155,482**	**76.50%**	**3.50%**	**0.80%**	**5,761**	**2,567**

and autistic people in mental health hospital with the longest length of stay

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Allocating Resources

Metric	Percentage of people with a learning disability and autistic people in mental health hospitals with the longest length of stay		
Domain	Allocating Resources		
Domain Subgroup	Learning disabilities and people who are autistic		
MDT	Mental Health and Learning Disabilities	**MDT Priority**	
ICB Commissioning Lead	MHLDA Commissioning Director (Nicola Smith)	**Clinical Lead**	Deputy CMO MHLDA (Valsraj Koranvangattu)
In NOF 2026/27?			

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	52%	Latest Data (Local)	Jun-26
National Rank	27/36	RAG Rating	A/R

Insight (based on most up-to date published data)		
Gap to next quartile	To improve to quartile 2 -9.0% To improve to median -8.5%	New metric for 2026/27 NOF

*Indicative RAG based on Quartile – NHSE RAG methodology to be determined

Most up-to-date performance position based on the local assessment of published data

Percentage of patients to describe booking a general practice appointment as easy

Metric	Percentage of patients to describe booking a general practice appointment as easy		
Domain	Experience of Care		
Domain Subgroup	Experience		
MDT	Primary Community and Neighbourhood	**MDT Priority**	Yes
ICB Commissioning Lead	Director of Primary and Community Care (Sukh Singh)	**Clinical Lead**	Primary Care (Ash Peshen)
In NOF 2026/27?			

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	68%	Latest Data (National)	March 2026
National Rank	38/42	RAG Rating	R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	69.10%	Latest Data (Local)	Jul-2026 (Wave 26)
National Rank	33/36	RAG Rating	R

Insight (based on most up-to date published data)							
Gap to next quartile	To improve to quartile 3	4.9%	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	6.6%		61.3%	66.4%	67.6%	68%

Most up-to-date performance position based on the local assessment of published data

I practice professional reporting they were able to get an appointment with that professional

Metric	Percentage of patients with a preferred general practice professional reporting they were able to get an appointment with that professional		
Domain	Effectiveness and experience of care		
Domain Subgroup	Patient experience		
MDT	Primary, Community and Neighbourhood	**MDT Priority**	No
ICB Commissioning Lead	Director of Primary and Community Care (Sukh Singh)	**Clinical Lead**	Primary Care (Ash Peshen)
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided by NHSE in advance of ICB Annual Assessment)			
Current Performance (National)	76.4%	Latest Data (National)	Mar-26
National Rank	29/42	RAG Rating	A/R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	63.00%	Latest Data (Local)	Jul-26 (Wave 26)
National Rank	26/36	RAG Rating	G/A

Insight (based on most up-to date published data)							
Gap to next quartile	To improve to quartile 1	9.70%	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	1.05%		57.30%	74.50%	87.4%	76.40%

Worsening position - No highest quartile performance for last 7 waves. Lowest quartile performance in wave 25.

12 month adult admission rate for people with a learning disability or who are autistic

Metric	12 month adult admission rate for people with a learning disability or who are		
Domain	Experience of Care		
Domain Subgroup	Patient Flow		
MDT	Mental Health and Learning Disabilities	**MDT Priority**	TBC
ICB Commissioning Lead	MHLDA Commissioning Director (Nicola Smith)	**Clinical Lead**	MHLDA
In NOF 2026/27?	Yes – new metric		

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	5 per million	Latest Data (Local)	Jul-26
National Rank	1/36	RAG Rating	G

Insight (based on most up-to date published data)		
Gap to next quartile	To improve to quartile 1 n/a To improve to median n/a	New metric for 2026/27 NOF

Contextual metric

Percentage of inappropriate out of area placement adult acute mental health bed days

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Metric	Percentage of inappropriate out of area placement adult acute mental health bed days		
Domain	Experience of Care		
Domain Subgroup	Patient Flow		
MDT	MHLDA	**MDT Priority**	TBC
ICB Commissioning Lead	MHLDA Commissioning Director (Nicola Smith)	**Clinical Lead**	MHLDA (Valsraj Koranvangattu)
In NOF 2026/27?	Yes		

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	OAP09a: Acute MH: 1% OAP09b: MHLDA acute / rehab: 13%	Latest Data (Local)	Jun-26
National Rank	24/42	RAG Rating	G/A

Insight (based on most up-to date published data)							
Gap to next quartile	To improve to Band 1	OAP09a	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
				12.33%	4.00%	3.94%	2.00%

*NB – Methodology changed from NOF 2025/26 to NOF 2026/27

Average number of days from discharge ready date and actual discharge date

Metric	Average number of days from discharge ready date and actual discharge date		
Domain	Experience of Care		
Domain Subgroup	Patient Flow		
MDT	UEC & Flow	**MDT Priority**	Yes
ICB Commissioning Lead	Director of UEC & Flow (Mark Atkinson)	**Clinical Lead**	Secondary Care (James MacDonald)
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	1.13	Latest Data (National)	March 2026
National Rank*	32/42	RAG Rating	R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	1.09	Latest Data (Local)	Jun-2026
National Rank	27/36	RAG Rating	A/R

Insight (based on most up-to date published data)

Gap to next quartile	To improve to quartile 2	-0.15	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	-0.15		1.30	1.53	1.22	1.13

Provider Level Data

Provider	Number of patients discharged in total	Total bed days lost due to delayed discharge	Average days from Discharge Ready Date to date of discharge (inc 0 day delays)	To improve to Q2	To improve to median
DARTFORD AND GRAVESHAM NHS TRUST	2,016	2,430	1.21	-0.27	-0.27
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	3,351	4,545	1.36	-0.42	-0.42
MEDWAY NHS FOUNDATION TRUST	1,686	3,024	1.79	-0.86	-0.85
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	2,555	439	0.17	-	-
NHS Kent and Medway ICB Total	**9,608**	**10,438**	1.09	-0.15	-0.15

Most up-to-date performance position based on the local assessment of published data

NHS Talking Therapies reliable recovery rate

Effectiveness of Care

Metric	NHS Talking Therapies reliable recovery rate		
Domain	Effectiveness of Care		
Domain Subgroup	Outcomes		
MDT	Mental Health and Learning Disabilities	**MDT Priority**	
ICB Commissioning Lead	MHLDA Commissioning Director (Nicola Smith)	**Clinical Lead**	Deputy CMO MHLDA (Valsraj Koranvangattu)
In NOF 2026/27?			

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	49%	Latest Data (National)	March 2026
National Rank	22/42	RAG Rating	A/R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	49%	Latest Data (Local)	March 2026
National Rank	22/42	RAG Rating	A/R

Insight (based on most up-to date published data)							
Gap to next quartile	To improve to quartile 2	0.0%	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	0.0%			46%	45%	49%

Most up-to-date performance position based on the local assessment of published data

y admissions in the last 90 days of life (NEW 26/27 OF Metric)

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Metric	Percentage of people with 3 or more emergency admissions in the last 90 days of life		
Domain	Effectiveness of Care		
Domain Subgroup	Outcomes		
MDT	UEC and Flow	**MDT Priority**	TBC
ICB Commissioning Lead	Director of UEC and Flow	**Clinical Lead**	TBC
In NOF 2026/27?	Yes – new metric		

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	4.57	Latest Data (Local)	2024
National Rank	3/42	RAG Rating	G

Insight (based on most up-to date published data)		
Gap to next quartile	To improve to quartile n/a To improve to median n/a	New metric for 2026/27 NOF

Percentage of patients who receive all 8 diabetes care processes

Effectiveness of Care

Metric	Percentage of patients who receive all 8 diabetes care processes		
Domain	Effectiveness of care		
Domain Subgroup	Managing Long Term Conditions		
MDT	Primary Community & Neighbourhood	**MDT Priority**	Yes
ICB Commissioning Director	Director of Primary and Community Care (Sukh Singh)	**Clinical Lead**	Primary Care (Ash Peshen)
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	35.29%	Latest Data (National)	Q3 2025/26
National Rank	38/42	RAG Rating	R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	49.81%	Latest Data (Local)	Q4 2025/26
National Rank	38/42	RAG Rating	R

Insight (based on most up-to date published data)							
Gap to next quartile	To improve to quartile 3	4.04%	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	6.01%		51.4%	51.4%	49.8%	35.3%

Neighbourhood Level Data

Neighbourhood	Numerator	Denominator	Value	To improve to quartile 3	To improve to median	Add. patients to q3	Add. patients to median
Dartford, Gravesham & Swanley	8,355	18,925	14.0%	40.52%	42.68%	7,668	8,078
Canterbury, Coastal & Faversham	5,745	13,290	20.4%	34.11%	36.27%	4,533	4,821
Medway	11,250	24,040	21.6%	32.95%	35.12%	7,922	8,443
Sittingbourne & Sheppey	3,900	8,550	24.1%	30.40%	32.56%	2,599	2,784
Thanet & Deal	8,200	15,720	25.6%	28.96%	31.13%	4,553	4,894
Folkestone, Hythe & Dover	6,735	12,825	26.1%	28.42%	30.59%	3,645	3,923
Maidstone, Malling and The Weald	10,430	19,220	26.4%	28.18%	30.35%	5,417	5,833
Sevenoaks, Tonbridge and Tunbridge Wells	7,090	13,160	26.4%	28.17%	30.34%	3,707	3,992
Ashford & Rural	5,790	9,765	31.9%	22.59%	24.76%	2,206	2,417

Most up-to-date performance position based on the local assessment of published data

who have their cholesterol levels managed to NICE guidance

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Metric	Percentage of patients with GP recorded CVD who have their cholesterol levels managed to NICE guidance		
Domain	Effectiveness of care		
Domain Subgroup	Managing Long Term Conditions		
MDT	Primary Community & Neighbourhood	**MDT Priority**	Yes
ICB Commissioning Lead	Director of Primary and Community Care (Sukh Singh)	**Clinical Lead**	Primary Care (Ash Peshen)
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Hospital)			
Current Performance (National)	45.65%	Latest Data (National)	Q3 2025/26
National Rank	40/42	RAG Rating	R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	45.65%	Latest Data (Local)	Q3 2025/26
National Rank	40/42	RAG Rating	R

Insight (based on most up-to date published data)

Gap to next quartile	To improve to quartile 3	2.75%	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	5.29%		41.8%	41.49%	43.12%	45.65%

Neighbourhood Level Data

Neighbourhood	Numerator	Denominator	Value	To improve to quartile 3	To improve to median	Add. patients to q3	Add. patients to median
Thanet & Deal	4,850	11,880	40.8%	7.58%	10.12%	900	1,202
Folkestone, Hythe & Dover	3,910	9,555	40.9%	7.48%	10.02%	715	957
Dartford, Gravesham & Swanley	4,775	11,215	42.6%	5.82%	8.36%	653	938
Ashford & Rural	3,055	6,690	45.7%	2.73%	5.27%	183	353
Canterbury, Coastal & Faversham	4,730	10,285	46.0%	2.41%	4.95%	248	509
Sittingbourne & Sheppey	2,195	4,760	46.1%	2.29%	4.83%	109	230
Medway	5,940	12,680	46.8%	1.55%	4.09%	197	519
Maidstone, Malling and The Weald	5,945	11,785	50.4%	-	0.49%	0	58
Sevenoaks, Tonbridge and Tunbridge Wells	5,120	9,935	51.5%	-	-	0	0
NHS Kent and Medway ICB Total	**40,520**	**88,785**	**45.65%**	**2.75%**	**5.29%**	**2,442**	**4,697**

NB: Scoring methodology for NOF 2026/27 compares performance to baseline (TBC – based on Q1 26/27 performance)

Percentage of hypertension patients treated to target

Metric	Percentage of hypertension patients treated to target		
Domain	Effectiveness of care		
Domain Subgroup	Managing Long Term Conditions		
MDT	Primary Community & Neighbourhood	**MDT Priority**	Yes
ICB Commissioning Lead	Director of Primary and Community Care (Sukh Singh)	**Clinical Lead**	Primary Care (Ash Peshen)
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Hospital)			
Current Performance (National)	65.39%	Latest Data (National)	Q3 2025/26
National Rank	41/42	RAG Rating	R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	65.39%	Latest Data (Local)	Q3 2025/26
National Rank	41/42	RAG Rating	R

Insight (based on most up-to date published data)

Gap to next quartile	To improve to quartile 3	2.81%	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	3.95%		67.61%	64.39%	64.64%	65.39%

Neighbourhood Level Data

Neighbourhood	Numerator	Denominator	Value	To improve to quartile 3	To improve to median	Add. patients to q3	Add. patients to median
Dartford, Gravesham & Swanley	28,200	44,300	63.66%	4.54%	5.68%	2,013	2,518
Ashford & Rural	15,185	23,630	64.26%	3.94%	5.08%	931	1,200
Thanet & Deal	25,225	39,065	64.57%	3.63%	4.77%	1,417	1,863
Medway	33,500	51,745	64.74%	3.46%	4.60%	1,790	2,380
Folkestone, Hythe & Dover	20,250	30,745	65.86%	2.34%	3.48%	718	1,069
Sevenoaks, Tonbridge and Tunbridge Wells	22,910	34,720	65.99%	2.21%	3.35%	769	1,165
Canterbury, Coastal & Faversham	22,765	34,340	66.29%	1.91%	3.05%	655	1,046
Maidstone, Malling and The Weald	29,115	43,575	66.82%	1.38%	2.52%	603	1,100
Sittingbourne & Sheppey	12,270	18,100	67.79%	0.41%	1.55%	74	281
NHS Kent and Medway ICB Total	**209,420**	**320,220**	**65.39%**	**2.81%**	**3.95%**	**8,998**	**12,649**

NB: Scoring methodology for NOF 2026/27 compares performance to baseline (TBC – based on Q1 26/27 performance)

Back to Agenda

Patients on the GP severe mental illness register receiving a full health check

Metric	Patients on the GP severe mental illness register receiving a full health check		
Domain	Effectiveness of Care		
Domain Subgroup	Managing Long Term Conditions		
MDT	Mental Health and Learning Disabilities	**MDT Priority**	TBC
ICB Commissioning Lead	TBC	**Clinical Lead**	TBC
In NOF 2026/27?	Yes – new metric		

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	59%	Latest Data (Local)	Q4 25/26
National Rank	32/42	RAG Rating	A/R

Insight (based on most up-to date published data)		
Gap to next quartile	To improve to target 1%	New metric for 2026/27 NOF

l for patients with a learning disability or who are autistic (Banded score)

Metric	Percentage of annual health checks completed for patients with a learning disability or who are autistic (Banded score)		
Domain	Effectiveness of Care		
Domain Subgroup	Managing Long Term Conditions		
MDT	Mental Health and Learning Disabilities	**MDT Priority**	No
ICB Commissioning Lead	Director of Strategic Change and Population Health	**Clinical Lead**	MHLDA
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	Band 3	Latest Data (National)	Q4 2025/26
National Rank	33/42	RAG Rating	A/R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	11.15% (Band 2)	Latest Data (Local)	June 2026
National Rank	31/36 (raw % value)	RAG Rating	G/A

Insight (based on most up-to date published data)

			Q1	Q2	Q3	Q4
Gap to next quartile	Banded score – target met in previous year, current month performance below previous year To reach Q1 each month, the percentage of Health checks carried out must be more than the same time period last year	**2025/26**	1	1	2	3

Banding methodology

1 = 75% target was met in the previous year and the latest performance is at/above where it was at this point in the previous year
2 = 75% target was met in the previous year but the latest performance is below where it was at this point in the previous year
3 = 75% target was not met in the previous year but the latest performance is above where it was at this point in the previous year
4 = 75% target was not met in the previous year and the latest performance is at/below where it was at this point in the previous year

Target met in previous year?	76.5%	Y
Current performance	2.96	
At same point in previous year	3.90	
Performance at/above previous year?		N
Band		2

	April	May	June	July	August	September	October	November	December	January	February	March
2025/26	3.9%	8.0%	12.8%	18.6%	23.9%	30.7%	36.8%	43.5%	49.6%	58.4%	67.8%	76.5%
2026/27	2.96%	6.03%	11.15%									

Percentage of children (aged 0-9) prescribed antibiotics in the last 12 months

Patient Safety

Fixed national target: at or below 27%. Metric achieving national target, but in Quartile 2

Metric	Percentage of children (aged 0-9) prescribed antibiotics in the last 12 months		
Domain	Patient Safety		
Domain Subgroup	Safe Practice		
MDT	Executive Committee	**MDT Priority**	
ICB Commissioning Lead	Chief Nursing Officer	**Clinical Lead**	Chief Pharmacist
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	25.9%	Latest Data (National)	March 2026
National Rank	17/36	RAG Rating	G
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	26.04%	Latest Data (Local)	May-26
National Rank	14/36	RAG Rating	G/A

Insight (based on most up-to date published data)

Gap to next quartile	To improve to target	-1.04%	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
				27.60%	26.90%	26.10%	25.90%

Neighbourhood Level Data

Neighbourhood	Numerator	Denominator	Value	To improve to quartile 1	To improve to median	Add. patients to q1	Add. patients to median
Sittingbourne & Sheppey	3,827	12,738	30.04%	-5.02%	-2.58%	-640	-329
Ashford & Rural	3,934	16,130	24.39%	-	-	0	0
Medway	9,298	39,127	23.76%	-	-	0	0
Sevenoaks, Tonbridge and Tunbridge Wells	5,933	25,067	23.67%	-	-	0	0
Dartford, Gravesham & Swanley	8,223	35,408	23.22%	-	-	0	0
Maidstone, Malling and The Weald	7,518	33,432	22.49%	-	-	0	0
Thanet & Deal	4,126	19,367	21.30%	-	-	0	0
Canterbury, Coastal & Faversham	4,072	19,346	21.05%	-	-	0	0
Folkestone, Hythe & Dover	3,418	16,866	20.27%	-	-	0	0

Number of neonatal deaths and stillbirths per 1,000 total births (banded score)

Patient Safety

Metric	Number of neonatal deaths and stillbirths per 1,000 total births (banded score)		
Domain	Patient Safety		
Domain Subgroup	Safe Outcomes		
MDT	Executive Committee	**MDT Priority**	No
ICB Commissioning Lead	Chief Nursing Officer	**Clinical Lead**	
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	4.55	Latest Data (National)	2024
National Rank	Banded score	RAG Rating	A/R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	4.55	Latest Data (Local)	2024
National Rank	11/42	RAG Rating	G/A

Insight (based on most up-to date published data)

			Q1	Q2	Q3	Q4
Gap to next quartile	To improve to quartile 1	Banded score	4.16	4.16	4.55	4.55
	To improve to median					

2025/26

NHS Kent and Medway Integrated Care Board

Year	Births	Crude stillbirth rate	Stabilised stillbirth rate	Stabilised stillbirth rate 95% CI	Crude neonatal mortality rate	Stabilised neonatal mortality rate	Stabilised neonatal mortality rate 95% CI	Crude extended perinatal mortality rate	Stabilised extended perinatal mortality rate	Stabilised extended perinatal mortality rate 95% CI
2020	19,247	2.60	3.02	2.46 to 3.69	1.15	1.46	1.16 to 1.80	3.74	4.48	3.80 to 5.25
2021	19,873	3.72	3.69	3.10 to 4.51	1.52	1.61	1.22 to 2.20	5.23	5.30	4.56 to 6.28
2022	19,646	3.56	3.47	2.95 to 4.09	1.17	1.38	1.02 to 1.95	4.73	4.85	4.19 to 5.69
2023	18,562	2.26	2.66	2.10 to 3.39	1.35	1.50	1.12 to 2.06	3.61	4.16	3.50 to 5.03
2024	18,846	2.65	2.94	2.39 to 3.62	1.60	1.61	1.24 to 2.11	4.24	4.55	3.85 to 5.41

Mortality rate compared with the group average

- Over 15% lower
- 5 to 15% lower
- Within 5%
- Over 5% higher
- Suppressed due to small numbers

Scoring:
1.00 = >15% below average
2.00 = 5 – 15% below average
3.00 = within 5% of average
4.00 = over 5% above average

Sickness absence rate

People

Metric	Sickness absence rate		
Domain	People and workforce		
Domain Subgroup	People and workforce		
MDT	Operational HR	**MDT Priority**	No
ICB Commissioning Lead	Director of People	**Clinical Lead**	
In NOF 2026/27?	Yes		

Q4 NHS Oversight Framework Performance (as provided on Model Health System)			
Current Performance (National)	4.56%	Latest Data (National)	Q3 25/26
National Rank	24/42	RAG Rating	A/R
Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	3.12%%	Latest Data (Local)	Apr-26
National Rank	15/37	RAG Rating	G/A

Insight (based on most up-to date published data)

Gap to next quartile	To improve to next quartile	-0.55%	**2025/26**	**Q1**	**Q2**	**Q3**	**Q4**
	To improve to median	n/a		3.09%	3.18%	3.18%	4.58%

Breakdown by Staff Group

Kent and Medway ICB – April 2026

ORG_NAME	STAFF_GROUP	FTE_DAYS_LOST	FTE_DAYS_AVAILABLE	SICKNESS_ABSENCE_RATE_PERCENT
NHS Kent and Medway ICB	Nurses & health visitors	98	2,405	4.07
NHS Kent and Medway ICB	Managers	102	2,714	3.76
NHS Kent and Medway ICB	Central functions	221	6,332	3.49
NHS Kent and Medway ICB	Scientific, therapeutic & technical staff	44	1,702	2.59
NHS Kent and Medway ICB	Senior managers	16	2,072	0.77
NHS Kent and Medway ICB	**All staff groups**	**586**	**18,820**	**3.12**

Number of general practitioners per 100k head of weighted population

People

Metric	Number of general practitioners per 100k head of weighted population		
Domain	People		
Domain Subgroup	Workforce		
MDT	Primary Community & Neighbourhood (TBD)	**MDT Priority**	TBD
ICB Commissioning Lead		**Clinical Lead**	
In NOF 2026/27?	Yes – New metric		

Most up-to-date performance position based on the local assessment of published data			
Current Performance (Local)	49.58	Latest Data (Local)	Jun-2026
National Rank	36/36	RAG Rating	R

Insight (based on most up-to date published data)			
Gap to next quartile	To improve to quartile 3	8.19	New metric for 2026/27 NOF
	To improve to median	9.94	

Most up-to-date performance position based on the local assessment of published data

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Cyber Assurance Report
Key question	Can the Board be assured that NHS Kent and Medway ICB has effective governance, oversight and control arrangements in place to manage cyber security risks, respond to emerging threats and maintain organisational resilience?
Executive Lead	Dr Mayur Vibhuti, Chief Digital, Data and Information Officer
Author	Vivek Singh, Chief Technology Officer

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☐ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

The Board is asked to:

1. **NOTE** the contents of the report
2. **RECEIVE** assurance that appropriate governance, risk management and control arrangements are in place to manage cyber security risk across the ICB.
3. **NOTE** the findings from the independent cyber security and DSPT assessments.
4. **NOTE** the residual risks and improvement actions set out in the report.
5. **ENDORSE** the proposed approach to ongoing cyber assurance and reporting.

Executive summary:
Independent assessments undertaken during 2025/26 provide positive assurance regarding the maturity of the ICB's cyber security arrangements. An independent cyber security audit awarded Substantial Assurance, and the independent DSPT assessment reported a high level of confidence in the organisation's self-assessment. No significant control weaknesses or urgent recommendations were identified. This report provides assurance and updates to the ICB Board on Cyber Security. This report is also written to create awareness about the clear asks and responsibilities that the ICB Executive needs to fulfil. Both of these objectives are in line with the letter issued by NHSE on the 10 June 2026. The Board is updated, via this report, that the right cybersecurity measures are in place in Kent and Medway, risks are checked and managed, and improvements are continually carried out across the organisation. The report assures the Committee members that the right foundations and measures are in place to protect the ongoing provision of services to the public. The report also informs the committee of the organisations assured position against the national DSPT framework criteria, and further actions that we being undertaken to consolidate this position and mitigate ongoing risks.
Proposed next steps:
Subject to Board discussion, progress the improvement actions outlined within the report and continue routine oversight through established governance arrangements, with further assurance updates brought to the Board as required.

Governance pathway to date:

Meeting name:	Date:	Outcome:
Executive Committee	8 July 2026	Assurance

Contact for further information	Mayur Vibhuti mayurvibhuti@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable

COMPLIANCE NOTES:
This report is a review of current status and assurance position.

Conflicts of interest
Are there any conflicts associated with authors or reporting officers? ☐ Yes ☒ No *If yes, please confirm how the conflict has been managed.*

FOI status
Is this report disclosable under FOI? ☒ Yes ☐ No *If no, please specify why:*

Financial implications
Are there financial implications associated with this report? ☐ Yes ☒ No *If yes, please describe:*

Legal implications
Are there legal implications associated with this report? ☒ Yes ☐ No Integrated Care Boards (ICBs) have statutory and legal responsibilities for cyber security and information governance to ensure patient safety and data privacy.

Quality and safety implications
Are there quality or safety implications associated with this report? ☒ Yes ☐ No Cyber security has critical patient safety and care quality implications, as breaches can severely disrupt frontline operations, leading to delayed treatments, postponed surgeries, misdirected medical records, and in severe cases can contribute to patient harm or death.

Patient and public engagement
Are there patient and public engagement implications associated with this report? ☐ Yes ☒ No *If yes, please describe. If no, please specify why:*

KENT AND MEDWAY CYBER ASSURANCE REPORT

1. INTRODUCTION

Kent and Medway Integrated Care Board (ICB) recognises that cyber security is a critical enabler of safe, effective and resilient healthcare services. As digital technologies become increasingly embedded across health and care, the organisation faces a growing responsibility to protect patient information, safeguard essential systems and maintain service continuity against an evolving cyber threat landscape. This report provides Executive and Board-level assurance regarding the management of cyber security risks within the ICB, the effectiveness of current governance and control arrangements, and the organisation's overall cyber resilience position.

The report has been prepared in response to recent NHS England guidance on Board and Executive assurance for cyber security risk and draws upon the findings of independent assurance reviews undertaken during 2025 and 2026. These reviews include the independent Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) assessment and an independent cyber security audit, both of which provide strong evidence of mature governance, effective risk management and robust cyber security controls across the organisation.

While the independent reviews identified only limited low-risk improvement opportunities, cyber security remains a continuously evolving challenge. Accordingly, the report also sets out a programme of continuous improvement activities designed to strengthen resilience further, ensure compliance with emerging national requirements, and support the delivery of secure digital transformation across Kent and Medway. Through sustained executive oversight, clear accountability and ongoing investment in cyber capabilities, the ICB aims to maintain a strong and proportionate cyber security posture that protects patients, staff and services.

This paper therefore seeks to provide assurance to the Executive Committee and Board that cyber security risks are being effectively managed, that independent assurance has confirmed the strength of current arrangements, and that a structured plan is in place to address emerging risks and support continuous improvement.

Overall assurance statement

The overall assurance conclusion is positive. Independent reviews have confirmed that Kent and Medway ICB has effective cyber governance, risk management and control arrangements in place, with no significant control weaknesses or urgent recommendations identified. The principal residual risks relate to business continuity and cyber recovery evidence, supplier compliance with cyber standards, and the need to maintain resilience against an evolving threat landscape. Improvement actions are underway through established executive governance routes, and the Board can take reasonable assurance that current controls are operating effectively while recognising that continued oversight is required for the residual risks and improvement plan.

2. STRATEGIC ALIGNMENT

Cyber Security preparedness and measures to keep the Kent and Medway ICB systems secure and compliant, and being assured about them, is fundamental to the ICB being able to deliver on its strategic objectives. Cyber assurance, like other digital capabilities, is a key enabler in the ICB being able to drive the analogue to digital agenda, and commission our healthcare services sustainably and safely.

3. MAIN REPORT: CYBER SECURITY ASSURANCE

Independent Assurance Position

Kent and Medway ICB has received strong independent assurance regarding its cyber security, information governance and organisational resilience arrangements. Two external reviews completed during 2025/26 concluded that the organisation maintains effective governance, robust security controls and mature risk management processes. The independent CAF-aligned Data Security and Protection Toolkit (DSPT) assessment reported a high level of confidence in the ICB's self-assessment, while the independent cyber security audit awarded **Substantial Assurance**, the highest level of assurance available within the audit framework.

For Board assurance purposes, the reference to an overall High classification within the CAF-aligned DSPT methodology should be read as a positive confidence assessment of the organisation's position and evidence base. It does not indicate a high-risk control weakness. The independent assessment identified only two low-risk observations, and these relate to strengthening documentation and evidence of business continuity arrangements rather than weaknesses in core cyber security controls.

Governance, Accountability and Risk Management

The reviews found that cyber security is supported by well-established governance structures, clear executive accountability and effective organisational oversight. Cyber and information risks are managed through the corporate risk management framework, with regular monitoring, escalation and reporting mechanisms in place. Strong leadership from the Senior Information Risk Owner (SIRO), established Information Governance arrangements and Board oversight provide assurance that cyber security is being managed as a strategic organisational risk rather than solely a technical concern. Policies and procedures are aligned with NHS England requirements and national standards, helping maintain compliance and resilience across the organisation.

Areas of Strength

The independent reviews identified a number of significant strengths across the cyber security control environment:

- **Strong governance and risk management**, with cyber risks clearly identified, monitored and subject to executive oversight.
- **Effective cyber awareness and training**, supported by structured training programmes, testing and engagement from senior leaders.

- **Mature technical security controls**, including Cyber Essentials Plus accreditation, vulnerability management, patching processes and secure system configurations.
- **Robust identity and access management**, incorporating Multi-Factor Authentication, access reviews and privileged account management.
- **Comprehensive monitoring, incident response and recovery arrangements**, supported by regular testing and lessons-learned processes.
- **Effective supplier and third-party assurance**, ensuring cyber risks associated with the supply chain are identified and managed appropriately.

The reviews also recognised the organisation's strong backup and recovery capabilities, proactive management of technology lifecycle risks, and continued investment in maintaining cyber resilience across critical services and infrastructure.

Taken together, these areas of strength support the assurance conclusion that cyber security is being managed through an appropriate balance of Board oversight, executive accountability and operational control. The findings provide evidence that the ICB has established controls in place and that the remaining actions are focused on assurance maturity, documentation and continuous improvement.

Findings and Improvement Opportunities

Importantly, neither review identified any significant cyber security weaknesses, control failures or urgent recommendations. The DSPT assessment identified only two low-risk observations relating to the documentation of Business Impact Assessments and evidence of business continuity testing following organisational restructuring. Similarly, the cyber security audit identified two routine recommendations concerning the annual refresh of cyber awareness training and the updating of governance Terms of Reference. These findings represent opportunities to strengthen assurance and documentation arrangements rather than deficiencies in the control environment.

Continuous Improvement Priorities

Whilst the overall assurance position is strong, the report recognises that cyber security remains an evolving challenge which requires continued investment and organisational focus. A programme of improvement activity has therefore been established to strengthen resilience further and ensure continued alignment with emerging NHS England requirements.

Key priorities include:

- Development of a Kent and Medway Cyber Strategy.
- Preparation for future CAF-aligned DSPT requirements.
- Review of supplier compliance with Multi-Factor Authentication and cyber security standards.
- Completion of Business Impact Assessments and business continuity testing programmes.
- Strengthening governance arrangements and executive cyber leadership.
- Continued management of technology lifecycle and emerging cyber risks.
- Enhanced collaboration with regional and national partners to support system-wide cyber resilience.

Board oversight action plan

The following action plan summarises the improvement activity requiring continued executive and Board oversight. Dates are proposed for monitoring purposes and should be confirmed through the relevant governance route.

Action	Accountable lead	Status	Target date	Reporting and escalation route
Refresh annual cyber awareness training in response to the independent audit recommendation.	Chief Technology Officer	In progress	31 Jan 2027	Executive Committee and Board as required
Review and update Information Governance Groups post following DDI organisational restructure	Senior Information Risk Owner	In progress	31 Jan 2027	Executive Committee for assurance
Complete Business Impact Assessments and evidence business continuity testing following DDI organisational restructuring.	Chief Technology Officer	Planned	31 Jan 2026	Digital governance and corporate risk management routes, with escalation through Executive Committee
Review supplier compliance with MFA, DSPT and relevant cyber security standards.	Chief Digital, Data, Information Officer	Planned	31 Mar 2027	Supplier assurance reporting through executive governance and Board assurance updates
Develop the Kent and Medway Cyber Strategy and prepare for future CAF-aligned DSPT requirements.	Chief Digital, Data, Information Officer	Planned	31 Mar 2027	Executive Committee oversight, with further assurance reporting to Board

Assurance Conclusion

The current assurance position is positive. The independent DSPT and cyber security reviews provide significant assurance that Kent and Medway ICB has effective governance, oversight and control arrangements in place for cyber security risk. The limited findings are low risk and are being addressed through the action plan set out above. Residual risks remain in relation to business continuity evidence, supplier compliance and the evolving cyber threat landscape, and these will continue to require Executive and Board oversight. On this basis, the Board can take reasonable assurance from the present position while maintaining oversight of delivery against the agreed improvement actions.

4. KEY RISKS, MITIGATIONS, AND CONTROLS

The following table sets out the principal residual cyber risks requiring ongoing Executive and Board oversight. These are areas where management attention remains necessary alongside the positive assurance already obtained from the independent reviews.

Strategic Risk	Current Assurance	Key Mitigation
Business continuity and cyber recovery assurance	Low-risk findings identified by DSPT review	Complete BIAs, restoration priorities and testing programme
Supplier and compliance risk	Strong controls but known supplier compliance gaps	Review supplier MFA/DSPT compliance and prepare for CAF 4.0
Evolving cyber threat landscape	Substantial Assurance from audit	Develop Cyber Strategy, strengthen leadership, investment and system-wide resilience

5. REQUIRED OUTCOMES AND NEXT STEPS

The meeting is asked to:

- **NOTE** the contents of the report
- **RECEIVE** assurance that appropriate governance, risk management and control arrangements are in place to manage cyber security risk across the ICB.
- **NOTE** the findings from the independent cyber security and DSPT assessments.
- **NOTE** the residual risks and improvement actions set out in the report.
- **ENDORSE** the proposed approach to ongoing cyber assurance and reporting.

The next steps following consideration by the meeting will be:

- Progress the Board oversight action plan set out in this report.
- Confirm accountable leads, target dates and reporting routes through the relevant governance groups.
- Provide further assurance updates to the Executive Committee and Board through the agreed reporting cycle.

6. SUPPORTING DOCUMENTATION

The following documents are available to support the content of this paper:

- *PRN02540 - Board and executive assurance - cyber security risk_June 2026.pdf* : NHSE Cyber Security Letter to Chief Execs and Chairs, dated 10th June 2026.
- *NHS Kent and Medway ICB-ICT-DSPT-d.docx* : Draft DSPT Audit report for 2025-26, June 2026.
- *NHS Kent and Medway ICB-ICT-Cyber Security-f.docx : External Cyber Security Audit report, Dec 2025*

Appendices

Appendix 1: Cyber Assurance Report

Title of report	**Board and Executive Assurance for Cyber Security**		
Reporting officer	Dr Mayur Vibhuti, Chief Digital, Data & Information Officer NHS Kent & Medway	**Date of meeting**	22.09.2026
Lead SRO	Dr Mayur Vibhuti, Chief Digital, Data & Information Officer NHS Kent & Medway		

1.0 Executive and Board Asks Summary

This report provides an overview of Kent and Medway Integrated Care Board's responsibility to effectively manage cyber security risks amid increasing digital transformation and threats, and the ICBs current plans and status of assurance against the cyber risks.

This report is aligned with the guidance published by NHSE on the 10th of June, and subsequently issued to all ICBs:

NHS England » Board and executive assurance: cyber security risk

Key aspects of the NHSE notification include:

Cyber Security Governance:

- Boards and executives must ensure organization-wide cyber risk management with clear programs and governance.
- Appoint a senior executive responsible for cyber security to oversee measures, risk management, and improvements.
- Regular assurance on emergency preparedness and testing recovery plans is essential.

Data Security and Protection Toolkit (DSPT):

- All NHS organizations must comply with DSPT, aligned with the Cyber Assessment Framework (CAF), with submissions due by June 2026.
- The toolkit covers managing risks, protecting data, detecting events, minimizing impact, and sharing information appropriately.
- From September 2026, new policies will address multi-factor authentication, high-severity alerts, and endpoint detection, with updates to CAF 4.0.

Key Cyber Resilience Outcomes:

- Asset management involves maintaining an up-to-date inventory, classifying assets, and managing lifecycle.

- Supply chain management requires understanding third-party risks, including security controls in contracts.
- Identity and access controls demand unique identification, multi-factor authentication, and regular review.
- Vulnerability management includes scanning, prioritizing, remediating, and tracking vulnerabilities.
- Backup and restore processes must be tested regularly, with secure storage and offline copies.
- Security monitoring should cover critical systems, with logs centrally collected and validated.
- Incident response plans must be tested, with clear roles, communication, and lessons learned.

Overall:

- Organizations are expected to demonstrate control, evidence of compliance, and continuous improvement to enhance resilience against cyber threats.

2.0 Executive Assurance: Summaries of Independent Review Findings

- **Independent (Draft) DSPT Assessment, June 2026** (detailed in section 2.0 in this report)

The independent CAF-aligned DSPT assessment provides substantial assurance that Kent and Medway ICB has strong governance arrangements for information governance, data protection, cyber security and resilience. The assessor reported a high level of confidence in the organisation's self-assessment and identified several areas of good practice, including Board oversight, executive accountability, risk management and policy governance. Only two low-risk findings were reported, both relating to business continuity documentation during a period of organisational restructuring. No significant governance, compliance or cyber security weaknesses were identified. The assessment therefore confirms a mature and well-controlled governance environment, with minor improvements planned to further strengthen business continuity assurance arrangements.

- **Independent Review of Cyber Security, December 2025** (detailed in section 3.0 in this report)

The independent cyber security audit awarded Kent and Medway ICB **Substantial Assurance**, providing strong assurance that cyber risks are being effectively managed through a mature governance framework, comprehensive risk management arrangements and well-established technical controls. The review identified significant areas of good practice across cyber governance, security

awareness, vulnerability management, identity and access management, monitoring, incident response and supply chain security. Only two routine recommendations were raised, both relating to continuous improvement activities rather than control weaknesses. No urgent or significant cyber security concerns were identified. The audit therefore demonstrates that Kent and Medway ICB has a strong and resilient cyber security posture, supported by effective governance, executive oversight and independent external assurance through Cyber Essentials Plus accreditation.

3.0 Kent and Medway ICB Position Statement on Governance and (Draft) DSPT Assessment, June 2026

The independent Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) assessment provides strong assurance that Kent and Medway ICB has established and effective governance arrangements for data protection, information governance, cyber security and resilience. The review concluded that there is a **high level of confidence in the accuracy of the ICB's self-assessment**, with the majority of assessed outcomes meeting or exceeding the required standards and only two low-risk findings identified.

The assessment found that governance arrangements are mature and embedded throughout the organisation. There is clear executive accountability for information governance and cyber security, supported by strong leadership from the Senior Information Risk Owner (SIRO) and Caldicott Guardian. Oversight is provided through established governance structures, including the Information Governance Management Group (IGMG), ensuring that information risks are routinely monitored, escalated and reviewed at the appropriate level. The independent assessor specifically identified governance and risk management as areas of good practice.

The ICB demonstrates a comprehensive policy framework aligned to NHS England requirements, UK GDPR, the Data Protection Act and wider national standards. Policies are regularly reviewed and updated, ensuring ongoing compliance and alignment with emerging cyber security and information governance requirements. In addition, a structured corporate risk management framework is in place which provides visibility of information and cyber risks through centralised risk registers and Board reporting mechanisms.

Importantly, the assessor confirmed agreement with the vast majority of the organisation's self-assessment submissions, demonstrating that the ICB has accurately assessed its own security and governance maturity. The report concludes that the overall confidence level in the veracity of the DSPT submission is **High**, reflecting minimal deviation between the organisation's assessment and the independent review.

The review also identified several strengths that support the ICB's overall governance position, including:

- Strong Board-level governance and accountability arrangements.

- Clear organisational leadership for information governance and security.
- Effective risk management and escalation processes.
- Comprehensive and regularly maintained policy frameworks.
- Robust backup and recovery arrangements, including secure and routinely tested backups.
- Effective management of information rights requests, data protection obligations and incident management processes.

While the report assigns an overall risk assurance rating of **High**, it is important to recognise that this rating reflects the NHS England CAF methodology rather than a significant failure of governance or cyber security controls. Under the national scoring framework, an organisation is automatically categorised as "High" risk where two or more assessed outcomes do not fully meet the minimum achievement level, regardless of whether the underlying findings are low risk. In Kent and Medway ICB's case, only two areas were identified where evidence was not fully available to support achievement of the relevant outcomes. Both findings were assessed as **Low Risk**.

The first finding related to the absence of directorate-level Business Impact Analyses (BIAs) and documented restoration priorities for services and systems. The assessor acknowledged that the organisation maintains a Corporate Business Continuity Plan and identified that the gap arose due to ongoing organisational restructuring and change programmes. The recommendation is therefore focused on documenting and formalising restoration priorities once organisational structures have stabilised rather than addressing a deficiency in governance arrangements.

The second finding concerned the absence of documented evidence demonstrating that impact statements used in business continuity and cyber resilience planning are periodically validated through formal testing or review exercises. Again, the assessor recognised that this was linked to organisational change activity and recommended the introduction of a structured validation process once restructuring has concluded. The finding does not indicate an absence of business continuity planning but rather a need to strengthen documentary evidence and assurance processes.

Overall, the assessment demonstrates that Kent and Medway ICB has a strong governance framework, clear executive accountability, effective risk management processes and mature information governance arrangements. The independent review found only two low-risk observations, both related to business continuity documentation and assurance activities impacted by organisational change. There were no significant concerns identified regarding information governance leadership, data protection compliance, cyber security management, backup arrangements, incident response processes or Board oversight. The findings therefore represent targeted opportunities for improvement rather than material weaknesses in the control environment.

4.0 Kent and Medway ICB Summary Position on Cyber Security: Independent ICT (Information & Communications Technology) Review of Cyber Security, December 2025

The independent Cyber Assessment Framework (CAF)-aligned Data Security and Protection Toolkit (DSPT) assessment provides strong assurance that Kent and Medway ICB has established and effective governance arrangements for data protection, information governance, cyber security and resilience. The review concluded that there is a **high level of confidence in the accuracy of the ICB's self-assessment**, with the majority of assessed outcomes meeting or exceeding the required standards and only two low-risk findings identified.

The independent internal audit review of cyber security awarded **Substantial Assurance**, the highest assurance rating available within the audit framework. This provides strong independent assurance that Kent and Medway ICB has a robust cyber security control environment, effective governance arrangements and appropriate processes in place to identify, manage and mitigate cyber risks. The review concluded that internal controls are operating effectively and that cyber risks are being actively managed across the organisation.

Overall Cyber Security Position

The audit found that Kent and Medway ICB has implemented a mature and structured approach to cyber security, underpinned by established governance, risk management and operational controls. Cyber risks are clearly identified within the corporate risk management framework and are monitored through formal governance processes, supported by regular reporting and oversight arrangements. The organisation's Risk Management Strategy explicitly includes cyber risks and associated mitigations, ensuring that cyber security is addressed as a strategic organisational risk rather than solely as a technical issue.

The review identified that governance arrangements supporting cyber security are well established, with appropriate management structures in place to oversee cyber risk and resilience. Senior leaders receive cyber security training and regular cyber risk reporting, enabling informed decision-making and demonstrating executive ownership of cyber security matters. Cyber risks are discussed through regular governance meetings and monitored via the organisational risk register.

Areas of Good Practice

The audit identified a significant number of strengths across the cyber security control environment.

Strong Governance and Cyber Risk Management

The organisation has established governance structures that support the identification, escalation and management of cyber risks. Cyber security is embedded within wider organisational risk management arrangements, with risks individually defined and monitored rather than treated as a single generic risk.

Formal assurance is provided through the organisation's Cyber Essentials Plus accreditation, which was recognised positively within the review.

Effective Security Awareness and Training

The review found a comprehensive cyber awareness and training programme in operation. Staff training is supported by a formal policy, tailored training needs analysis, simulated exercises and compliance testing. Enhanced training is provided for staff working in higher-risk roles, while senior leaders actively participate in cyber awareness initiatives, helping to reinforce a positive cyber security culture across the organisation.

Mature Technical Security Controls

The audit identified strong technical controls across the organisation's digital estate, including:

- Secure-by-design architecture and configuration standards.
- Cyber Essentials Plus accreditation.
- Secure baseline configurations for endpoints and servers.
- Centrally managed vulnerability and patch management processes.
- Regular vulnerability scanning and security assessments.
- Managed processes for legacy and end-of-life technology.
- Network protections designed to prevent unauthorised external access and mitigate denial-of-service attacks.

Robust Identity and Access Management

The review highlighted a mature approach to access control, including:

- Formal Identity and Access Management policies.
- Joiners, movers and leavers processes.
- Quarterly access reviews.
- Multi-Factor Authentication for web-based and privileged accounts.
- Single Sign-On capabilities.
- Separate administrator accounts.
- Monitoring of anomalous user activity and system access.

Strong Monitoring, Incident Response and Recovery

The organisation has comprehensive logging and monitoring arrangements in place, including centralised log management, security monitoring and alerting capabilities. Incident response procedures are integrated with business continuity arrangements and are regularly tested. The audit confirmed that post-incident reviews and lessons learned exercises are routinely undertaken to support continuous improvement.

The Data Security review also identified particular strengths in backup and recovery arrangements, including geographically separated backups, quarterly testing and established procedures to support recovery from cyber incidents.

Effective Supply Chain Security

The organisation has implemented controls to manage third-party and supplier cyber risks through procurement processes, security assessments, DTAC reviews, DPIAs and contractual security requirements. Supply chain dependencies are mapped and assessed to ensure cyber risks associated with suppliers are understood and managed appropriately.

Audit Findings

Importantly, the review identified **no urgent or important recommendations**, no control failures and no operational effectiveness concerns. The audit made only **two routine recommendations**, both relating to governance and continuous improvement rather than weaknesses in cyber security controls. These were:

1. To refresh cyber awareness training content annually rather than every two years.
2. To complete the overdue review of the Information Governance Management Group Terms of Reference.

Both recommendations were accepted by management and do not indicate significant weaknesses within the cyber security control environment. The auditors confirmed that the key governance, compliance and risk mitigation controls assessed during the review were operating effectively and were considered to be "in place".

Key Risks Under Management

The review noted that the organisation was actively managing known technology lifecycle risks, including:

- End-of-life Microsoft Office 2016/2019 products.
- End-of-support Windows 10 devices *(Completed migration)*
- Legacy Windows Server 2012 infrastructure *(Completed migration)*.

The audit confirmed that plans were already in place with South, Central and West CSU (SCW) to migrate affected systems and reduce associated risks. These risks were therefore recognised, monitored and subject to ongoing mitigation activity.

5.0 Continuous Improvement and Action Plan:

Based on:

- the directive issued by NHSE in the 10th June publication issued to ICBs,
- recommendations from the external reviews, and
- other known gaps and challenges,

the following planned actions will be undertaken, as outlined in the below table, to further strengthen its cyber position and proactively mitigate emerging risks.

Sl. No.	Action	Why	Plan	Owner	Criticality
1.	Develop KMICB Cyber Strategy	Known gap – needed for strategic direction, alignment with industry and national standards and planning	Initiate Draft: Oct 2026 Complete/Board Approved: Mar 2027	Director of DDI, KSS.	Low
2.	Review and update ICB Cyber Training Plans	Identified in Dec'25 Review	Complete by Dec 2027.	Deputy Director of Corporate IT, KSS DDI.	Low
3.	Update Terms of Reference for IGMG	Identified in Dec'25 Review	Complete by Dec 2027, in line with wider KSS DDI Governance changes	Deputy Director of Corporate IT, KSS DDI.	Low
4.	Review new CAF Aligned DSPT v 0.4	Due to be published, notified via NHSE publication.	Complete by Oct 2026, and subsequently plan for 2026-27 DSPT.	Deputy Director of Corporate IT, KSS DDI.	High
5.	Review MFA (Multi Factor Authentication) and DSPT Compliance status of all Digital solutions' suppliers.	Known gap with DSPT 25-26 submissions.	Complete by Dec 2026, aligned with interim DSPT submission.	Deputy Director of Corporate IT, KSS DDI + Other ICB Directors.	High
6.	Complete Business Impact Assessment (BIA) documentation for all ICB functions.	Gap identified via DSPT 25-26 submissions.	Complete by Dec 2026.	Deputy Director of Corporate IT, KSS DDI + EPRR Team	Low

7.	Complete and evidence testing against Business Continuity arrangements	Gap identified via DSPT 25-26 submissions.	Complete by Mar 2027.	Deputy Director of Corporate IT, KSS DDI	Low
8.	Complete deployment of new Office (Apps for Enterprise) in Primary Care	Known and identified on Dec 25 report.	Complete by Sep 2026	Deputy Director, GPIT, KSS DDI	High
9.	Member of Executive Team holding Cyber Security responsibilities	Strongly recommended in NHSE notification dated 10th June	Complete by Sep 2026 (via appointment against CDDIO role for KSS DDI)	Chief Executive Officer, K&M ICB	High

Additional Considerations to be worked upon:

- Developing an understanding of system wide impact, across organizational boundaries, including primary care and suppliers.
- Develop a greater understanding of the developing threat landscape, and proactively planning actions aligned to that. This includes zero click AI attacks on emails for example.
- More robust project and progress tracking.
- Budgetary and investment planning around Cyber.
- Closer direct working with Regional and National colleagues.
- Design the model to deliver cyber capabilities at scale for Kent and Medway and Surrey and Sussex ICBs, and also for the SE.

6.0 Key Risks

1. Business Continuity and Recovery Assurance

Risk: The independent DSPT assessment identified gaps in documented Business Impact Assessments (BIAs), restoration priorities and evidence of testing and validation of business continuity arrangements. Whilst assessed as low risk, a major cyber incident could significantly affect the organisation's ability to prioritise and restore critical services if documentation and assurance arrangements are incomplete.

Mitigations

- Complete Business Impact Assessments for all ICB functions.
- Define and document restoration priorities for critical services and systems.
- Undertake and evidence regular testing of business continuity and recovery arrangements.
- Strengthen assurance processes once organisational restructuring has stabilised.

2. Emerging NHS Cyber Requirements and Supplier Security Compliance

Risk: NHS England is introducing enhanced requirements relating to CAF alignment, Multi-Factor Authentication (MFA), Endpoint Detection and Response (EDR), and supplier cyber assurance. The report identifies supplier DSPT and MFA compliance as a known gap, creating potential exposure through third-party providers and digital supply chains.

Mitigations

- Review MFA and DSPT compliance across all digital suppliers.
- Assess supplier cyber security controls through procurement, DTAC, DPIA and contractual processes.
- Review and prepare for CAF 4.0 and future DSPT requirements.
- Strengthen oversight of third-party cyber risks and dependencies.

3. Evolving Cyber Threat Landscape and Strategic Cyber Capability

Risk: The report recognises that cyber threats continue to evolve, including increasingly sophisticated attacks and emerging risks associated with AI-enabled threats. Whilst current controls are strong, there is a strategic risk that organisational capability, investment and planning may not keep pace with future threats and increasing digital dependency across health and care systems.

Mitigations

- Develop and implement a Kent and Medway Cyber Strategy.
- Appoint an Executive-level lead with cyber security responsibilities.
- Improve cyber investment and budget planning.
- Increase collaboration with regional and national cyber teams.
- Develop greater understanding of system-wide cyber dependencies across primary care, suppliers and partner organisations.

- Strengthen programme management and oversight of cyber improvement activity.

6.0 Conclusion

A detailed review of all elements of the letter/publication from NHSE has been done, and while it calls out for ICB Board and Exec attention, all the aspects of the recommendations in the letter are well covered by the work the ICB is underway, and comprehensively via the DSPT framework submissions. The ICB is on track to complete the final 2025-26 DSPT submission at the end of June 2026, once the external final audit review reports are thoroughly reviewed and actioned.

Report to	NHS Kent and Medway Integrated Care Board
Meeting date	Tuesday, 22 September 2026
Report Title	Data Tools and Governance: Board Assurance
Key question	Is the Board assured that appropriate governance, information governance and approval processes are in place for the data tools and platforms the ICB uses?
Executive Lead	Mayur Vibhuti, Chief Digital, Data and Information Officer
Author	Mayur Vibhuti, Chief Digital, Data and Information Officer

Which of the organisation's strategic objectives does the report support:	
☐ Commission the right services each year	☐ To ensure financial sustainability over three years
☐ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the Meeting:

The Board is asked to:

1. **NOTE** the contents of the report.
2. **TAKE ASSURANCE** that appropriate governance, information governance and approval arrangements are in place for the data tools and platforms currently used by the ICB.
3. **NOTE** the specific governance considerations relating to the Federated Data Platform (FDP) set out in this paper.

Executive summary:
This paper responds to an action from the Chief Executive, following questions raised by the ICB Board in June 2026 to provide the Board with assurance on the data tools and platforms used across the ICB and the governance arrangements in place to manage them. All locally managed data platforms operate under established information governance, contractual and security controls, with access managed through role-based permissions and regular audit. National programmes – the Federated Data Platform (FDP) and the Kent & Sussex Secure Data Environment – operate within NHS national governance frameworks, with local oversight applied where required. The principal issue for Board awareness relates to public confidence rather than information governance compliance and specifically concerns the FDP. Local information governance work for the FDP has been completed, and no local patient data is currently flowing through it. The ICB's Digital, Data and Involvement Group (DDIG) has co-produced a local social licence, 'Our Data for Our Good', to maintain public trust in the ICB's use of data; this engagement has not yet extended to the FDP given its national status.

Proposed next steps:
Ongoing review of local information governance requirements before any expansion of FDP use. Continue public engagement and public transparency on the ICB's use of data. Maintain routine assurance reporting to the Board on data platforms and governance.

Governance pathway to date:

Meeting name:	Date:	Outcome:
Executive Management Team	9 September 2026	Reviewed and endorsed for submission to the Board for assurance

Contact for further information	Mayur Vibhuti, Chief Data, Digital and Information Officer, mayurvibhuti@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities, and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)

COMPLIANCE NOTES:

☒ No/Not applicable (please indicate why an assessment was not required)
Not applicable. This is an assurance report on existing governance arrangements and does not propose a change in policy or service delivery.

Conflicts of Interest

Are there any conflicts associated with authors or reporting officers?
☐ Yes ☒ No
If yes, please confirm how the conflict has been managed.

FOI Status

Is this report disclosable under FOI?
☒ Yes ☐ No
If no, please specify why:

Financial Implications

Are there financial implications associated with this report?
☐ Yes ☒ No
If yes, please describe:

Legal Implications

Are there legal implications associated with this report?
☐ Yes ☒ No
If yes, please describe:

Quality and Safety Implications

Are there quality or safety implications associated with this report?
☐ Yes ☒ No
If yes, please describe:

Patient and Public Engagement

Are there patient and public engagement implications associated with this report?
☒ Yes ☐ No
If yes, please describe. If no, please specify why:
Yes. Engagement is delivered through the Digital, Data and Involvement Group (DDIG), which has co-produced the ICB's local social licence ‘Our Data for Our Good’ to support transparency and public confidence in the ICB's use of data.

DATA TOOLS AND GOVERNANCE: BOARD ASSURANCE

1. INTRODUCTION

1.1 This paper is presented to the Board in response to an action from the Chief Executive, following questions raised by the previous ICB Board meeting regarding the data tools and platforms used across the ICB and the governance arrangements supporting them. It addresses three key questions: whether tools are nationally approved, whether local approvals and information governance (IG) requirements have been completed, and whether there are any governance, IG or risk issues the Board should be aware of.

2. STRATEGIC ALIGNMENT

2.1 Robust data governance underpins the ICB's ability to commission effectively, maintain public trust, and operate as a high-performing organisation. This paper supports the Board's oversight of organisational governance and risk management.

3. ASSURANCE ON DATA TOOLS AND GOVERNANCE

3.1 The Board is asked to take assurance that appropriate governance, information governance, security and approval arrangements are in place for the data tools and platforms used by the ICB. Oversight is exercised through established governance arrangements, with nationally provided tools operating within national frameworks and locally managed platforms subject to approved local governance and information governance controls. The responses below address the three key areas on which the Board has sought assurance.

3.2 **Is this a nationally approved tool?** The ICB's data platforms comprise a mix of nationally mandated or provided tools (including the Federated Data Platform, the Kent & Sussex Secure Data Environment, NHS England's Health Insights and NHS Futures) and locally commissioned platforms (including the KMCR Population Health Platform and the Kent & Medway Data Warehouse/Microsoft Power BI). All are used within their intended national or local governance frameworks.

3.3 **Have the necessary local approvals and information governance requirements been completed?** Yes, for all platforms. Regarding the Federated Data Platform, initial information governance work is completed and will be reviewed before any further expansion of use, as is normal practice. No local patient data currently flows through the FDP.

3.4 **Are there any governance, information governance or risk issues the Board should be aware of?** The principal issue is one of public confidence rather than IG compliance. The ICB's Digital, Data and Involvement Group (DDIG) has co-produced a local social licence, ‘Our Data for Our Good’, to maintain transparency and public trust; this engagement has not yet extended to the FDP given its national status. All other platforms are supported by established governance arrangements, including data access committees, information governance forums and routine audit.

4. KEY RISKS, MITIGATIONS, AND CONTROLS

4.1 The key risk relates to public confidence in the Federated Data Platform, given its national supplier arrangements, rather than to information governance compliance.

4.2 This is being mitigated through continued public engagement, transparent public communication, and review of local IG requirements before any expansion of FDP use. Across all other platforms, controls include role-based access, pseudonymisation, data sharing agreements, and routine audit, overseen through established local governance structures.

5. OTHER CONSIDERATIONS

5.1 National policy on platforms such as the FDP continues to evolve. The Board should maintain ongoing oversight of the ICB's approach and ensure transparency with citizens is sustained as arrangements develop.

6. REQUIRED OUTCOMES AND NEXT STEPS

6.1 The Board is asked to:

- **NOTE** the contents of the report.
- **TAKE ASSURANCE** that appropriate governance, information governance and approval arrangements are in place for the data tools and platforms currently used by the ICB.
- **NOTE** the specific governance considerations relating to the Federated Data Platform (FDP) set out in this paper

6.2 The following next steps should be noted:

- Complete review of local IG requirements before any expansion of FDP use.
- Continue public engagement and public transparency on the ICB's use of data.
- Maintain routine assurance reporting to the Board.

7. SUPPORTING DOCUMENTATION

7.1 There are no supporting documents relevant to this report.

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report Title	Corporate Risk Register and Board Assurance Framework
Key question	Does the Board Assurance Framework provide the Board with sufficient visibility of the ICB's principal strategic risks and associated assurances, and is the Board assured that appropriate arrangements are in place to monitor and manage the organisation's risk profile?
Executive Lead	Claire Robson, Company Secretary and Director of Corporate Affairs
Author	Claire Robson, Company Secretary and Director of Corporate Affairs

Which of the organisation's strategic objectives does the report support:	
☐ Commission the right services each year	☐ To ensure financial sustainability over three years
☐ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the Meeting:

The Committee is asked to:

1. **NOTE** the revised Board Assurance Framework (BAF).
2. **NOTE** the Corporate Risk Register (CRR).
3. **RECEIVE ASSURANCE** regarding the organisation's principal strategic risks and associated controls and assurances.

Executive summary:

This paper presents the updated 2026/27 Board Assurance Framework and Corporate Risk Register and provides the Board with an overview of the organisation's principal strategic risks, the effectiveness of associated controls and the assurance available regarding delivery of the ICB's strategic objectives.

The Board Assurance Framework has been further developed in response to feedback from the Audit and Risk Committee. The revised framework strengthens the connection between each strategic risk, the outcomes the ICB is seeking to achieve, the potential impact on patients and the population, the effectiveness of controls and the evidence available to demonstrate progress. Greater emphasis has been placed on whether arrangements are delivering measurable improvements, rather than solely confirming that processes, governance structures or documentation are in place.

All five strategic risks remain above the Board's defined risk appetite. Four risk scores remain unchanged from the position reported in July. BAF3, relating to system strategy and the effective use of commissioning levers, has reduced from 16 to 12 following approval and publication of the Integrated Care Strategy and Commissioning Intentions. The likelihood score has reduced, while the impact remains unchanged. Further reduction will depend on the strategy and commissioning intentions being translated into provider contracts, pathway changes, performance trajectories and demonstrable improvements in outcomes.

The revised BAF identifies progress in strengthening strategic commissioning, financial governance, performance oversight and organisational development. However, significant gaps remain in demonstrating that the new arrangements are fully embedded and delivering their intended impact. These include completion of the commissioning and contracting reset, consistent use of data and intelligence, clearer evidence of benefits realisation, finalisation of delegated decision-making arrangements, implementation of commissioning capability development and stronger evidence that organisational culture work is improving behaviours, delivery and organisational learning.

The Board is asked to consider whether the revised BAF provides a sufficiently clear account of the current risk exposure, the outcomes expected from mitigating action and the evidence required to demonstrate that controls are effective.

Proposed next steps:

The Board Assurance Framework will continue to be updated through routine review with Executive Leads and scrutiny by the relevant assurance committees. The next phase of development will focus on strengthening measurable assurance of impact, completing the outstanding mitigating actions, and ensuring that reporting clearly distinguishes between arrangements being established and evidence that those arrangements are delivering improved outcomes.

Particular attention will be given to:

- evidencing the impact of commissioning decisions and levers on access, quality, outcomes, inequalities and value for money;
- completing the commissioning and contracting reset and embedding the revised governance and delegated decision-making arrangements;
- strengthening the use of integrated performance, finance, quality and population health intelligence;
- demonstrating delivery of recurrent financial improvement without unacceptable consequences for quality, safety or access;
- evidencing the impact of commissioning capability development and the new commissioning model; and
- strengthening assurance that culture and organisational development activity is improving staff experience, speaking-up arrangements, organisational learning and delivery.

The Corporate Risk Register will continue to be reviewed alongside the BAF to ensure appropriate alignment between operational, emerging and strategic risks. Any material changes in risk exposure, significant gaps in assurance or failure to deliver agreed mitigating actions will be escalated through the relevant committee and to the Board.

Governance pathway to date:		
Meeting name:	Date:	Outcome:
Audit and Risk Committee	April 2026	Noted
ICB Board	19 May 2026	Noted
Audit and Risk Committee	3 July 2026	Reviewed Quarter 1 BAF and CRR, considered risk position and ongoing development of the framework, and provided assurance for onward reporting to the Board.

Contact for further information	Claire Robson, claire.robson24@nhs.net

COMPLIANCE NOTES:
Equality, health inequalities, and quality impact assessment
If this report is presented for decision/approval, please complete:

COMPLIANCE NOTES:

Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

This paper is for assurance on governance and risk management and does not involve decisions impacting patients or services.

Conflicts of Interest

Are there any conflicts associated with authors or reporting officers?
☐ Yes ☒ No
If yes, please confirm how the conflict has been managed.

FOI Status

Is this report disclosable under FOI?
☒ Yes ☐ No
If no, please specify why:

Financial Implications

Are there financial implications associated with this report?
☐ Yes ☒ No
If yes, please describe:

Legal Implications

Are there legal implications associated with this report?
☐ Yes ☒ No
If yes, please describe:

Quality and Safety Implications

Are there quality or safety implications associated with this report?
☐ Yes ☒ No
If yes, please describe:

The refreshed Board Assurance Framework and updated Corporate Risk Register support the Board's ongoing oversight of quality and safety risks.

Patient and Public Engagement

Are there patient and public engagement implications associated with this report?
☐ Yes ☒ No
If yes, please describe. If no, please specify why:

COMPLIANCE NOTES:
There are no specific patient or public engagement implications in relation to this paper.

CORPORATE RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

1. INTRODUCTION

1.1 This paper presents the updated 2026/27 Board Assurance Framework and Corporate Risk Register to support the Board's oversight of the principal risks to delivery of the ICB's strategic objectives and the assurance available regarding the effectiveness of controls and mitigating actions.

1.2 The BAF has been further developed following the Quarter 1 review and feedback from the Audit and Risk Committee. The revised framework places greater emphasis on expected outcomes, patient and population impact, measurable evidence of effectiveness and the distinction between controls being established and evidence that those controls are delivering the intended improvement.

2. STRATEGIC ALIGNMENT

2.1 The Board Assurance Framework is aligned to the ICB's corporate objectives and provides a clear line of sight between strategic priorities, principal risks and sources of assurance.

2.2 The Corporate Risk Register complements the BAF by providing visibility of operational and emerging risks. The two documents are reviewed together to support alignment between operational risk management, the ICB's evolving risk profile and the principal strategic risks requiring Board oversight.

3. BOARD ASSURANCE FRAMEWORK

3.1 Overview

The Board Assurance Framework continues to be the primary mechanism through which the Board gains assurance on the management of the principal risks to delivery of its strategic objectives. It sets out for each risk:

- Clear risk articulation (IF / THEN / RESULTING IN / DEFINED BY)
- Executive ownership and Committee oversight
- Risk ratings (inherent, current and target)
- Risk appetite and status
- Key controls and sources of assurance
- Gaps in control and/or assurance
- Mitigating actions and delivery trajectory

The revised BAF now includes, for each principal risk, a clearer statement of the expected outcomes and potential impact on patients and the population. It also identifies the evidence that should demonstrate whether controls and mitigating actions are effective. This is intended to shift the focus from assurance that processes and

governance arrangements exist towards evidence that those arrangements are improving delivery, outcomes and organisational effectiveness.

The current version provided at Appendix 1 to this report reflects further iteration with Executive Leads and incorporates improvements to presentation, including strengthened visibility of risk position and alignment to risk appetite.

3.2 Headline Risk Position

A consolidated summary of the BAF is provided below:

	BAF1	BAF2	BAF3	BAF4	BAF5
Current Risk	16	16	16	12	16
Target	8	9	9	4	8
Risk Appetite	Cautious (10)	Cautious (10)	Cautious (10)	Cautious (10)	Open (12)
Status	Out of appetite	Out of appetite	Out of appetite	Out of appetite	Out of appetite

The updated headline BAF records current scores of 16, 16, 12, 12 and 16 respectively. All five risks remain outside appetite.

At the current reporting point, all five strategic risks remain outside the Board's agreed risk appetite. BAF1, BAF2, BAF4 and BAF5 retain their reported current scores. BAF3 has reduced from 16 to 12, reflecting the approval and publication of the Integrated Care Strategy and Commissioning Intentions and the resulting reduction in the assessed likelihood of the risk.

The reduction in BAF3 represents progress in establishing the strategic framework. However, the risk remains outside appetite, and further assurance is required that the strategy is being translated consistently into delivery requirements, provider contracts, pathway redesign, investment decisions, performance trajectories and measurable improvements for patients and communities.

For the remaining risks, the current position reflects continuing work to embed controls and address assurance gaps. The absence of further reductions should not be taken to indicate that no progress has been made. Rather, the available evidence does not yet demonstrate that the relevant controls have operated for sufficient time or with sufficient consistency to justify a lower residual risk assessment.

3.3 Key Themes from the BAF

The updated BAF reflects continued development following review by the Audit and Risk Committee and places greater emphasis on expected outcomes, patient and

population impact, and evidence of effectiveness. Particular attention has been given to strengthening the link between strategic risks, key controls, sources of assurance and mitigating actions.

A number of common themes emerge across the strategic risks:

- The need to move from establishing governance, commissioning and organisational development arrangements to demonstrating their effectiveness and impact.
- Continued development of strategic commissioning capability, including embedding Commissioning Multidisciplinary Teams and strengthening the use of intelligence, population health data and benefits realisation.
- Ongoing work to strengthen financial sustainability, governance and control arrangements.
- The importance of maintaining clear alignment between strategy, commissioning intentions, provider delivery, performance trajectories and outcomes.
- The need to strengthen assurance evidence so that the Board can clearly assess whether mitigating actions are delivering the intended improvements.

Whilst progress has been made in a number of areas, including approval of the Integrated Care Strategy and Commissioning Intentions and the further development of commissioning and governance arrangements, significant work remains to bring all strategic risks within the Board's agreed risk appetite.

3.4 Risk Position and Trajectory

The current risk position is:

- all five principal strategic risks remain outside the Board’s agreed risk appetite;
- BAF3 has reduced from 16 to 12;
- the remaining current risk scores are unchanged;
- BAF3 and BAF4 are closer to the cautious appetite threshold of 10, but remain outside appetite;
- BAF1, BAF2 and BAF5 remain materially above their stated appetite levels; and
- further reductions will require evidence that controls and mitigating actions are embedded and are delivering demonstrable improvements, rather than evidence of programme activity alone.

The trajectory for each risk should be reviewed at each reporting point against the completion of mitigating actions and the availability of measurable assurance. Where milestones have passed without completion, the BAF should record a revised date, accountable owner and the effect of delay on the current and forecast risk position.

3.5 Ongoing Development of the BAF

The BAF has been reviewed to address the Audit and Risk Committee's feedback on the articulation of risk, the specificity of controls, the use of measurable indicators and the clarity of assurance arrangements. Expected outcomes and patient and population impacts have been added, and the framework now describes the types of evidence that should demonstrate whether controls are effective.

Further development should focus on:

- ensuring that controls describe arrangements that are currently operating, rather than planned future activity;
- distinguishing positive assurance from expected future success measures;
- assigning clear owners and realistic completion dates to mitigating actions;
- updating overdue actions rather than retaining historic target dates;
- recording how committee scrutiny has affected the assessment of each risk;
- ensuring risk trajectories reflect the anticipated effect and timing of mitigating actions; and
- providing concise evidence that completed actions have improved outcomes or reduced exposure.

4. CORPORATE RISK REGISTER

4.1 The Corporate Risk Register is presented as the most recent position following updates by risk owners.

4.2 The register has been reviewed alongside the Board Assurance Framework to ensure appropriate alignment between corporate and strategic risks, including the escalation of risks with the potential to affect delivery of the ICB's strategic objectives.

4.3 A detailed review remains underway to ensure continued alignment between the Corporate Risk Register and the BAF, including confirmation of risk descriptions, controls, scoring methodologies and mitigating actions. Outcomes of this review will continue to be scrutinised through Audit and Risk Committee and reported to the Board through routine assurance reporting arrangements where appropriate.

5. KEY RISKS, MITIGATIONS, AND CONTROLS

5.1 There remains a risk that the BAF and Corporate Risk Register do not provide sufficiently timely or measurable evidence of the effectiveness of risk management arrangements. This is particularly relevant where new governance, commissioning, financial, performance and organisational development arrangements have been established but have not yet operated for long enough to demonstrate sustained impact.

5.2 This risk is mitigated through Executive ownership, routine review of the BAF and Corporate Risk Register, scrutiny by the relevant assurance committees, oversight by the Audit and Risk Committee and escalation to the Board. The inclusion of expected

outcomes, patient and population impacts, assurance gaps, success measures and mitigating actions provides a stronger basis for assessing whether the principal risks are being effectively managed.

5.3 Further assurance will depend on evidence that planned actions have been completed and embedded, and that they are improving outcomes, reducing variation, strengthening financial delivery, supporting better decision-making and improving organisational capability. Where assurance remains limited or actions are delayed, this should be reflected in the risk score and trajectory.

6. OTHER CONSIDERATIONS

6.1 There are no other considerations relevant to this report.

7. REQUIRED OUTCOMES AND NEXT STEPS

7.1 The Meeting is asked to:

- **NOTE** the revised Board Assurance Framework (BAF).
- **NOTE** the Corporate Risk Register (CRR).
- **RECEIVE ASSURANCE** regarding the organisation's principal strategic risks and associated controls and assurances.

8. SUPPORTING DOCUMENTATION

8.1 There are no supporting documents relevant to this report.

Appendices:

Appendix 1: Board Assurance Framework
Appendix 2: Corporate Risk Register

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	10	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.

Headline Position (at a glance)

In response to feedback from the Audit and Risk Committee, the BAF has been further reviewed to strengthen the link between strategic risks, expected outcomes, patient and population impact, evidence of effectiveness and assurance. Future iterations will place greater emphasis on whether controls are delivering the intended improvements, rather than simply confirming that processes, groups or documentation are in place. Executive Leads will be asked to ensure that each risk clearly describes what success looks like, how patients and communities will benefit, what data or evidence supports progress, and where gaps in control or assurance remain.

	BAF 1	BAF2	BAF3	BAF4	BAF5
Current Risk	16	16	12	12	16
Target Risk	16	9	9	4	8
Risk Appetite	Cautious (10)	Cautious (10)	Cautious (10)	Cautious (10)	Open 12
Status	OUT of appetite	OUT of appetite	OUT of appetite	OUT of appetite	OUT of appetite
Trend (Q1 26/27)	→	→	↓	↓	→

All five strategic risks remain above risk appetite at Q1 2026/27. While no material deterioration is observed during this period, progress is evidenced in a number of areas. In particular, BAF3 has reduced from 16 to 12 following Board approval and publication of the Integrated Care Strategy and Commissioning Intentions, with the probability score reducing to 3 and the impact score remaining at 4. Further reductions are anticipated as contract negotiations conclude and associated controls become embedded. Positive progress is also being seen in commissioning maturity (BAF4) reflected by a lowering in the current risk rating, although significant delivery risks remain in relation to financial sustainability (BAF2).

Board Assurance Framework 2026-2027
BAF1: Commission the Right Services each Year

BAF1: Commission the Right Services Each Year			
Objective: 1. Annual commissioning cycle aligned to population needs			
Strategic Risk: Failure to commission services that are fully aligned to population needs, evidence, and system priorities, resulting in poor outcomes, inefficiencies, and missed statutory duties.			
IF the ICB fails to commission services that are fully aligned to population needs, robust evidence, and agreed system priorities **THEN** commissioning processes and decisions may not adequately address demand, variation, or strategic objectives **RESULTING IN** poor health outcomes, inefficiencies in resource use, increased unwarranted variation, and potential failure to meet statutory duties **DEFINED BY** indicators such as gaps between need and provision, adverse quality or performance metrics, external regulatory feedback, evidence of unmet population needs, complaints or escalations, and system partners reporting misalignment between commissioned services and strategic priorities.			
Expected Outcomes: Successful management of this risk will be demonstrated by clear commissioning work programmes, commissioning processes and evidence that commissioning decisions are directly improving access, quality, outcomes, value for money and equity for the population of Kent and Medway. Using evidence to identify and drive focussed areas of system change, commissioned services should increasingly reflect population health need, reduce unwarranted variation, support delivery of agreed strategic priorities and demonstrate clear benefits for patients, communities and the wider system. The Board should expect to be assured that commissioning processes are robust and that commissioning decisions for approval are supported by clear needs analysis, patient and community insight, outcome measures, financial and activity modelling, and a defined benefits realisation approach. Over time, assurance should demonstrate that commissioned services are delivering the intended improvements and that underperformance is identified and addressed through commissioning processes, contract management, quality oversight and review.			
Impact on Patients and Population: If this risk is not effectively managed, patients and communities may experience services that do not reflect their needs, variation in access or quality, poorer outcomes, and missed opportunities to address health inequalities. Effective management of this risk should result in more responsive, equitable and evidence-based services, with commissioning decisions informed by population health intelligence, patient experience, clinical outcomes and engagement with local communities.			
Lead Executive	**Lead Teams**	**Lead Assurance Committee**	**Date Added to BAF**
Chief Commissioning Officer	Commissioning Finance	Finance and Performance Committee Quality, Safety and Patient Experience Committee	Apr-26

Risk Ratings:			
	Inherent	**Current**	**Target**
Impact / Likelihood	**4 x 4**	**4 x 4**	**4 x 2**
Score	**16**	**16**	**8**

Board Assurance Framework
2026-2027
BAF1: Commission the Right Services each Year

Risk Trajectory:				
Q4 25/26	**Q1 26/27**	**Q2**	**Q3**	**Q4**
N/A	**16** →	**16** →	**-**	**-**

Risk Appetite:	Cautious 10	Status (In / Out Appetite)	OUT

Key Controls (what is in place)	Gaps in Control (what is not yet in place)
• Annual commissioning cycle in place: ○ Five year strategy and three year commissioning plan in place and signed off by Board, setting strategic direction ○ Commissioning policy available to guide decision making process and signed off by board ○ Commissioning intentions published each year in draft ahead of a summer engagement exercise, finalised in September ○ Commissioning letters sent to all major providers in September to provide six months' notice of commissioning changes ○ Planning process run according to national planning guidance and timetable, securing signed contracts with all providers ahead of the financial year. • Each element of the commissioning cycle runs according to best practice: ○ Identification of key areas of variation in local performance ○ Development of key programmes of work targeting local variation ○ Needs assessments developed to inform areas of commissioning development work (drawing on local data, JSNAs etc) MDT, clinical, patient, public and partner insight drawn on to inform commissioning programmes Commissioning proposals	• Commissioning strategy documentation exists and will continue to be brought to the Board for approval at the relevant point in the commissioning cycle e.g. the finalised commissioning intentions document. Key gaps in analytical, BI and population health teams limit capacity to deliver the extent of analysis and needs assessment that could be available to inform commissioning in the medium term. • Commissioning arrangements have not yet all been reviewed in detail for VFM, clinical and quality outcomes and coherence with system strategy. • Clear commissioning work programmes – particularly focussed on the ICB's role to tackle demand management, key performance issues and local variation – are under development. These will be developed on a quarterly basis. • Contract management reset not yet fully embedded with gaps on benefits realisation as a result, leading to a gap between theoretical and real world impact. • ExCo commissioning subgroup is in place and CMDTs launched on 1 July. However, this is a new model for the ICB and will take time to embed. Clarity of decision making rights/processes and alignment to contracting processes and escalations will need to be developed to prevent unnecessary escalation of decisions. • Commissioning not always delivered in line with commissioning policy, especially where commissioning exercises started before its existence, or where urgency is required. • CMDTs in process of standardising key documentation to ensure that it is docked into the wider organisation's governance and processes, but this is not yet in place to the right standard.

take account of a clear opportunity analysis and reflect best practice in terms of service design, quality and outcomes sought and value for money. Proposals are aligned to strategic intent, national models of care, wider NHS priorities and developing Modern Service Frameworks. ○ Commissioning proposals are backed by clear contract and finance models which will deliver benefits around service quality and performance, clinical outcomes and value. ○ Performance monitoring allows for contractual enforcement of commissioning intent where appropriate, records achievement of desired outcomes and creates part of the evidence base for ongoing review of service level commissioning. • Commissioned services are reviewed, with a focus on local variation, with a focus on whether services are commissioned coherently and in a way which directly addresses the identified needs and opportunities for improvement for the population of Kent and Medway, including the identification of opportunities to secure general improvement and to reduce inequalities in access, quality and outcomes. • Staff are offered structured learning through the Commissioning Development programme and ongoing development opportunities which aim to raise capability and support the ongoing improvement of the quality of all commissioning work. K&M ICB is also an active participant in national learning and network opportunities, such as the national neighbourhood strategic commissioning development programme. • CMDTs have standard operating procedures and documentation docked into the wider organisation's governance and processes. Clear governance in place with clear delegation of authority to act based on clear SoRDs and SFIs..	• Although CMDTs are the right way to work, they do require the ICB to effectively triangulate quality, safety, financial, contracting, commissioning, digital and data intelligence together to establish clear baselines, areas of concern/variation, transparently discuss options and agree the preferred options for moving forward. • Ongoing consultation and post filling process in the Digital, Data and Intelligence • function hosted by NHS Surrey and Sussex ICB to ensure appropriate capacity and • capability is available to support CMDTs, along with an agreed service offer that clearly • defines the support and outputs that will be delivered. Target date: Q4 2026/27
Positive Assurances / Evidence of Effectiveness (what shows it is working)	**Gaps in Assurance (what evidence is missing)**

Board Assurance Framework
2026-2027
BAF1: Commission the Right Services each Year

Evidence of effectiveness should include measurable improvement in agreed priority outcome measures for commissioned services, reductions in unwarranted variation, improved access and waiting time performance in priority pathways, evidence that commissioned services are delivering intended quality and patient experience outcomes, and progress against inequalities indicators identified through commissioning intentions. • Governance established with CMDTs, Integrated Quality and Performance Group and Commissioning Subgroup of ExCo up and running. • Full suite of commissioning documents in place to underpin best practice commissioning against population needs assessment. • Strategic Commissioning Performance Report exists and being iterated for improvement • Quality, Safeguarding and Patient Experience Committee and Board reports detail performance on service outcomes and quality. • External reviews and joint working with regulators (e.g. NHS England, CQC) supports with analysis of performance against expectations • Improvement demonstrated in agreed priority outcome measures for commissioned services. • Reduction in unwarranted variation across Kent and Medway. • Improvement in access, waiting times and service performance for priority pathways. • Evidence that commissioned services are delivering intended quality, safety and patient experience outcomes. • Progress against health inequality indicators identified through commissioning intentions. • Positive feedback from patients, clinicians and system partners regarding commissioned services.	• CMDTs launched on 1 July; quarterly work programmes now being developed . • Strategic commissioning skills development still underway. SCPR still iterating towards final form. • Recent commissioning enshrines outcomes to be achieved (e.g Neighbourhood GP contract) and there are signs of positive performance improvement. but embryonic • Greater focus on the demand management programmes the ICB can own and lead on behalf of the system, reducing pressure on activity and capacity and the financial position across organisations.

Board Assurance Framework
2026-2027
BAF1: Commission the Right Services each Year

• Demonstrated delivery of planned benefits arising from commissioning decisions.	
Mitigating Actions to Address Gaps	**Target Date**
Commissioning intentions developed for the 2027-28 commissioning cycle alongside the final Five year Strategy and Three Year Commissioning Plan. Commissioning development approach designed to support full functionality of CMDTs Recruitment to gaps in CMDTs and specifically in population health, analysis and BI. SFIs and SoRD reviewed and governance decision on new arrangements in train Standard documentation in place for CMDTs operation Quarterly work programmes, prioritisation of areas of ICB focus, resources and capabilities aligned to the delivery of key work programmes, outcomes framework (finance, performance) driving prioritisation and impact decisions	The commissioning intentions are due to be finalised in September 2026, and will be closely followed by the development of contracting letters to providers to be shared on 30 September. The ICB is currently developing its programme plan to achieve the majority of its contracting processes by December, with long stop items required to be completed by the end of the financial year. The CMDTs will be underpinned by an initial set of forward-looking quarterly delivery plans by the end of September, focussed on what can be achieved before winter. The delivery plans will set out more clearly the inputs required to deliver on the business plan aims.
Current Performance – Highlights	
The ICB's commissioning intentions have been the subject of extensive engagement and the ICB's commissioning intentions are supported by patients, the public and partners. The next stage is to be clearer about how the ICB will drive the delivery of the commissioning intentions. This will require a mix of upfront work programmes and negotiation with system partners about areas of focus. This work is taking place at pace and there is a range of good work in place to build on.	

Board Assurance Framework 2026-2027
BAF2: To ensure financial sustainability over 3 years

BAF2: To ensure financial sustainability over 3 years			
Objective: Provide system leadership through a robust financial strategy, utilising commissioning levers to ensure long-term financial sustainability and value for money across the health system.			
Strategic Risk: Failure to maintain financial sustainability over a three-year period, leading to budget deficits, compromised service quality, and inability to invest in transformation or meet statutory financial targets.			
IF the ICB is unable to maintain financial sustainability over a three-year planning period, due to pressures on expenditure, suboptimal cost-control measures, or insufficient delivery of required efficiencies **THEN** the organisation may fail to deliver a balanced financial plan and be unable to meet its statutory financial duties **RESULTING IN** budget deficits, reduced ability to invest in transformation and service improvement, potential regulatory escalation, and risks to the quality, safety, and continuity of commissioned services **DEFINED BY** indicators such as deviation from financial plan trajectories, recurrent vs non-recurrent savings gaps, adverse external financial assessments, reduced liquidity, increased resilience on temporary measures, audit findings, and evidence of constrained investment affecting strategic and operational priorities			
Expected Outcomes: Successful management of this risk will be demonstrated by the ICB and wider system operating within agreed financial plans while maintaining safe, high-quality services and protecting the ability to invest in transformation, prevention and service improvement. Financial recovery and sustainability should be achieved through recurrent, evidence-based and clinically informed actions that support value for money without creating unacceptable risks to quality, access, patient experience or health inequalities. This will be underpinned by triangulated commissioning, finance, contracting and data-led change programmes, agreed by all parties. The Board should expect to see a clear line of sight between financial plans, cost improvement programmes, commissioning decisions, contract management, service quality and patient outcomes. Assurance should demonstrate that financial controls are operating effectively, savings are recurrent and deliverable, and any quality, safety or access impacts are identified, assessed and mitigated.			
Impact on Patients and Population: If this risk is not effectively managed, financial pressures may reduce the ICB's ability to invest in service improvement, transformation and prevention, and may affect the continuity, quality or accessibility of commissioned services. Effective management of this risk should support sustainable services, better use of NHS resources, improved value for money, and continued investment in priorities that improve outcomes and reduce inequalities for the population of Kent and Medway.			
Lead Executive	**Lead Teams**	**Lead Assurance Committee**	**Date Added to BAF**
Chief Finance Officer	Finance	Finance and Performance Committee	Apr-26
Risk Ratings:			
	Inherent	**Current**	**Target**

Board Assurance Framework
2026-2027
BAF2: To ensure financial sustainability over 3 years

Impact / Likelihood	4 x 4	4 x 4	3 x 3
Score	16	16	9
Risk Trajectory:			

Q4 25/26	Q1 26/27	Q2	Q3	Q4
N/A	16 →	16 →	-	-

Risk Appetite:	Cautious 10	Status (In / Out Appetite)	OUT

Key Controls (what is in place)	Gaps in Control (what is not yet in place)
1. Monthly reporting of the financial position with a detailed analysis of variances and the underlying drivers that sit behind them. Regular financial envelope **monitoring and reporting covering:** a. Monthly finance reporting cycle should aim to close the ledger position by Working Day 5 with a clear timetable and accountability. b. Implement **early warning triggers** with deterioration thresholds and growth pressures (>2% variance): c. Flash reporting of the financial position to Executive Committee for early review, insight, and challenge. d. Hold monthly Budget Holder meetings with **deep-dive reviews** for high-risk areas (e.g. AACC – Fast Track reviews). e. Ensure clear ownership of **financial envelopes** and Cost Improvement Programme (CIP) at directorate/service level. 2. **Bridge analysis** from current position to year-end, focusing on non-recurrent risks and mitigations, how they came about and what recurrent pressures are factored into the Medium-Term Plan for 2027/28.	1. Updating **Atamis contract register** which is the centralised procurement and contract management system to track tenders, manage supplier relationships, and monitor contract performance. Progress has been made in terms of ownership and actions from the working group to move this forward. I

Board Assurance Framework
2026-2027
BAF2: To ensure financial sustainability over 3 years

3. Weekly **review of efficiencies** to review progress and identify and mitigate any impediments to delivery. 4. Introduce **scenario modelling** (best/ mid/ worst case) for key risks such as, demand growth, acuity, workforce and capability gaps. 5. Production and review Forecast Outturn modelling which is used to inform mitigating actions to achieve the financial plan. 6. Remediation plan is underway following the Contract and Procurement and Financial Reporting Reviews into the organisation. This remediation plan covers short, medium, and long term actions for completion with 12 months, with identified owners and milestone dates. 7. Active engagement with partners to share financial risks and solutions. 8. Shared ICB-wide commissioning, contracting and finance work programmes 9. Equality, Health Inequalities and Quality Impact Assessment policy and process in place to ensure either positive impact or mitigations are taken if possible negative impact of service changes or cost improvement programmes	
Positive Assurances / Evidence of Effectiveness (what shows it is working)	**Gaps in Assurance (what evidence is missing)**
Evidence of effectiveness should include delivery against recurrent financial recovery trajectories, demonstrable achievement of cost improvement schemes without adverse quality or safety impacts, confirmation that major decisions include quality and equality impact considerations, improved forecast accuracy, reduced reliance on non-recurrent mitigations, and evidence that investment decisions are aligned to agreed strategic and population priorities. 1. Monthly reporting to **Finance and Performance Committee** and onward transmission to Board for oversight. This includes reporting of both the in-month and cumulative position, together with reporting of efficiency performance.	1. Embedding of updated Standing Financial Instructions and Scheme of Delegation is underway, with conformity to the new control environment to be monitored. 2. Stocktake of the ICB's **Corporate cost reduction programme** to ensure recurrent pay and non-pay budgets in Admin and Programme and their corresponding actuals are within the target expenditure limit of £39.1m for 2026/27.

Board Assurance Framework
2026-2027
BAF2: To ensure financial sustainability over 3 years

2. Internal and external audits of financial controls and reporting undertaken with a clean external audit opinion for 2026/27 3. **Monthly reporting to NHS England** with a detailed review of in-month and cumulative performance and discussion of risks and mitigations. 4. Updated Standing Financial Instructions and Scheme of Delegation signed off and present within organisation providing clarity as to control environment and authorisation levels 5. Forecast Outturn documentation provides a tracker of risks and mitigations not present in the ledger position with a review of the underlying position. 6. Fina**ncial Recovery Group** reporting to Executive Committee and to Finance and Performance Committee to inform of efficiency delivery. 7. EHQIAs summary reported to Integrated Quality and Performance Group and Quality, Safeguarding and Patient Experience Committee. **Success Measures** Success will be demonstrated by: • delivery of the agreed financial plan and medium-term financial trajectory; • increased proportion of recurrent rather than non-recurrent efficiencies; • clear evidence that cost improvement schemes have been assessed for quality, safety, patient experience and inequalities impact; • major contracts and commissioning decisions including outcome-based financial and performance measures; • routine reporting showing the relationship between financial position, delivery risk, service performance and patient outcomes; • evidence that resources are increasingly aligned to strategic priorities, prevention, neighbourhood working and pathways where the greatest improvement opportunity exists.	Coding of the expenditure budgets to the national chart of accounts for corporate costs, divided by the population, **should = £19.40** per weighted population.

Board Assurance Framework
2026-2027
BAF2: To ensure financial sustainability over 3 years

Mitigating Actions to Address Gaps	Target Date
Completion of remediation plans across Contracting and Procurement and Financial Reporting	March 2027
Full embedding of the revised Standing Financial Instructions and Scheme of Delegation	November 2026

Current Performance – Highlights

The overall control environment continues to strengthen, with the revised Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation now approved and implementation underway across the organisation. The focus has moved from framework development to embedding the revised governance arrangements and monitoring compliance with the new control environment.

The organisation continues to face financial delivery challenges, particularly in relation to the achievement of recurrent efficiencies and the management of underlying financial pressures. Weekly oversight through the Financial Recovery Group, supported by detailed Forecast Outturn modelling, provides early visibility of financial risks and mitigations and supports timely corrective action where schemes are off trajectory.

Following the Contracting and Procurement Review and Financial Reporting Review, formal remediation plans have been established with identified ownership, milestones and governance oversight arrangements. Delivery of these plans is being monitored through established reporting structures, with actions focused on strengthening financial controls, improving forecasting accuracy, enhancing procurement compliance and ensuring more consistent contract management arrangements.

Further work is underway to improve financial transparency and assurance through the continued development of the Atamis contract register, strengthening ownership and oversight of contractual commitments across the organisation.

Monthly reporting to Executive Committee, Finance and Performance Committee and the Board continues to provide oversight of financial performance, efficiency delivery, financial risks, mitigations and forecast outturn. Reporting increasingly focuses on the underlying position, including risks and mitigations that are not yet reflected within the ledger position, to support informed decision-making and early intervention where required.

Alongside in-year financial management, work continues to strengthen the medium-term financial approach through improved planning assumptions, scenario modelling and clearer identification of recurrent pressures to support development of the 2027/28 financial plan and longer-term financial sustainability.

Board Assurance Framework
2026-2027
BAF3: Lead strategy and ensure commissioning levers deliver impact

BAF3: Lead strategy and ensure commissioning levers deliver impact			
Objective: Provide system leadership through a clear strategy for healthcare and use commissioning levers to drive improvement			
Strategic Risk: Inability to implement a system-wide strategy or apply effective commissioning levers, resulting in missed recovery targets, persistent health inequalities, and failure to deliver transformation			
IF the ICB is unable to implement a coherent, system-wide strategy, or once implemented is unable to convert the system strategy into specific delivery requirements across commissioning intentions, provider contracts, performance trajectories, pathway standards, investment decisions and incentives **THEN** the organisation will be limited in its ability to drive consistent delivery, influence provider behaviour, and secure the transformation required to meet system objectives and national expectations **RESULTING IN** missed or delayed improvement against elective, urgent and emergency care, mental health, community and prevention priorities; persistent variation in access, quality and outcomes across Kent and Medway; slower reduction in health inequalities; weaker delivery confidence with NHS England and system partners; and reduced ability to demonstrate the impact of commissioning decisions **DEFINED BY** evidence such as slippage against recovery trajectories, inconsistent adoption of standardised pathways, contracts not reflecting agreed outcomes or incentives, limited use of performance levers where providers are off track, variation indicators remaining outside agreed tolerances, delayed implementation of prevention and inequalities priorities, and Board or committee reports that do not clearly link strategy, commissioning action, delivery and patient or population impact.			
Expected Outcomes: Successful management of this risk will be demonstrated by a clear line of sight from strategy to delivery; each major commissioning decision should identify the population need being addressed, the expected outcome, the provider or pathway change required, the contract or performance lever being used, the trajectory for improvement, and the evidence that benefits are being realised. The Board should see that strategic priorities are reflected in 2027/28 commissioning intentions, major provider contracts, pathway redesign, investment and disinvestment decisions, quality and performance frameworks, and system delivery plans. Specific outcomes should include sustained improvement in priority recovery trajectories, reduced variation between places and providers, measurable progress on prevention and inequalities indicators, stronger use of data to trigger corrective action, and clearer evidence that commissioning levers are improving access, quality, outcomes, patient experience and value for money.			
Impact on Patients and Population: If this risk is not effectively managed, patients may continue to experience different levels of access, waiting times, quality and outcomes depending on where they live or which provider they use. Communities with the greatest health inequalities may not benefit from prevention, early intervention, neighbourhood working or pathway redesign at the pace required. Effective management should result in more consistent access to priority services, stronger recovery in elective, urgent, and emergency care, mental health and community pathways, improved prevention and earlier intervention, and clearer evidence that commissiong decisions are reducing inequalities and improving population health across Kent and Medway.			
Lead Executive	**Lead Teams**	**Lead Assurance Committee**	**Date Added to BAF**
Chief Medical Officer	CMDTs	Quality, Safeguarding and Patient Experience Committee	Apr-2026

Board Assurance Framework
2026-2027
BAF3: Lead strategy and ensure commissioning levers deliver impact

Risk Ratings:				
	Inherent	Current	Target	
Impact / Likelihood	4 x 5	4 x 3	3 x 3	
Score	20	12	9	
Risk Trajectory:				
Q4 25/26	Q1 26/27	Q2	Q3	Q4
N/A	16 →	12 ↓	-	-
Risk Appetite:	Cautious 10	Status (In / Out Appetite)	OUT	

Key Controls (what is in place)	Gaps in Control (what is not yet in place)
• Board assurance framework and committee oversight arrangements in place with primary assurance provided through QSPE in relation to commissioning outcomes, quality, patient experience, health inequalities and transformation delivery, and supporting assurance provided through Finance and Performance Committee in relation to contracting, performance trajectories, incentive mechanisms and resource deployment. • Five-year system strategy approved by Board. 2027/28 commissioning intentions that set out priority areas for improvement, expected outcomes, delivery requirements and alignment to recovery trajectories have been published and are being engaged on.Integrated performance and commissioning framework established to bring together activity, finance, quality, outcomes, inequalities and patient experience measures, with agreed tolerances and escalation routes through IQPG, Executive Committee and Board committees.	• Commissioning and contracting reset remains variable across portfolios, with some contracts and pathway plans not yet clearly specifying outcomes, incentives, quality requirements, inequalities measures or escalation consequences. • Data and intelligence are not yet used consistently to identify variation, prioritise commissioning action, test whether interventions are working, or trigger timely corrective action where trajectories are off track. • System operating model, partner accountabilities and decision rights are not yet fully embedded, creating risk that delivery issues are escalated late or resolved inconsistently across providers and places.

Board Assurance Framework
2026-2027
BAF3: Lead strategy and ensure commissioning levers deliver impact

• Contracting and commissioning reset in delivery, including strengthened contract schedules, clearer outcome requirements, incentives and standardised pathway expectations for major providers across elective, urgent and emergency care, community, mental health and prevention priorities. • Governance routes through IQPG, Finance and Performance Committee, QSPE Committee and Board are being used to test whether strategy, performance, finance, quality and risk reporting are aligned and whether issues are escalated when delivery deviates from agreed trajectories. • System leadership arrangements, including SLG, provider forums and joint committee routes, provide mechanisms to agree shared priorities, resolve delivery barriers and secure partner commitment to system-wide improvement actions. • Prevention and early intervention commissioning is being expanded through areas such as cardiometabolic risk, anticipatory care, neighbourhood working and population health management, with quarterly tracking expected to show changes in activity, access, inequalities and outcomes.	
Positive Assurances / Evidence of Effectiveness (what shows it is working)	**Gaps in Assurance (what evidence is missing)**
Evidence of effectiveness should include quarterly reporting that shows whether commissioning levers are changing delivery in practice. This should include measurable movement in agreed recovery trajectories, reduced variation between places and providers, delivery against prevention and inequalities indicators, patient experience and quality outcomes, and evidence that contract mechanisms, pathway changes, incentives, investment decisions and escalation actions are having the intended effect. Assurance should distinguish between activity completed, such as a	• Integrated Board reporting not yet consistently demonstrating end-to-end line of sight from strategy to outcomes and impact of commissioning levers. • Limited routine assurance on the effectiveness of commissioning interventions (i.e. evidence that levers are driving intended change).

Board Assurance Framework
2026-2027
BAF3: Lead strategy and ensure commissioning levers deliver impact

framework or contract being in place, and evidence of impact, such as improved access, reduced waits, better outcomes or reduced inequalities. • Regular IQPG and Finance & Performance Committee reporting demonstrating trajectory management, delivery against recovery plans and use of commissioning levers. • System Leadership Group and Executive Committee evidence of active system alignment, decision-making and resolution of delivery risks. • QSPE Committee assurance on quality, safety and patient outcomes linked to commissioning decisions. • NHS Oversight Framework ratings and regional feedback evidencing increasing system alignment and delivery confidence. • Integrated Board reporting providing routine, evidence-based escalation and corrective action where performance is off track. **Success Measures** • System strategy formally approved and into a delivery plan by Q2 26/27, with named owners, trajectories, and benefits measures for each major priority. • All major 2027/28 contracts and commissioning intentions include agreed outcomes, performance trajectories, quality requirements, inequalities measures, incentives and escalation routes. • Priority recovery trajectories for elective care, urgent and emergency care, mental health and community services show sustained improvement over successive quarters from Q3 2026/27. • Quarterly reporting shows reduced unwarranted variation between places and providers, including clear action where performance remains outside agreed tolerances.	

Board Assurance Framework
2026-2027
BAF3: Lead strategy and ensure commissioning levers deliver impact

NHS Kent and Medway

• Prevention and inequalities indicators, including smoking, cardiometabolic risk and neighbourhood priorities, have agreed baselines by Q2 and improvement trajectories from Q4 2026/27. • Quarterly impact assessments demonstrate whether specific commissioning interventions, including pathway redesign, incentives, investment shifts and contractual levers, are improving access, quality, outcomes and value for money.	

Mitigating Actions to Address Gaps	Target Date
Finalise, approve and publish system strategy with clear delivery plan, trajectories and commissioning intentions	End Q2 26/27
Embed single integrated performance and commissioning dashboard across IQPG, ExCo and Board with agreed metrics and escalation thresholds	Q2-Q3 26/27
Complete contracting reset, including aligned incentives, standardised pathways and strengthened contract schedules across all major providers	Q3 26/27
Implement revised integrated reporting framework linking strategy, delivery, finance and risk, with routine Board oversight and escalation	Q2 26/27
Define and embed system operating model, roles and accountabilities for delivery across ICB, providers and place partnerships	Q3 26/27
Establish routine evaluation of commissioning levers (impact assessment framework) demonstrating effect on outcomes and performance	Q3-Q4 26/27
Strengthen committee forward plans and assurance flows, ensuring clear ownership and reduction of duplication across governance structures	Q2 26/27
Complete revision of Quality Engagement and Risk Escalation Framework	Q3 26/27

Current Performance – Highlights
IQPG is now established as the principal route for integrated oversight of system performance, delivery risk and recovery trajectories. A Director of Performance is in post, strengthening organisational grip and providing clearer ownership of performance intelligence, escalation and improvement support. The next phase of assurance must demonstrate that the system strategy, 2027/28 commissioning intentions, provider contracts, pathway changes and reporting arrangements are not only in place but are influencing delivery. In particular, Board and committee reporting should show whether commissioning levers are improving elective, urgent and emergency care, mental

Board Assurance Framework
2026-2027
BAF3: Lead strategy and ensure commissioning levers deliver impact

health, community and prevention priorities; reducing unwarranted variation between places and providers; supporting inequalities commitments; and enabling earlier corrective action where agreed trajectories are not being met.

Board Assurance Framework 2026-2027
BAF4: Develop into a High-Performing Commissioning Organisation

BAF4: Develop into a High-Performing Commissioning Organisation			
Objective: Move from transactional contracting to strategic commissioning, with robust governance and capability			
Strategic Risk: Failure to embed a strategic commissioning model and robust governance undermining organisational maturity, financial sustainability, and external confidence			
IF the ICB fails to embed a strategic commissioning model supported by clear, robust, and consistently applied governance processes, including decision-making pathways, assurance arrangements, and role clarity **THEN** the organisation may be unable to operate as a mature, high-performing strategic commissioner, weakening its ability to make evidence-based decisions, drive transformation, and ensure accountability **RESULTING IN** reduced organisational credibility and external confidence, misaligned or inefficient commissioning decisions, impaired financial sustainability, duplication or gaps in oversight, and slower progress towards the ICB's strategic objectives **DEFINED BY** indicators such as inconsistent application of governance frameworks, feedback from regulators or partners regarding immaturity of commissioning processes, unclear decision-making routes, delays or rework in programme approvals, variable quality of commissioning proposals, weak assurance flows through committees, and evidence that governance gaps impact financial delivery, transformation, or system confidence.			
Expected Outcomes: Successful management of this risk will be demonstrated by evidence that the ICB is operating as a mature strategic commissioner, with clear decision-making, effective use of intelligence, strong governance, and consistent delivery of commissioning priorities. The commissioning model should result in better quality proposals, more timely decisions, clearer accountability, stronger benefits realisation and improved confidence from partners, providers, staff and the Board. The expected outcome is not simply that CMDTs, governance routes and training programmes are in place, but that they are improving the quality, pace, consistency and impact of commissioning decisions. The Board should be able to see evidence that decisions are being made at the right level, supported by the right information, with clear intended benefits and follow-through on delivery.			
Impact on Patients and Population: If this risk is not effectively managed, commissioning decisions may be delayed, inconsistent or insufficiently informed by evidence, leading to slower service improvement and weaker impact for patients and communities. Effective management of this risk should mean that commissioning capability directly supports better access, quality, patient experience, value for money and outcomes for the population of Kent and Medway.			
Lead Executive	**Lead Teams**	**Lead Assurance Committee**	**Date Added to BAF**
Chief Commissioning Officer	Commissioning	Finance and Performance Committee	Apr-2026
Risk Ratings:			
	Inherent	**Current**	**Target**
Impact / Likelihood	**4 x 4**	**4 x 3**	**4 x 1**

Board Assurance Framework
2026-2027
BAF4: Develop into a High-Performing Commissioning Organisation

Score	16	12	4
Risk Trajectory:			

Q4 25/26	Q1 26/27	Q2	Q3	Q4
N/A	16 →	12 ↓	-	-

Risk Appetite:	Cautious 10	Status (In / Out Appetite)	OUT

Key Controls (what is in place)	Gaps in Control (what is not yet in place)
• Delivery against commissioning intentions monitored and achieving expected benefits ○ Five year strategy and three year commissioning plan in place and signed off by Board, setting strategic direction ○ Commissioning policy available to guide decision making process and signed off by board ○ Commissioning intentions published each year in draft ahead of a summer engagement exercise, finalised in September ○ Commissioning letters sent to all major providers in September to provide six months' notice of commissioning changes ○ Planning process run according to national planning guidance and timetable, securing signed contracts with all providers ahead of the financial year. • Each element of the commissioning cycle run according to best practice ○ Robust needs assessment in place and available ahead of each year's commissioning cycle ○ Wider insight available to inform every commissioning exercise including collated engagement and data pack	• Commissioning strategy documentation exists and is ready for Board approval but has not been finalised post engagement. • 2027-28 commissioning intentions drafted but are not yet agreed by Board. • Key gaps in analytical, BI and population health teams limit the capacity to deliver the extent of analysis and needs assessment that could be available to inform commissioning in the medium term. • Commissioning arrangements have not yet all been reviewed in detail for VFM, clinical and quality outcomes and coherence with system strategy. • Contract management reset not yet fully embedded with gaps on benefits realisation as a result, leading to a gap between theoretical and real world impact. • ExCo commissioning subgroup is in place and CMDTs launched on 1/7. However, SFIs and SoRD review not yet finalised leading to ongoing lack of clarity around authority and decision making rights and unnecessary escalation of decisions. • Commissioning not always delivered in line with commissioning policy, especially where commissioning exercises started before its existence. • CMDTs in process of standardising key documentation to ensure that it is docked into the wider organisation's governance and processes, but this is not yet in place to the right standard.

○ Commissioning proposals take account of a clear opportunity analysis and reflect best practice in terms of service design, quality and outcomes sought and value for money. Proposals are aligned to strategic intent. ○ Commissioning proposals are backed by clear contract and finance models which will deliver on benefits around service quality and performance, clinical outcomes and value. ○ Performance monitoring allows for contractual enforcement of commissioning intent where appropriate and creates part of evidence base for ongoing review of service commissioning. ○ Evaluation of whether outcomes improvements envisioned in the commissioning exercise are achieved. • Evidence of increased commissioning capability demonstrated through peer review, quality assessment of business cases, and successful delivery of commissioning programmes ○ All staff are offered basic 'bronze' training programme in all components of strategic commissioning ○ More advanced modules of commissioning capability training are available for those who lead or need to develop capability as part of a widely-capable CMDT. ○ 'Gold' level commissioning development arrangements are available to those leading each part of the commissioning CMDT. These will reflect best practice and cutting edge development, drawing on external expertise to widen perspective and learning. • CMDTs have standard operating procedures and documentation docked into the wider organisation's governance and processes. Clear governance in place with clear delegation of authority to act. Governance processes are used to ensure CMDT working is fully operational and to test the application of cutting edge commissioning expertise and thinking in all new proposals. • CMDT leads are offered coaching support in their leadership role to develop their ability to facilitate truly multidisciplinary working and create the right	• CMDTs launched on 1/7 but not fully staffed or developed. Detailed programme of commissioning development has been agreed, and mandatory training is in final stages of development. However, development not yet delivered. • SCPR still iterating towards final form. • Outcomes now being articulated in new commissioning arrangements (acute contracts, primary care neighbourhood contract) but full cycle not yet run to analyse success.

culture for high performance commissioning function. CMDT conference held annually and quarterly in 2026/27 to ensure that CMDT development is monitored and that consistency and best practice are promoted.	
Positive Assurances / Evidence of Effectiveness (what shows it is working)	**Gaps in Assurance (what evidence is missing)**
Evidence of effectiveness should include improved quality of commissioning proposals, reduced unnecessary escalation or rework, clearer use of population health and patient insight in business cases, evidence that benefits realisation is tracked after decisions are made, improved staff confidence in commissioning processes, and feedback from partners and providers that commissioning arrangements are clearer, more strategic and more effective. Success will be demonstrated by: • commissioning decisions being made at the appropriate level, with reduced unnecessary escalation and clearer audit trails; • commissioning proposals consistently setting out population need, patient insight, quality impact, financial impact, intended outcomes and benefits realisation; • routine use of population health intelligence, patient experience and inequalities data in commissioning decisions; • improved timeliness and consistency of commissioning proposals through CMDTs and governance routes; • evidence that agreed commissioning benefits are tracked and achieved; • staff reporting increased confidence in strategic commissioning processes; • partners and providers reporting improved clarity, consistency and confidence in the ICB's role as a strategic commissioner; • commissioning decisions demonstrably improving outcomes, quality, access and value for money.	• Commissioning capability programme and Board development programme not yet running but nearing end of design phase.

Board Assurance Framework
2026-2027
BAF4: Develop into a High-Performing Commissioning Organisation

Mitigating Actions to Address Gaps	**Target Date**
CMDTs fully up and running	July 2026
SCPR iterated to final version	July-Sept 2026
Commissioning capability programme running	July 2026
Current Performance – Highlights	
CMDTs have been launched and initial development activity has taken place, including the staff conference and development of standard documentation. The next stage of assurance needs to demonstrate whether these arrangements are changing practice and improving the quality and impact of commissioning decisions. During Quarter 2, assurance should focus on whether CMDTs are consistently using population health data, patient insight, quality intelligence, activity and finance information to shape commissioning proposals, and whether decisions made through the new model are delivering clearer outcomes and benefits.	

Board Assurance Framework 2026-2027
BAF5: Renew our Culture for long-term sustainability

BAF5: Renew Our Culture for Long-Term Sustainability			
Objective: Embed a culture that supports psychological safety, collaboration, accountability, and innovation demonstrated by colleague feedback			
Strategic Risk: Lack of cultural renewal and behavioural framework adoption, leading to disengaged workforce, inconsistent behaviours, and failure to deliver transformation.			
IF the organisation does not achieve increased staff engagement scores, emphasising that they have not moved forward from the culture review **THEN** colleagues may not exhibit the behaviours, ways of working, or collective accountability required to deliver the ICB's strategic objectives **RESULTING IN** a disengaged and demotivated workforce, inconsistent standards of conduct and collaboration, reduced organisational credibility, weakened delivery capability, and slower progress against strategic priorities **DEFINED BY** staff pulse and national survey scores improving MoM/YoY and benchmarking improved against ICBs nationally, appraisal completion at 95% and reduced Freedom to Speak Up cases			
Expected Outcomes: Successful management of this risk will be demonstrated by a culture in which colleagues understand expectations, feel able to speak up, work collaboratively across teams, and take ownership for delivery, learning and improvement. The organisation should show evidence of increasing psychological safety, consistent leadership behaviours, improved staff engagement, effective use of Freedom to Speak Up and complaint's themes, and stronger alignment between culture, performance and delivery. The Board should expect to see that culture work is not treated as a standalone organisational development programme, but as an enabler of better governance, better commissioning, improved patient experience, stronger delivery and more effective learning from risks, complaints, incidents and staff feedback.			
Impact on Patients and Population: If this risk is not effectively managed, organisational culture may affect the ICB's ability to listen, learn, respond and deliver improvements for patients and communities. A positive, open and accountable culture should support better decision-making, earlier escalation of concerns, more effective learning from complaints and patient experience, stronger collaboration with partners, and improved delivery of services for the population of Kent and Medway.			
Lead Executive	**Lead Teams**	**Lead Assurance Committee**	**Date Added to BAF**
Chief People and Culture Officer	HR/Workforce	People Committee	Apr-2026

Risk Ratings:

	Inherent	Current	Target
Impact / Likelihood	**4 x 4**	**4 x 4**	**4 x 2**
Score	**16**	**16**	**8**

Risk Trajectory:

Q4 25/26	Q1 26/27	Q2	Q3	Q4

Board Assurance Framework
2026-2027
BAF5: Renew our Culture for long-term sustainability

N/A	16 →	16 →	-	-
Risk Appetite:	**Open 12**	**Status (In / Out Appetite)**	**OUT**	

Key Controls (what is in place)	Gaps in Control (what is not yet in place)
• Behavioural framework embedded in recruitment, retention, appraisal, and development • Appraisal comms plan and engagement with line managers • OD programmes and leadership coaching • Regular staff engagement and feedback mechanisms • Directors Network refreshed and engagement high • Cultural audits and action plans in place with measurable outcomes • Executive team coach in place, developing the leadership of the organisation • Board Development in place which includes Strategic Development • Strategic Development Programme developed and plan to roll out	• No systematic audit of manager compliance with core people processes (e.g. 1:1s) • **Inclusion of staff working for K&M, but hosted elsewhere e.g. DDI function**
Positive Assurances / Evidence of Effectiveness (what shows it is working)	**Gaps in Assurance (what evidence is missing)**
Evidence of effectiveness should include improved staff engagement and pulse survey results, evidence that colleagues feel able to speak up, appraisal and management compliance, reduced or better-managed employee relations themes, evidence that Freedom to Speak Up and complaints themes are informing organisational learning, and examples of changes made as a result of staff, patient or stakeholder feedback. • HR and OD reports • Staff surveys (Monthly and yearly) • Appraisal Data	• Culture Group is newly established and not yet operating a regular reporting cycle to Executive Committee • Establishing quarterly Pulse Survey aligned to the People Promise baseline data not yet established • OD Plan approved April 2026 is establishing the foundations for organisational development following implementation of the new operating model. Regular reporting against delivery and outcomes will be embedded to strengthen assurance and oversight, particularly as engagement and co-

• Freedom to Speak Up data (reported to People Committee and Exec Committee) • Executive oversight of culture metrics through Culture Group **Success Measures** Success will be demonstrated by: • improved staff engagement and pulse survey scores over time; • increased confidence in speaking up and evidence that concerns are acted upon; • appraisal and objective-setting processes consistently reflecting values, behaviours and accountability; • evidence that Freedom to Speak Up, complaints and patient experience themes are triangulated and used to inform organisational learning; • improved consistency of people management practice, including one-to-ones, development conversations and team engagement; • Board and committee reporting showing how culture supports delivery, risk management, patient experience and organisational improvement; • demonstrable examples of changes to practice, process or behaviour arising from staff and patient feedback.	development of the three-year People Strategy begins during September and October 2026.

Mitigating Actions to Address Gaps	Target Date
Inaugural Culture Group to be held and regular reporting cycle to Executive Committee	May 2026
Inclusive leadership and EDI session for Executive Team	May 2026
Quarterly pulse survey results reported to Executive Committee	June 2026
Establish mechanisms for FSTU themes to be mapped into OD Plan	June 2026

Board Assurance Framework
2026-2027
BAF5: Renew our Culture for long-term sustainability

Colleague Handbook refreshed	September 2026
Options to Capture manager compliance with core people processes	September 2026
Six-month OD Plan mid-point review completed	October 2026

Current Performance – Highlights

The Culture Review Implementation Steering Group concluded in April 2026, with the OD Plan approved by Executive Committee and baseline expectations for people management established. Current HR indicators provide some assurance, including appraisal completion and sickness absence performance; however, the March 2026 pulse survey indicates reduced confidence during a period of organisational change and staff confidence in speaking up remains an area requiring further focus. The next stage of assurance should demonstrate how the OD Plan, Culture Group, Freedom to Speak Up themes, complaints and patient experience insight are being triangulated to support organisational learning, improve leadership behaviours and strengthen delivery for patients and communities.

Risk, Controls and Actions Report - 11/09/2026

Register: Corporate
Status: Open
Confidentiality Status: Board Part 1 (Public)

Risk Area	Control Description	Risk Rating	Action Description	Risk Review Narrative
Ref: 1682 **Title:** Neurodevelopmental (ADHD / ASD) Demand and Financial Pressure **There is a risk that:** Demand for ADHD and autism assessments continues to grow at a rate significantly above planned assumptions, with high referral volumes and backlog clearance driving increased assessment activity, particularly through independent sector providers operating under Right to Choose arrangements where activity levels are more difficult to control. **Leading to:** Assessment activity and associated monitoring costs exceeding planned levels across both ICB-commissioned and out-of-area providers. **Resulting in:** A material financial pressure for the ICB, potentially increasing the forecast outturn position, reducing the system's ability to deliver its financial plan, and creating further operational and commissioning challenges in managing demand for neurodevelopmental services. **Risk Owner:** Kate Calvert **Committee:** Finance and Performance Committee **Directorate/Function:** Finance Directorate	Regular reporting of neurodevelopmental demand, activity, and financial pressures to EMT, with escalation of material variances and approval of mitigating actions. Active demand and activity management through contract monitoring, including review of AQP activity, referral trends, and implementation of agreed mitigations. Award and mobilisation of Surrey and Borders ADHD/Autism backlog support contract	**Risk Category:** (Corporate & Finance) Finance (system values) **Residual** Likelihood: 4 Yellow; Impact: 4 Yellow; Total: 16 Red **Inherent** Likelihood: 5 Yellow; Impact: 4 Yellow; Total: 20 Red **Target** Likelihood: 3 Green; Impact: 4 Yellow; Total: 12 Amber	Strengthen oversight and reporting of Right to Choose referral flows **Planned completion date:** 30th Sep 2026 Develop and evaluate alternative pathway to reduce reliance on high-cost RTC provision **Planned completion date:** 13th Nov 2026 KCHFT Triage development for ADHD adults and ADHD/Autism childrens services **Planned completion date:** 13th Nov 2026 Contract meetings to be held monthly with all contracted providers and material right to choose NCA providers **Planned completion date:** 30th Jun 2026 **Overdue** Contract variations issued to all contracted providers to enact new non mandatory pricing **Planned completion date:** 30th Jun 2026 **Overdue**	**Actions** Commissioning actions have been reviewed and updated **Controls** All controls have been reviewed an updated

Risk Area	Control Description	Risk Rating	Action Description	Risk Review Narrative
Ref: 1700 **Title:** Non delivery of RTT **There is a risk that:** Providers do not deliver RTT plans **Leading to:** under-delivery against Indicative Activity	Activity plans set in the ICB aligned to budgets ICS provider contract meetings Contract process begun	**Risk Category:** (Corporate & Finance) Programme delivery **Residual** Likelihood: 4 Yellow; Impact: 4 Yellow; Total: 16 Red **Inherent**		**Risk Reviewed** MTW's RTT recovery plan has been submitted and reviewed, with ICB feedback returned to the Trust and further discussion now

Plans **Resulting in:** increased backlog clearance and system plan failure **Risk Owner:** Jonathan Wilson **Committee:** Finance and Performance Committee **Directorate/Function:**		Likelihood 4 Yellow Impact 4 Yellow Total 16 Red **Target** Likelihood 2 Green Impact 3 Green Total 6 Yellow			progressing at executive level. Retention of the RTT consequence is r for consideration while monitoring delivery,and other potential contractual action being considered if the recovery plan is not delivered. ISP and other elective services commissioned outside of system acutes is being actively monitored and managed with mitigations in place
				Actions	RTT performance by acute provider is undertaken monthly by the contracting team with a monthly oversight report produced. Discussions with Maidstone and Tunbridge Wells have taken place in relation to under-delivery with a Remedial Action Plan having been produced by the trust and this will be monitored and supported by the ICB.

Risk Area	Control Description	Risk Rating	Action Description	Risk Review Narrative
Ref: 1586 **Title:** Failure to meet our statutory duty regarding Special Educational Needs and Disabilities (SEND) **There is a risk that:** the ICB is unable to meet the health aspects of the SEND improvement plan for Kent **Leading to:** the failure to meet our statutory duties and risk the Local Areas being unable to deliver the improvement plans **Resulting in:** potential harm to children and young people as it could affect their ability to reach their full potential. Defined by long waits for diagnosis, affecting their ability to have the right support, for example neurodevelopmental assessments and therapies, including speech and language support. Lack of health input into EHCPs, Annual Reviews and Tribunals. Families who do not receive the right level of support may have to stop work, leading to financial hardship. Children & young people may not have the chance of doing well at school and securing employment on finishing affected. **Risk Owner:** Sue Gibbons **Committee:** Improving Outcomes and Experience Committee **Directorate/Function:** SEND	6 monthly monitoring visits by the Department of Education (DfE) and NHSE of both the Kent and Medway plans Yearly CQC/Ofsted monitoring meetings. National and regional coordination with ICB engagement in local and regional delivery plans ICB Chief Nurse Officer is Executive lead for SEND SEND Kent Partnership Board - attended by CNO and ICB Associate Director for SEND Services and Director of Education for KCC and the Medway SEND Partnership Board co-chaired by the ICB Chief Nurse Children and Young People Neuro Developmental transformation programme is monitoring waiting times and responsible for support whilst waiting initiatives . The Balanced system being implemented to support reduction of waiting times for Speech, language and communication needs (SCLN) Close working with the Community Procurement Programme during the transformation / implementation phases	**Risk Category:** (Patient/People Outcomes) Impact on the safety of patients, staff or public (physical/psychological harm) **Residual** Likelihood 4 Yellow / Impact 4 Yellow / Total 16 Red **Inherent** Likelihood 4 Yellow / Impact 4 Yellow / Total 16 Red **Target** Likelihood 2 Green / Impact 4 Yellow / Total 8 Amber	Engage with national and regional advisers and forums to pre-empt changes to SEND legislation expected in 2027 **Planned completion date:** 1st Jun 2027	**Risk Reviewed** Kent Inspection t… place at beginnin… July , awaiting outcome letter . Risk remains unchanged **Risk Reviewed** 28.5.26 - risk reviewed and issues and controls amended accordingly

Risk Area	Control Description	Risk Rating	Action Description	Risk Review Narrative
Ref: CRR8 **Title:** Access to Mental Health Acute Inpatient Beds (Urgent and Emergency Care: CRFD) **There is a risk that:** Due to an increased number of patients clinically ready and fit for discharge **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	New Record Provider Quality Meetings Mental Health, Learning Disabilities and Autism Provider Collaborative Board oversight of mental health programme. Investment in community crisis alternatives. Piloting of Transfer of Care Hub. System Patient Flow Improvement	**Risk Category:** (Patient/People Outcomes) Impact on the safety of patients, staff or public (physical/psychological harm) **Residual** Likelihood 4 Yellow / Impact 4 Yellow / Total 16 Red **Inherent** Likelihood / Impact / Total		**Risk Reviewed** 12/06/20206 - Risk reviewed and risk rating increased to RED 16. The previous reduction to AMBER is not considered appropriate given the continuing level of patient safety risk associated with

that are clinically unsafe

Resulting in: resulting in poor outcomes, possible major injury and others not receiving care in the right place at the right time

Risk Owner: Ed Waller

Committee: Improving Outcomes and Experience Committee

Directorate/Function: Adult Mental Health

Plan led by Mental Health Provider Trust.
Daily Health and Social Care Clinically Ready for Discharge Reviews.
Development of a Mental Health and Housing Strategy

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.

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 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 ARRs, 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

4	4	16
Yellow	Yellow	Red

Target

Likelihood	Impact	Total
2	3	6
Green	Green	Yellow

reduced access to acute psychiatric inpatient beds.

KMMH acute bed capacity continues to be significantly and adversely impacted by high numbers of patients who are clinically ready for discharge but remain in hospital because there is no suitable onward placement or package of support available. This is resulting in ongoing flow pressures across the acute pathway, reducing timely access to inpatient admission for patients who require acute psychiatric care and increasing the risk of harm, delayed treatment, extended waits in unsuitable settings, and escalation of clinical risk.

The key drivers remain multifactorial and include limited availability of appropriate supported living, residential and nursing care placements; delays in securing packages of care; provider reluctance to accept referrals for people with complex mental health needs; and

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 step down/D2A beds. MADE events attended with providers. Housing strategy in process with external providers to increase housing availbility 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 weekley meeting
Use of Private Bed
Clinical risk assesment and clinical management of individual placements

inconsistent understanding of thresholds, risk tolerance and discharge pathw across partner agencies.

Additional mitigations are being progressed. An urgent award has been made for five additional crisis beds in the Thanet area, expected to come online in September/October. Plans are also being developed to commission ten step-down/Discharge to Assess beds in partnership with KCC, which should support improved flow and reduce delays for patients who no longer require an acute inpatient bed but cannot yet return home or move to longer-term accommodation.

Multi-agency workshops continue to be convened to strengthen relationships, improve shared understanding, and address barriers to discharge. Positive outputs to date include improved joint understanding of thresholds for

referral into supported living, and recognition of the need to adopt a more strengths-based, positive risk-taking approach. This includes reducing reliance on supported living packages where they are not clinically required and promoting a “home first” approach wherever safe and appropriate.

KCC is re-procuring its residential care, nursing care and supported living provider framework to address current gaps in market capacity and responsiveness. Current providers will also be invited to participate in a workshop with KMMH, with the aim of improving working arrangements, clarifying escalation routes, and reducing the frequency with which referrals are declined.

Capital funding has also been secured to support the development of Clinical Assessment Centres at 50% of Type 1 Emergency Departments. These centres will

	complement the co-located 24/7 Safe Haven model by providing an enhanced clinical offer, supporting admission avoidance, improving crisis response, and reducing avoidable demand on acute psychiatric inpatient beds. Despite these mitigations, the risk remains RED 16 at this stage due to the current and continuing impact of delayed discharges on acute bed availability, patient flow, and timely access to safe and appropriate inpatient care.
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 numbers

Adult Acute Mental Health Flow …

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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…

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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 o 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.

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Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Report from the Executive Committee
Key question	Is the Board content to note the report and receive assurance from the committee?
Executive Lead	N/A
Author	Adam Doyle, Chief Executive Officer

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☒ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

The Board is asked to note the report from the Executive Committee for assurance.

Executive summary:

The Executive Committee has met twice since the last meeting of the Executive Committee on 12 August and 9 September. This paper provides an update on the key items of discussion at these meetings.

Proposed next steps:
N/A

Governance pathway to date:		
Meeting name:	Date:	Outcome:
Board	Standing item	Assured

Contact for further information	Adam Doyle

COMPLIANCE NOTES:

Equality, health inequalities and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?
☐ Yes ☒ No

FOI status

Is this report disclosable under FOI?
☒ Yes ☐ No

Financial implications

Are there financial implications associated with this report?
☐ Yes ☒ No

Legal implications

Are there legal implications associated with this report?
☐ Yes ☒ No

COMPLIANCE NOTES:
Quality and safety implications
Are there quality or safety implications associated with this report? ☐ Yes ☒ No
Patient and public engagement
Are there patient and public engagement implications associated with this report? ☐ Yes ☒ No

REPORT FROM THE EXECUTIVE COMMITTEE

1. INTRODUCTION

This report summarises matters considered by the Executive Committee at its meetings held on 12 August and 9 September 2026. It provides assurance to the Board that the Committee has maintained oversight of key strategic, operational, financial, quality and governance matters, and has taken decisions or sought further assurance where required to support delivery of the organisation's priorities.

2. STRATEGIC ALIGNMENT

The work of the Executive Committee supports the organisation's governance and assurance arrangements by enabling executive oversight of service commissioning, system transformation, financial sustainability, organisational performance and the effective management of risk.

3. STRATEGIC OBJECTIVE 1 – COMMISSION THE RIGHT SERVICES EACH YEAR

Update of progress with delivery of comprehensive stroke services for Kent and Medway - The Executive Committee received an update on the delivery of comprehensive stroke services across Kent and Medway. The William Harvey Hospital development was reported to be progressing in line with the agreed programme, and a weekday mechanical thrombectomy service is in place locally, supported by London providers outside normal operating hours. The updated travel time analysis has now been completed and continues to support the position previously agreed under judicial review. The paper is presented to the Board for assurance.

Kent and Medway Maternity Services Review - The Committee received an update on progress with the Kent and Medway maternity services review. There is strong provider engagement, with all providers having signed up to the principles of the review.

The Committee reviewed the draft Terms of Reference for the proposed Maternity Programme Board and supported their submission to the Board for approval. During the discussion, members emphasised the importance of clearly distinguishing between two separate but related workstreams: the immediate programme of work focused on stabilisation and improvement of current maternity quality and safety concerns and the longer-term strategic review and redesign of maternity services.

Better Care Fund (BCF) 2026/7 plan - The Committee noted NHS England's approval of the 2026/27 Better Care Fund plan and confirmation that the applicable national requirements have been met. The Committee supported a joint review of the Better Care Fund. The scope of the review will be developed through the commissioning multidisciplinary team and brought back to the Executive Committee.

Urgent and Emergency Care Clinical Pathway - The Committee approved the proposed direction of travel for a system-wide clinical pathway based on the four layers of care, intended to protect acute hospital capacity for those with the greatest clinical need while strengthening neighbourhood and intermediate care. The paper is presented to the Board for approval.

Q1 review of the transfer of Children and Young Peoples Mental Health Services (CYPMHS) and the All Age Eating Disorder Service (AAEDS) to KMMH - The Committee received assurance that the transfer of children and young people's mental health services and the all-age eating disorder service has been completed safely following a comprehensive mobilisation process. The remaining digital integration work is being managed through established governance arrangements. The Committee agreed that the formal transfer programme could close and that continuing oversight would be undertaken through the contract management process. The paper is presented to the Board for assurance.

Independent All-Age Review of Mental Health, Learning Disability, Autism and ADHD Services in Kent and Medway - The Committee agreed to proceed with an independent, phased, all-age review of mental health, learning disability, autism and ADHD services, jointly owned with local authorities. The scope is to be revised into clearly defined workstreams addressing integrated children's services, integrated adult services and NHS mental health provision.

Talking Therapies - In line with the organisation's Standing Financial Instructions, the Committee approved the two-year extension to the NHS Talking Therapies contract for Kent and Medway. The contract was awarded to Vita Health Group from 1 April 2024 for an initial three-year term, with provision to extend for up to a further two years.

4. STRATEGIC OBJECTIVE 2 – TO ENSURE FINANCIAL SUSTAINABILITY OVER THREE YEARS

Month 4 Finance Report - The Committee considered the month four financial position and noted a number of material pressures. Monthly meetings with executive leads will therefore be used to validate the in-month and year-to-date position and agree any required budgetary adjustments.

Autism and ADHD Right To Choose – Needs led clinical prioritisation, financial risk and pathway development - The Committee reviewed the financial and clinical risks associated with Autism and ADHD Right to Choose arrangements. The Committee requested a consolidated position statement, setting out the likely year-end financial outcome, associated risks and proposed mitigating actions. The paper is presented to the Board.

5. STRATEGIC OBJECTIVE 3 – LEAD STRATEGY AND ENSURE COMMISSIONING LEVERS DELIVER IMPACT

Commissioning Intentions - The Executive Committee reviewed stakeholder feedback on the Commissioning Intentions and the proposed revisions to the supporting documents and recommends their approval by the Board. The Board paper explains how the feedback

shaped the final proposals, identifies which suggestions were not adopted and the reasons for this. The Committee was assured that the Commissioning Intentions would improve commissioning outcomes and agreed that, should material risks crystallise during implementation, these would be brought back to the Board to enable consideration of the resulting choices and decisions.

Winter Planning 2026-2027 - The Committee considered the emerging approach to winter planning for 2026/27 following the publication of national guidance. A single-item System Leaders Group meeting has been arranged to secure formal system sign-off before submission to NHS England, with provider chief executives and primary care represented. The Interim Chief Commissioning Officer was confirmed as the designated executive lead for winter planning.

Briefing on Local Government Reorganisation (LGR): Government Decision and Implications -The Committee received a briefing on local government reorganisation and considered the implications for neighbourhood boundaries, partnership governance and the way in which the ICB may need to operate alongside four unitary authorities. The Board will discuss this further at a future development session.

Section 75 Contract Arrangements - The Executive Committee approved the proposed Section 75 contractual arrangements. The arrangement does not represent new expenditure or a commitment of additional funds and therefore does not require Board approval.

Long Waits in the Medway NHSFT Ear, Nose and Throat Service provided for the patients of Dartford, Gravesham and Swanley - In relation to the Medway NHS Foundation Trust ear, nose and throat service, the Committee considered findings concerning long waits experienced by patients from Dartford, Gravesham and Swanley. Although the position had improved, the review identified process weaknesses and gaps in escalation. The Committee commissioned a formal lessons-learned review to strengthen early-warning and escalation arrangements and requested advice on whether a wider review of the ENT service model was required.

6. STRATEGIC OBJECTIVE 4 – DEVELOP INTO A HIGH-PERFORMING COMMISSIONING ORGANISATION

Kent and Medway Strategic Commissioning Performance Report (SCPR) - NHS Oversight Framework (2026/27) - The Committee considered the implications of the 2026/27 NHS Oversight Framework for the Strategic Commissioning Performance Report. The 2026/27 data has yet to be uploaded onto Model Health System. The assessments are therefore based on the published data earlier in August and benchmarked against nationally published data to give indicative scoring using draft methodology. The paper is presented to the Board for assurance.

Emergency Preparedness, Resilience and Response (EPRR) Policy - The Committee approved the revised Emergency Preparedness, Resilience and Response Policy and was assured that it supported the ICB in meeting its statutory duties and national guidance.

Governance Handbook - The Committee supported the revised structure and modernisation of the Governance Handbook and recommends it for Board approval. The

document is intended to operate as a practical framework for effective decision-making and is aligned to the Standing Financial Instructions and Standing Orders. The final document is presented to the Board for approval.

7. STRATEGIC OBJECTIVE 5 – RENEW OUR CULTURE FOR LONG-TERM SUSTAINABILITY

NHS Kent and Medway People Strategy - The Committee supported the proposed approach to the development of a three-year People Strategy (2027–30) to provide NHS Kent and Medway with a clear, longer-term framework for the people, culture, leadership and organisational capability required to support its strategic ambitions. The strategy will be presented to the Remuneration and People Committee and to the Board in November for approval.

8. OTHER ITEMS

Subgroup escalation report - The Executive Committee received reports from each of its subgroups.

Board Assurance Framework and Corporate Risk Register - The Executive Committee received the updated Board Assurance Framework and Corporate Risk Register, noting that further development of the BAF remained in progress.

Private Office Report - The Executive Committee received a report from the Private Office providing assurance on governance, complaints, FOI, legal matters, audit, communications and executive priorities.

9. KEY RISKS, MITIGATIONS, AND CONTROLS

Whilst no new strategic risks are formally escalated through this report, the Executive Committee wishes to draw the Board's attention to a number of areas that require continued oversight and assurance.

The Committee discussed the delivery of the financial plan and the management of in-year financial pressures. Whilst actions are in place to strengthen financial grip and control, the scale of the challenge and the requirement to deliver financial recovery remain significant areas of risk that will require continued executive and Board oversight.

The Committee also reviewed the financial and operational risks associated with Autism and ADHD Right to Choose arrangements, including continued demand growth, affordability and pathway sustainability. These matters have been considered in greater detail by the Finance and Performance Committee and are reported separately within the September Board papers. However, given the potential scale of financial exposure and wider service implications, the Executive Committee considers this to remain an area requiring ongoing Board visibility and scrutiny.

The Committee considered the risks associated with delivery of the Four Layers of Care model and wider urgent and emergency care transformation. The substantive proposal is presented separately to the Board for approval and represents a significant system

transformation programme requiring sustained system leadership, provider alignment and delivery across organisational boundaries.

The Committee also reviewed winter preparedness arrangements. The detailed winter plan is presented separately to the Board and remains a key priority for the organisation and wider system given the operational, performance and resilience risks associated with the forthcoming winter period.

In addition, the Committee noted the strategic implications arising from Local Government Reorganisation and major transformation programmes, including maternity services and mental health services. Whilst progress is being made, these programmes represent significant changes to future service delivery, partnership arrangements and organisational operating models and will require continued monitoring through established governance arrangements.

The Executive Committee will continue to monitor these issues closely and will ensure that any material deterioration in performance, financial position, delivery confidence or risk profile is escalated promptly to the Board

10. OTHER CONSIDERATIONS

Overall, the Executive Committee was assured that appropriate governance and management arrangements are in place across the areas considered. The Committee identified no matters requiring immediate escalation to the Board beyond those already highlighted within individual reports. The Committee will continue to monitor progress in relation to commissioning intentions, service transformation, winter preparedness, workforce development and statutory responsibilities, and will provide further updates to the Board as required.

11. REQUIRED OUTCOMES AND NEXT STEPS

The Board is asked to note the report for assurance.

12. SUPPORTING DOCUMENTATION

None.

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Report from Quality, Safeguarding and Patient Experience
Key question	Is the Board content to note the report and receive assurance from the committee?
Executive Lead	Jennie Hall, Chief Nursing and Experience Officer
Author	Hugh McIntyre, Chair of the Quality, Patient Experience and Safeguarding

Which of the organisation's strategic objectives does the report support:	
☐ Commission the right services each year	☐ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☐ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

The Board is asked to note the report from the Quality, Safeguarding and Patient Experience Committee.

Executive summary:

This report provides an update from the meeting of the Quality, Safeguarding and Patient Experience Committee held on Tuesday, 1 September 2026.

Proposed next steps:
N/A

Governance pathway to date:		
Meeting name:	Date:	Outcome:
N/A		

Contact for further information	Hugh McIntyre

COMPLIANCE NOTES:
Equality, health inequalities and quality impact assessment
If this report is presented for decision/approval, please complete: Has an assessment been undertaken? ☐ Yes (please attach the action plan as an appendix to this paper) ☒ No/Not applicable (please indicate why an assessment was not required)
Conflicts of interest
Are there any conflicts associated with authors or reporting officers? ☐ Yes ☒ No *If yes, please confirm how the conflict has been managed.*
FOI status
Is this report disclosable under FOI? ☒ Yes ☐ No *If no, please specify why:*
Financial implications
Are there financial implications associated with this report? ☐ Yes ☒ No *If yes, please describe:*
Legal implications
Are there legal implications associated with this report? ☐ Yes ☒ No

COMPLIANCE NOTES:
If yes, please describe:
Quality and safety implications
Are there quality or safety implications associated with this report? ☐ Yes ☒ No *If yes, please describe:*
Patient and public engagement
Are there patient and public engagement implications associated with this report? ☐ Yes ☒ No *If yes, please describe. If no, please specify why:*

REPORT FROM THE QUALITY, SAFEGUARDING AND PATIENT EXPERIENCE COMMITTEE

1. INTRODUCTION

This report provides an update from the meeting of the Quality, Safeguarding and Patient Experience Committee held on Tuesday, 1 September 2026.

2. STRATEGIC ALIGNMENT

The work of the Quality, Safeguarding and Patient Experience Committee aligns most directly with the ICB's strategic objective to lead strategy and ensure commissioning levers deliver impact. Through its oversight of quality, safeguarding, patient experience, risk management and impact assessment arrangements, the Committee supports the Board in ensuring that commissioning decisions are informed by evidence, focused on outcomes, and underpinned by appropriate assurance. The matters considered at the Committee also support the wider governance framework by enabling timely identification and escalation of quality and safety risks and ensuring that the ICB remains focused on improving services and outcomes for the population of Kent and Medway.

3. ITEMS TO ESCALATE TO THE BOARD

None.

4. ITEMS TO PROVIDE ASSURANCE TO THE BOARD

Terms of Reference (ToR) Update

Revised terms of reference highlighting the need for clearer boundaries between system design, commissioning responsibilities, and provider oversight were agreed.

Committee Risk Register and Board Assurance Framework (BAF)

The Committee noted clarification of governance alignment, including QSPE as the lead oversight Committee for BAF 3. Key risks discussed included funded nursing care exposure, safeguarding pressures, and continuing care system risks.

Strategic Commissioning Performance Report

The Committee received a provisional report, noting the transition to a new national performance framework, with changes in scoring methodology and loss of historical comparability. Emphasis was placed on focusing committee attention on deteriorating metrics and bottom-quartile performance rather than full data sets.

The proposal was for the SCPR to be reviewed by the clinical multidisciplinary teams and the Integrated Quality and Performance Group (IQPG) before reaching the Committee.

The Committee was assured regarding the governance arrangements for monitoring performance and escalating concerns, and supported the development of more targeted, intelligence-led reporting, with clear ownership of metrics and visibility of significant performance variances.

Quality Report

Three Providers (Kent and Medway NHS and Social Care Partnership Trust (KMMH), East Kent Hospitals University NHS Foundation Trust (EKHUFT) and Medway NHS Foundation Trust (MFT)), are currently in intensive monitoring. East Kent was highlighted as a high-concern provider with ongoing maternity safety and thematic issues.

KMMH showed concerns around community deaths and suicide risk, triggering a rapid quality review.

Notable cross-cutting concerns included incident management, organisational culture, safety culture challenges and deteriorating mortality indicators.

Infection prevention control showed improvement in some infections but rising risks in others such as Klebsiella and Pseudomonas.

Workforce capacity constraints in safeguarding and children's services were also highlighted.

The Committee commended the improvement in services for Looked After Children.

The Committee was assured by the report noting the strengthening of quality monitoring and escalation processes.

Medway ENT Final Report

A historical review covering approximately 3,950 patients found no significant harm identified. The issue was attributed to system/process gaps (including management and cultural issues), unclear referral pathways, and lack of early signal detection from patients or GPs.

The Trust had acknowledged and acted upon the findings. A triage approach was introduced to reduce unnecessary referrals and improve pathway management. No equivalent commissioning arrangements had been identified elsewhere. The Committee was assured by the Report and confirmed closure of the matter.

Children & Young People Mental Health Services / Eating Disorders Transfer

The transfer to the new provider was reported as completed with improved governance and clearer oversight arrangements. Previous concerns, including safeguarding risks, were confirmed as resolved and integrated into routine oversight. The Committee was assured by the Report noting exit arrangements in place for ongoing monitoring.

5. ITEMS TO NOTE

None.

6. KEY RISKS, MITIGATIONS, AND CONTROLS

The principal risks identified relate to the need to strengthen quality oversight, contract management arrangements and the clarity of risk reporting within the Committee's remit. In particular, the Committee noted that further work is required to ensure that mitigations and controls are clearly articulated within the risk register and Board Assurance Framework, and to clarify the Committee's role in relation to those risks. These risks are being mitigated through agreed actions to refine reporting arrangements, review and update the Committee's Terms of Reference, and ensure that future reports provide clearer evidence of controls, gaps in assurance and escalation routes to the Board where required.

7. OTHER CONSIDERATIONS

None.

8. REQUIRED OUTCOMES AND NEXT STEPS

9. SUPPORTING DOCUMENTATION

None.

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Report from Finance and Performance Committee
Key question	Is the Board content to note the report and receive assurance from the committee?
Executive Lead	Jonathan Wilson, Chief Finance Officer
Author	Elizabeth Butler, Non-Executive Member and Chair of the Finance and Performance Committee

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☐ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☒ For noting/information

Recommendation(s) to the meeting:

The Board is asked to note the report from Finance and Performance Committee.

Executive summary:

This report provides an update from the meeting of the Finance & Performance Committee held on 24 August 2026.

The Committee reviewed finance, performance, risk, procurement and commissioning matters for Month 4. Overall, the Committee received assurance in several areas, particularly in relation to the Strategic Commissioning Performance Report, contractual

oversight and procurement progress. However, partial assurance was noted for the Board Assurance Framework, the Committee Risk Register and the Autism and ADHD Right to Choose financial risk, reflecting the scale of financial, operational and commissioning challenges.
Proposed next steps:
• Extend a standing invitation to the Chair of the Audit and Risk Committee. • Review the ICB Board budget and clarify the causes of the percentage variance, including the impact of staff restructure and staff retained beyond the agreed date. • Complete updates to the BAF and Committee Risk Register before the next call for papers. • Use Month 5 run-rate information to assess the Autism and ADHD Right to Choose position and update the forecast outturn.
Governance pathway to date:

Meeting name:	Date:	Outcome:
N/A		

Contact for further information	Elizabeth Butler

COMPLIANCE NOTES:
Equality, health inequalities and quality impact assessment
If this report is presented for decision/approval, please complete: Has an assessment been undertaken? ☐ Yes (please attach the action plan as an appendix to this paper) ☒ No/Not applicable (please indicate why an assessment was not required)
Conflicts of interest
Are there any conflicts associated with authors or reporting officers? ☐ Yes ☒ No *If yes, please confirm how the conflict has been managed.*
FOI status
Is this report disclosable under FOI? ☒ Yes ☐ No *If no, please specify why:*

COMPLIANCE NOTES:
Financial implications
Are there financial implications associated with this report? ☒ Yes ☒ No *If yes, please describe:*
Legal implications
Are there legal implications associated with this report? ☐ Yes ☒ No *If yes, please describe:*
Quality and safety implications
Are there quality or safety implications associated with this report? ☐ Yes ☒ No *If yes, please describe:*
Patient and public engagement
Are there patient and public engagement implications associated with this report? ☐ Yes ☒ No *If yes, please describe. If no, please specify why:*

REPORT FROM THE FINANCE AND PERFORMANCE COMMITTEE

1. INTRODUCTION

This report provides a summary of the content of the meeting of the Finance and Performance Committee held on Monday, 24 August 2026.

2. STRATEGIC ALIGNMENT

Board committees form part of the governance structure of the organisation, supporting decision-making and assurance arrangements to enable effective delivery of priorities, sustainable use of resources, and timely management of risk.

3. ITEMS TO ESCALATE TO THE BOARD

None.

4. ITEMS TO PROVIDE ASSURANCE TO THE BOARD

- The Committee was assured by the Strategic Commissioning Performance Report, noting improving links between strategic metrics, operational performance, MDT oversight and the development of automated dashboard reporting.
- The Committee was assured by the Month 3 Contract Finance Insight briefing, while recognising that the position was based on flex and validated data and that future reporting would need to identify underlying drivers more clearly.
- The Committee noted progress in procurement, including improved visibility of spend, ownership of the contract register, development of the procurement pipeline and prioritisation of services for re-procurement or decommissioning.

5. ITEMS TO NOTE

- The Board is asked to note the Committee's partial assurance on the BAF, Committee Risk Register and Autism and ADHD Right to Choose financial risk.
- The Board is asked to note the continued need to strengthen transparency, data ownership, budget accountability and three-year financial sustainability reporting.
- The Board is asked to note the emerging risks associated with local government reorganisation, business intelligence capacity and procurement resource constraints.
- The Board is asked to note that further assurance will be dependent on delivery of action plans, Month 5 financial and activity data, and updates to risk and assurance reporting.

6. KEY RISKS, MITIGATIONS, AND CONTROLS

- The Committee remained only partially assured by the BAF and Committee Risk Register, with all BAF inclusions noted as outside appetite and updates required before the next call for papers.

- Financial sustainability remains a significant risk, with continued reliance on non-recurrent mitigations against recurrent cost pressures and the need to strengthen three-year reporting, ownership of data and budget accountability.
- Provider performance and activity delivery remain challenged, with risks noted across RTT delivery, acute provider recovery trajectories and potential contractual consequences where planned activity is not delivered.
- Autism and ADHD Right to Choose pathways present continuing in-year and future financial risk, including pressures on the £18.2m budget, constrained activity management, data limitations, provider pushback and dependency on Month 5 run-rate information.
- Local government reorganisation and potential fragmentation, including impacts relating to KCC, were identified as risks requiring further consideration.
- Business intelligence and contract and finance support capacity were noted as areas of risk, particularly in the context of workforce reductions and the removal of Arden and GEM CSU support.

7. OTHER CONSIDERATIONS

- The Committee noted the Terms of Reference and agreed further discussion was required on quorum requirements, particularly the current expectation that only one Non-Executive Director is required to make a quorate of 3 members.

8. REQUIRED OUTCOMES AND NEXT STEPS

The Board is asked to note the assurance received by the Committee, the areas of ongoing scrutiny and the actions agreed to strengthen governance, financial oversight, risk alignment and performance reporting.

- Extend a standing invitation to the Chair of the Audit and Risk Committee.
- Review the ICB Board budget and clarify the causes of the percentage variance, including the impact of staff restructure and staff retained beyond the agreed date.
- Complete updates to the BAF and Committee Risk Register before the next call for papers.
- Use Month 5 run-rate information to assess the Autism and ADHD Right to Choose position and update the forecast outturn.

9. SUPPORTING DOCUMENTATION

There is no supporting documentation relevant to this report.

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Report from the Remuneration and People Committee
Key question	Is the Board content to note the report and receive assurance from the committee?
Executive Lead	Indiana Pearce, Joint Chief People and Culture Officer
Author	Gurvinder Sandher, Non-Executive Member and Chair of the Remuneration and People Committee.

Which of the organisation's strategic objectives does the report support:	
☐ Commission the right services each year	☐ To ensure financial sustainability over three years
☐ Lead strategy and ensure commissioning levers deliver impact	☐ Develop into a high-performing Commissioning Organisation
☒ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

The Board is asked to note the report from the Remuneration and People Committee.

Executive summary:

This report provides an update from the meeting of the Remuneration and People Committee held on 8 September 2026.

Proposed next steps:

N/A

Governance pathway to date:		
Meeting name:	Date:	Outcome:
N/A		

Contact for further information	Gurvinder Sandher

COMPLIANCE NOTES:

Equality, health inequalities and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?
☐ Yes ☒ No
If yes, please confirm how the conflict has been managed.

FOI status

Is this report disclosable under FOI?
☒ Yes ☐ No
If no, please specify why:

Financial implications

Are there financial implications associated with this report?
☐ Yes ☒ No
If yes, please describe:

Legal implications

Are there legal implications associated with this report?
☐ Yes ☒ No
If yes, please describe:

Quality and safety implications

Are there quality or safety implications associated with this report?
☐ Yes ☒ No
If yes, please describe:

COMPLIANCE NOTES:
Patient and public engagement
Are there patient and public engagement implications associated with this report? ☐ Yes ☒ No *If yes, please describe. If no, please specify why:*

REPORT FROM THE REMUNERATION AND PEOPLE COMMITTEE

1. INTRODUCTION

This report provides a summary of the content of the meeting of the Remuneration and People Committee held on 8 September.

2. STRATEGIC ALIGNMENT

Board committees form part of the governance structure of the organisation, supporting decision-making and assurance arrangements to enable effective delivery of priorities, sustainable use of resources, and timely management of risk.

3. ITEMS TO ESCALATE TO THE BOARD

None.

4. ITEMS TO PROVIDE ASSURANCE TO THE BOARD

Board Assurance Framework Culture Risk - The Committee specifically reviewed the culture BAF risk, currently scored at 16, including the effects of turnover, skills loss and executive change. It challenged expired mitigation dates and requested clearer owners, realistic target dates and stronger mitigations. The Committee received assurance regarding management of the risk.

Workforce Compliance - Appraisal compliance stood at 94%, most statutory and mandatory training was above 85%, and Safeguarding Level 4 compliance had reached 100%.

Sickness and Workforce Wellbeing - Although sickness exceeded the target in July, it reduced to 3.75% in August, below the 4.33% target. The People Team continues to support managers on attendance, wellbeing and early intervention.

Improving Workforce Data and Oversight - ESR hierarchy alignment is due to be completed by the end of October, enabling stronger directorate-level reporting and better conversations between HR business partners and leadership teams. Work is also underway to strengthen workforce analytics and KPIs for occupational health and employee assistance services

Freedom to Speak Up - The organisation is identifying themes arising from concerns - particularly skills gaps, support for staff moving into new roles, management capability and one-to-one support - and recognising these as wider organisational responsibilities. The Committee was also reassured that work is underway to ensure there is no gap in Freedom to Speak Up provision when the current secondment ends, with internal, external and shared-service options being considered and formal approval required before December.

NHS People Portal – The ICB is one of the early adopters for new national replacement for ESR. The programme is in preparation stage and due to go fully live December 2027. A further Committee review has also been built into the forward plan. The Committee was assured regarding current programme governance.

5. ITEMS TO NOTE

N/A

6. KEY RISKS, MITIGATIONS, AND CONTROLS

N/A

7. OTHER CONSIDERATIONS

N/A

8. REQUIRED OUTCOMES AND NEXT STEPS

The Board is asked to note the report for assurance.

9. SUPPORTING DOCUMENTATION

None.

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report title	Transition Committee Closure Report
Key question	Can the Board be assured that the Transition Programme has delivered its core objectives and that all remaining activity, risks and responsibilities have been safely transferred into business-as-usual governance to enable the formal closure of the Programme and Transition Committee?
Executive Lead	Indiana Pearce, Joint Chief People Officer
Author	Laura Copas, Deputy Director of Transition

Which of the organisation's strategic objectives does the report support:	
☐ Commission the right services each year	☐ To ensure financial sustainability over three years
☐ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

The Board is asked to:

1. Take assurance that the Transition Programme has delivered the core requirements of the organisational transition.
2. Note the formal closure of the Transition Programme and Committee, and that responsibility for remaining actions, risks and oversight has transferred to the receiving committees and executive leads set out in the Closure Report.

Executive summary:

The Board is asked to take assurance that the Transition Programme has delivered the core requirements of the organisational transition. This includes completion of the organisational redesign from approximately 770 WTE to approximately 340 WTE within the required running cost envelope, completion of the major workforce and service transfers, and establishment of the governance and operating arrangements required for the new organisation.

The Programme has also established the OD Plan, Culture Group and revised appraisal framework to support the continued development of organisational capability and culture. The remaining workforce and capability activity has clear executive and committee oversight through business-as-usual arrangements, principally the Remuneration and People Committee.

All remaining strategic risks have been assigned to an appropriate receiving committee and executive owner, with defined BAU monitoring arrangements. The Transition Committee is therefore able to close with no outstanding matters requiring escalation to the Board.

Further detail is provided in the Transition Programme Closure Report which was approved by the Executive Committee in July 2026 at Appendix A.

The Board is asked to note that, while the structural requirements of the Transition Programme have been delivered, several activities will continue through business as usual. These include recruitment to remaining vacancies, completion of the compulsory redundancy and redeployment processes, continued delivery of the OD and Culture Plan, and the remaining service transfer and shared service activity.

The development of South East shared services and CSU exit arrangements will also continue beyond the life of the Transition Programme, with oversight transferred to the established regional and organisational governance arrangements.

The Board is therefore asked to note the formal closure of the Transition Programme and Committee, and that responsibility for remaining actions, risks and oversight has transferred to the receiving committees and executive leads set out in the Closure Report.

Proposed next steps:

N/A

Governance pathway to date:

Meeting name:	Date:	Outcome:
N/A		

Contact for further information	Laura Copas l.copas@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)
This paper is not for approval decision – it contains a progress update for noting/information. An EQIA has previously been shared for those staff affected by change as part of the Workforce Transition.

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?
☐ Yes ☒ No
If yes, please confirm how the conflict has been managed.

FOI status

Is this report disclosable under FOI?
☒ Yes ☒ No
If no, please specify why:

Financial implications

Are there financial implications associated with this report?
☒ Yes ☒ No
If yes, please describe:

Legal implications

Are there legal implications associated with this report?
☐ Yes ☒ No
If yes, please describe:

Quality and safety implications

Are there quality or safety implications associated with this report?
☐ Yes ☒ No
If yes, please describe:

COMPLIANCE NOTES:
Patient and public engagement
Are there patient and public engagement implications associated with this report? ☐ Yes ☒ No *If yes, please describe. If no, please specify why:*

TRANSITION PROGRAMME CLOSURE REPORT

1. INTRODUCTION

This report provides the formal close-down summary of the Transition Programme, established in May 2025 to oversee the organisational redesign of NHS Kent and Medway ICB, deliver the statutory running cost requirement of £19.40 per head, and ensure safe transition of functions, workforce and services into the new operating model. It confirms delivery against the Programme's core objectives, identifies residual areas requiring continued oversight, and sets out the governance arrangements for the transition into business-as-usual (BAU).

2. STRATEGIC ALIGNMENT

The Transition Programme is a key enabler in supporting Kent and Medway's progression towards becoming a high-performing organisation. The programme provides oversight of the delivery of the organisational redesign within the agreed running cost envelope, supporting the transition from a transactional contracting model to a more strategic commissioning approach.

3. BACKGROUND AND PROGRAMME OBJECTIVES

The Transition Programme was initiated following national requirements for all ICBs to:

- Operate within the £19.40 per head running cost envelope.
- Move to a leaner, strategic commissioning operating model, aligned to the Model ICB Blueprint.
- Reduce organisational size and complexity, including workforce redesign and service transfers.
- Establish sustainable arrangements for functions previously delivered through Commissioning Support Units (CSUs).
- Strengthen system collaboration through shared service models across the South East.

The Transition Committee was established in May 2025 to provide formal oversight, assurance and decision-making on all aspects of the programme.

4. DELIVERY AGAINST OBJECTIVES – WORKFORCE TRANSITION

4.1 Organisational Design and Structural Change – *Delivered*

The programme has delivered the structural redesign required for the new operating model:

- The ICB has moved from ~770 WTE to ~340 WTE, remaining within the required running cost envelope.
- The new organisational structure was launched on 1 April 2026, with implementation from 1 July 2026, following completion of consultation, check-and-challenge, slotting-in and selection processes.
- Voluntary redundancy and MARS schemes have concluded within planned parameters, with compulsory redundancy expected to be limited.

This represents the successful delivery of the structural requirements of the new organisation.

4.2 Organisational Readiness and Development – *Partially Delivered; Continues into BAU*

The structural redesign is complete, but workforce and capability development will continue beyond 1 July and will be overseen primarily via the Remuneration and People Committee.

4.2.1 Outstanding vacancies

58 vacancies remain within the new structure and will continue to be filled beyond 1 July through the agreed staged recruitment process. These include:

- Roles requiring external recruitment due to specialist skills not available internally.
- Posts where ring-fenced or competitive processes are still underway.
- Roles sequenced later to align with service transitions and shared service developments.

Any operating risks associated with unfilled posts—including capacity, resilience or continuity risks—will be managed via BAU governance (Executive Committee and directorate management arrangements), with strategic oversight from the Remuneration and People Committee, including monitoring of vacancy hotspots and interim mitigations.

4.2.2 Compulsory redundancy position

At programme close-down:

- Compulsory redundancy notice meetings are being planned.
- The current number of compulsory redundancies is 29.
- Colleagues currently “at risk” will remain in the organisation beyond 1 July while redeployment and formal processes conclude by the 30th of September 2026 in line with regional guidance.

These colleagues will continue to be supported through BAU HR and line management arrangements. Oversight of compulsory redundancy decisions, timelines and impacts will sit with the Remuneration and People Committee, supported by Executive Committee scrutiny.

4.2.3 Organisational Development Plan and Culture

The Transition Programme has established, but not completed, the OD and culture work required for the new organisation to operate as intended:

- An **Organisational Development (OD) Plan** has been developed and approved by the Executive Committee, with a phased implementation approach and five priority workstreams (Leadership and Culture; Operating Model and Ways of Working; Learning and Development/Strategic Commissioning Capability; People Experience, Inclusion and Wellbeing; and Change and Transition Capability).

- A **Culture Group** has been established, reporting to Executive Committee, to oversee delivery of the OD Plan and monitor staff experience, including quarterly pulse surveys and follow-up actions.
- The **appraisal framework** has been redesigned to align individual objectives with organisational priorities, including a mandatory strategic objective for managers, with the cycle running from 1 July to 30 September.
- An **all-staff conference on 7 July 2026** formally welcomed colleagues into the new organisation and support early embedding of the new operating model, strategic commissioning approach and culture.

These OD and culture activities are the primary mechanism through which the organisation will build the skills, behaviours and commissioning capability required to make the new structure work in practice. Oversight of OD delivery and associated workforce metrics will sit with the Remuneration and People Committee, with Executive Committee responsible for operational delivery.

5. DELIVERY AGAINST OBJECTIVES – SERVICE TRANSFERS

5.1 Completed Transfers

Between March and May 2026, 195 staff transferred to provider organisations. Completed transfers include:

- **Cancer and Diagnostic Services** to MTW (1 Apr 2026)
- **All Age Continuing Care (AACC)** to KCHFT (1 May 2026)
- **Medicines Optimisation** to KCHFT (1 May 2026)
- **Health and Care Partnership (HaCP) – Phase 1** to KMMH (staff 1 May 2026, and DDaT functions 1 August 2026)

Residual post-transfer actions (particularly for AACC) are being managed through a defined post-transfer plan under operational and Executive Committee oversight.

5.2 Outstanding Transfer – Specialised Mental Health and Section 117

The MHLDA and Section 117 transfer remains in progress. TUPE consultation is planned for Q2 2026, with a proposed go-live date currently targeted for August 2026, subject to dependencies around budget, governance and timelines.

Project governance is established, with oversight via operational programme boards and Executive Committee rather than the Transition Committee.

6. DELIVERY AGAINST OBJECTIVES – SHARED SERVICE DEVELOPMENT

The Transition Programme has established the foundations for shared service arrangements across the South East, but implementation continues beyond the programme's lifespan.

6.1 Digital, Data and Technology (DDaT)

- A joint DDaT service with Surrey and Sussex ICB is being developed, including transition of GPIT services from the CSU.
- Phase 1 consultation (senior leadership roles) has concluded; Phase 2 consultation with the wider workforce transfer to Surrey and Sussex launched on the 22 June 2026 with transfer planned on the 1 August 2026. It is anticipated that a restructure consultation with the future host organisation (Surrey and Sussex ICB) will commence on the 29 June 2026.
- The transfer of the Kent and Medway DDaT service transfer is due to take place on 1 August 2026.

6.2 South East Procurement Service

- Kent and Medway is leading development of a hosted South East Procurement shared service.
- Case for change, target operating model and mobilisation plan are due for approval through regional governance by the end of Q2 2026.
- Mobilisation is planned for October 2026, with stabilisation and CSU exit assurance by December 2026.

6.3 CSU Exit

- CSU arrangements remain in place through to 2027, with regional coordination via the Office of the South East ICBs.
- National guidance indicates that stranded costs should be minimised locally, with limited national support where all reasonable mitigations have been exhausted.

The governance route for the operational and financial risks associated with CSU exit and shared services will be agreed at the final Transition Committee meeting on 14 July 2026.

7. RISK CLOSE DOWN AND TRANSFER

Five risks remain open across three categories:

Workforce (2): Risks relating to staff engagement/organisational identity and commissioning capability/leadership readiness remain open, with mitigation through the OD plan. It is agreed that these will transfer to the Remuneration and People Committee as business-as-usual risks.

Shared service model (3): Three strategic risks remain open relating to the development of shared service models. The future oversight of these risks form part of the oversight and assurance via the SE Office of ICBs governance.

Each remaining risk has a designated receiving committee and executive owner, with clear BAU monitoring arrangements.

8. GOVERNANCE CLOSE DOWN AND ONWARD OVERSIGHT

The Transition Committee has fulfilled its purpose and can now be formally closed.

Future oversight will be delivered through the following governance arrangements:

Area	Receiving Committee	Executive Lead
Workforce capability, OD, culture, compulsory redundancy, vacancies	Remuneration & People Committee	Chief People Officer
Shared services and CSU exit	SE Procurement (hosted by K&M) reporting into Executive Committee. DDaT (hosted by S&S) into Joint DDI Transition Committee. Overall oversight of shared services and CSU exit via the SE Office of ICBs Joint Committee.	Chief Finance Officer Joint Chief Information and Innovation Officer Chief Executive Officer
MHLDA & Section 117 transfer	Executive Committee	Chief Commissioning Officer
Residual financial reconciliation	Finance & Performance Committee	Chief Finance Officer

9. OTHER CONSIDERATIONS

There are no other considerations.

10. REQUIRED OUTCOMES AND NEXT STEPS

The Transition Programme has:

- Delivered the structural redesign required to meet national expectations and the £19.40 per head running cost envelope.
- Safely completed major TUPE transfers and service transitions.
- Established the OD Plan, Culture Group and new appraisal framework as the primary vehicles for building capability and culture in the new organisation.
- Laid the foundations for shared service models across the South East.
- Reframed and transferred remaining strategic risks into BAU governance.

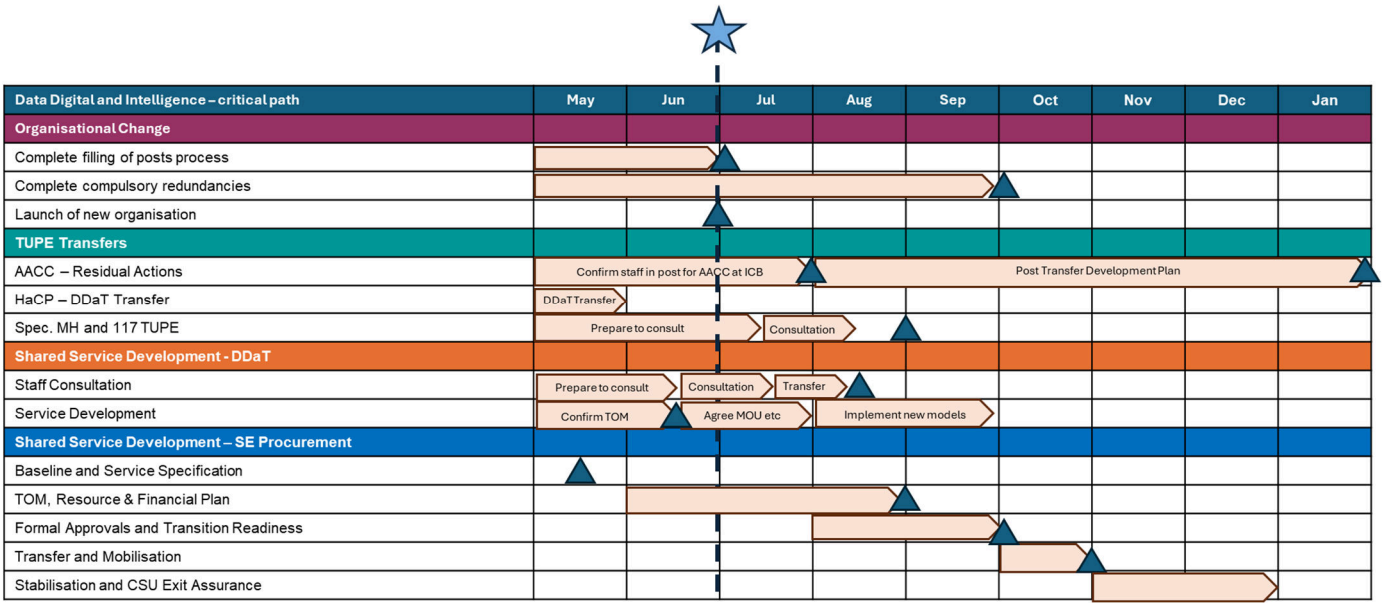
However, the work of making the new organisation operate as intended—with the right skills, behaviours and commissioning capability—will continue beyond the life of the programme. This will be driven through the OD Plan and overseen by the Remuneration and People Committee, alongside continued Executive focus.

Recommendations

1. **Approve** the formal close-down of the Transition Programme and Transition Committee.
2. **Approve** the transfer of remaining risks, actions and oversight responsibilities to BAU committees as set out in Section 8.
3. Note that while the structural requirements have been delivered, continued focus on OD, capability and shared services is essential to realise the full benefits of the new operating model.

11. SUPPORTING DOCUMENTATION

APPENDIX A: Timeline



Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report Title	South East (SE) Integrated Care Boards' (ICBs) Chief Executive Officers Joint Committee Report
Key question	Is the Board content to note the reports and receive assurance regarding decisions, risks and collaborative commissioning arrangements undertaken through the South East ICBs Chief Executive Officers Joint Committee under delegated authority?
Executive Lead	Adam Doyle, Chief Executive Officer
Author	Alison Edgington, OPIC Programme Director

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☒ For noting/information

Recommendation(s) to the Meeting:

The Board is asked to:

1. **NOTE** the reports from the South East ICBs Chief Executive Officers Joint Committee meetings held on 14 July and 11 August 2026
2. **RECEIVE** assurance on the decisions, programme progress, risks, and mitigating actions set out in the reports.

Executive summary:

This paper provides the Board with assurance on the activity, decisions and risks considered by the South East ICBs Chief Executive Officers Joint Committee at its meetings on 14 July and 11 August 2026. The Committee continues to oversee collaborative arrangements across the four South East ICBs, including the transfer of direct commissioning responsibilities, the transition of services following the closure of Commissioning Support Units, and the development of shared and hosted service arrangements.

At its July meeting, the Committee considered specialised commissioning arrangements, mobilisation of the Office of Pan ICB Commissioning, the South East ICB programme portfolio, and transition arrangements for Digital, Data and Intelligence, GPIT, Procurement, People Services, Clinical Effectiveness, Corporate Services and Ambulance Transformation. The Committee approved or endorsed a range of operating, hosting and transition arrangements intended to maintain service continuity and strengthen collaborative commissioning across the region.

At its August meeting, the Committee received further assurance on OPIC mobilisation, the South East ICB programme portfolio, Digital, Data and Intelligence transition and the regional transformation programme pipeline. Progress included confirmation of an interim Bristol data centre hosting arrangement for GPIT infrastructure, continued development of Procurement, People Services and Clinical Policy Unit arrangements, and agreement on the future direction of regional transformation programmes.

The principal areas requiring continued oversight are CSU transition readiness, workforce capacity and transfer arrangements, service continuity, funding and redundancy liabilities, and the complexity of the Digital, Data and Intelligence and GPIT transition. Although the interim Bristol hosting arrangement provides greater stability, longer-term infrastructure hosting, service levels and costs remain subject to further assurance.

Proposed next steps:

Implementation of the decisions and transition arrangements approved by the Joint Committee will continue through the relevant programme and governance structures. Particular focus will remain on OPIC readiness, CSU transition, workforce and service continuity, Digital, Data and Intelligence and GPIT arrangements, funding alignment and the development of clear criteria for determining the ownership and delivery of future regional programmes.

Further assurance will be provided to the Board through subsequent Joint Committee reports. Any matter requiring a specific ICB decision or approval will be brought through the appropriate ICB governance route.

Governance pathway to date:		
Meeting name:	Date:	Outcome:
South East ICBs Chief Executive Officers Joint Committee	14 July 2026	The Committee approved or endorsed arrangements relating to specialised commissioning, OPIC mobilisation, the South East ICB programme portfolio, Digital, Data and Intelligence and GPIT transition, Clinical Effectiveness, Procurement, People Services, Corporate Services and Ambulance Transformation. It also noted the associated workforce, service continuity, infrastructure, affordability and transition risks.
South East ICBs Chief Executive Officers Joint Committee	11 August 2026	The Committee approved the August programme update and associated highlight reports, received assurance on OPIC and Digital, Data and Intelligence transition, noted confirmation of the interim Bristol GPIT infrastructure hosting arrangement, and agreed the direction of travel for the regional transformation programme pipeline. Principal programme, workforce, financial and business continuity risks remained under active oversight.

Contact for further information	

COMPLIANCE NOTES:

Equality, health inequalities, and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

This paper provides assurance on matters previously considered through the South East ICBs Chief Executive Officers Joint Committee and does not itself seek approval for a new policy, service change, commissioning decision or resource allocation. Equality, quality and health inequality implications will need to be assessed through the relevant programme and ICB governance arrangements where specific proposals are developed for decision.

COMPLIANCE NOTES:

Conflicts of Interest

Are there any conflicts associated with authors or reporting officers?

☐ Yes ☒ No

If yes, please confirm how the conflict has been managed.

FOI Status

Is this report disclosable under FOI?

☒ Yes ☐ No

If no, please specify why:

Financial Implications

Are there financial implications associated with this report?

☒ Yes ☐ No

If yes, please describe:

The reports identify financial implications associated with shared and hosted service arrangements, programme resourcing, workforce transfer and potential redundancy liabilities, Digital, Data and Intelligence and GPIT transition, and the development of funding methodologies across the four ICBs. Any financial commitment requiring approval by NHS Kent and Medway ICB will be subject to the ICB's established financial governance and delegated authority arrangements.

Legal Implications

Are there legal implications associated with this report?

☒ Yes ☐ No

If yes, please describe:

The programmes include the development and implementation of hosted and collaborative arrangements, Memoranda of Understanding, workforce transfer arrangements and associated governance documentation. Any legal agreement or change to the ICB's own governance framework will be subject to separate review and approval through the appropriate route.

Quality and Safety Implications

Are there quality or safety implications associated with this report?

☒ Yes ☐ No

If yes, please describe:

The reports identify potential service continuity and patient service risks associated with workforce and service transfer, particularly within the Digital, Data and Intelligence and GPIT transition. These risks are being managed through the relevant programme arrangements and remain subject to Joint Committee oversight.

COMPLIANCE NOTES:
Patient and Public Engagement
Are there patient and public engagement implications associated with this report? ☐ Yes ☒ No *If yes, please describe. If no, please specify why:* No direct patient or public engagement is required in relation to this assurance report. Engagement requirements will be considered through the relevant programme and ICB governance arrangements as specific commissioning, service or operating model proposals are developed.

Report from South East Integrated Commissioning Boards' Chief Executive Officers Joint Committee held on 14th July 2026

Office of the South East ICBs

Report to: South East ICBs Joint Committee / ICB Boards
Report Sponsor: Adam Doyle, Chief Executive, Kent and Medway ICB/ Committee Chair
Report Author: Sumona Chatterjee, Executive Programme Director, Office of the SE ICBs
Meeting Date: 14th July 2026
Report Type: Board Assurance and Programme Oversight Report
Classification: Part 1 : Assurance Report

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1. Purpose

To provide ICB Boards with an update on key decisions, approvals, risks and collaborative programmes considered by the South East ICBs Joint Committee (JC) at its meeting on 14th July 2026.

2. Executive Summary

The Joint Committee continues to oversee the development of collaborative arrangements across the four South East ICBs in preparation for NHS England reforms, the transfer of direct commissioning responsibilities and service transfer arrangements due to the closure of Commissioning Support Units (CSUs).

The Committee approved or endorsed a number of significant decisions relating to:

- Specialised Commissioning contract management, commissioning intentions and service transformation.
- The continued mobilisation of the Office of Pan ICB Commissioning (OPIC).
- The Office of the South East ICBs programme portfolio and CSU transition plans.
- Host Digital, Data and Intelligence (DDI), GPIT and Corporate IT arrangements.
- The Clinical Policy Unit transition and BlueTech procurement.
- Procurement and People Services transition arrangements.
- Corporate Services and Ambulance Transformation governance and operating arrangements.

The Committee also considered a number of strategic risks, particularly relating to the unresolved GPIT infrastructure hosting arrangements, workforce attrition across CSU services, procurement resilience and business continuity during transition.

3. Key Matters for Board Attention: PART A

3.1 Executive Briefing of the South East Specialised Commissioning Joint Sub-Committee

The Joint Committee received an update on the joint approach to contract management, commissioning intentions for 2027/28 and delivery of the commissioner efficiency programme.

Key Points

- Future provider management will adopt a tiered and risk-based approach, underpinned by collaboration between ICBs and the regional specialised commissioning team.
- The commissioner efficiency programme reported £35 million in cost savings and £20 million in cost avoidance, largely through medicines optimisation and service initiatives.
- Commissioning intentions for 2027/28 will be developed through the Contracting, Finance and Value Improvement workstream, with provider engagement over the summer and confirmation by September 2026.
- The Committee noted the extension of HIV service contracts and specialised mental health provider collaborative arrangements.
- Signed Specialised Commissioning Delegation Agreements for all four ICBs were noted.

Decision

The Joint Committee endorsed:

- The cardiac transformation programme.
- The new risk-based contracting approach.
- The high-value improvement programme savings.
- The 2027/28 commissioning intentions process.
- Contract extensions for HIV services and specialised mental health provider collaboratives.
- The requirement for future ICB plans to reflect specialised commissioning and for each ICB to nominate a senior representative to the contracting and planning workstream.

Board Implications

Boards should note the increasing integration of delegated specialised commissioning within ICB planning and ensure that local commissioning intentions reflect the agreed regional approach.

3.2 OPIC Programme Update

The Committee received an update on mobilisation of the Office of Pan ICB Commissioning (OPIC), including governance, staff engagement and the development of the hosted operating model.

Key Points

- The OPIC Programme Board has been established and has met twice, with good attendance and engagement.
- Thames Valley ICB is developing the governance approach for a ring-fenced hosted unit within its operating model.
- Staff engagement commenced at the end of June and will continue through August 2026.
- A joint design workshop facilitated by NHS Horizons brought together ICB Chief Commissioning Officers and representatives to agree expectations, opportunities and ways of working.
- The programme recognises the need to balance regional standardisation with appropriate local flexibility.
- Earlier affordability and design risks have reduced following progress since the June meeting.

Board Implications

Boards should note the continued development of OPIC arrangements and maintain organisational readiness for the transfer of direct commissioning responsibilities in April 2027.

3.3 Office of the South East ICBs Programme Report

The Committee reviewed the July programme report and highlight reports covering CSU transition programmes and regional transformation programmes.

Key Points

- Programme governance architecture has been established and transition plans are progressing into Memoranda of Understanding.
- Responsibility is transferring from CSU closure arrangements into the new hosted and collaborative models.
- Procurement, People Services and DDI remain the highest-risk transition areas due to workforce attrition.
- Progress continues across Clinical Effectiveness, Ambulance Transformation, ADHD, Aseptic Services and Corporate Services.
- Tranche one programmes now have live transfer dates, with focused oversight of DDI, GPIT, Procurement and People Services.

Decision

The Joint Committee approved the July Programme Update Report and latest Highlight Reports.

Board Implications

Boards should note the progress made in establishing programme governance and transition plans, alongside the continuing need for active oversight of workforce, business continuity and delivery risks.

3.4. Digital, Data and Intelligence (DDI) Programme

The Committee considered an update on DDI, GPIT, Corporate IT and GPIT hosting arrangements.

Key Points

- Surrey and Sussex ICB will host GPIT services for Thames Valley, Kent and Medway, and Surrey and Sussex, and Corporate IT services for all four ICBs.
- The target transfer date is before January 2027, with October to November 2026 being pursued.
- Consultation and workforce transfer arrangements are progressing across participating ICBs.
- Surrey and Sussex ICB has confirmed that it cannot host the Bristol Data Centre infrastructure because of capacity and capability constraints.
- The GPIT infrastructure hosting position therefore remains unresolved and requires urgent contingency planning and national escalation.
- The Memorandum of Understanding and draft Target Operating Model will return to the 11th August Joint Committee for approval.

Decisions and Actions

- Urgently assess alternative regional data centre hosting options and compare arrangements in other regions.
- Escalate the Bristol Data Centre position through regional and national colleagues.
- Develop contingency plans for infrastructure hosting.
- Incorporate Thames Valley and Hampshire and Isle of Wight into the MOU and governance arrangements.

Board Implications

Boards should note that Corporate IT and GPIT hosting arrangements are progressing, but GPIT infrastructure hosting remains a significant business continuity risk requiring urgent resolution.

3.5. Ambulance Transformation Programme

The Committee considered a refreshed governance structure for ambulance commissioning and transformation.

Key Points

- The revised model separates commissioner-only discussions, strategic provider engagement, contracting and assurance forums.
- The approach is intended to streamline decision-making, reduce unnecessary attendance and clarify accountability.
- Regular updates will be provided to maintain ICB Board assurance.

Decision

Following the meeting, all Joint Committee members confirmed support for the governance structure.

Board Implications

Boards should note the revised regional governance arrangements and will continue to receive assurance through Joint Committee reporting.

PART B

4. NHS South East Regional Business Plan

The Committee reviewed the NHS South East Regional Business Plan and its alignment with emerging national, regional and ICB operating models.

Key Themes

- The plan consolidates strategic frameworks, operating models and regional objectives.
- The plan must remain agile in response to political, organisational and leadership changes.
- Roles and responsibilities across regional, ICB, provider and local authority arrangements require continuing clarification.
- The Committee supported regular reviews, including bi-monthly development discussions.
- A consistent regional approach to maternity service review is required, with shared questions and nominated leads.

Board Implications

Boards should expect the regional business plan to remain iterative and should ensure that local plans are aligned while retaining appropriate flexibility for local circumstances.

5. Clinical Policy Unit Programme

The Committee noted the successful transfer of the Clinical Effectiveness team from the CSU to Hampshire and Isle of Wight ICB supported by an MOU and proposals to standardise Individual Funding Request processes.

Decision

The Joint Committee approved:

- The interim Memorandum of Understanding for the Clinical Effectiveness team following its successful transfer to Hampshire and Isle of Wight ICB on 1 July 2026.
- Progression of procurement for the BlueTech system to support a single and consistent Individual Funding Request process across the four ICBs.

Board Implications

The arrangements support continuity, regional consistency and reduction of unwarranted variation while maintaining local commissioning accountability.

6. Procurement Programme

The Committee reviewed proposals for an accelerated transition of the Procurement function following significant CSU workforce attrition.

Decision

The Joint Committee approved:

- An accelerated lift-and-shift transfer of remaining Procurement staff into a hosted arrangement with Kent and Medway ICB to maintain business continuity.
- Approved the transitional Memorandum of Understanding.
- Recruitment of a Band 9 Programme Director, with costs shared equally between participating ICBs, to lead the immediate transition and development of the future operating model.

Board Implications

Boards should note the fragility of the current Procurement service and the need for accelerated action to protect business continuity while a sustainable collaborative model is developed.

7. HR, OD and EDI Programme (People Services)

The Committee considered the future provider and programme leadership arrangements for People Services following CSU closure.

Decision

The Joint Committee approved:

- DELT as the People Services provider for an initial 12 to 18-month period to ensure continuity of services and staff transfer.
- Appointment of a shared Band 9 Programme Director for one year, funded equally across ICBs on a non-recurrent basis.
- Further development of the programme scope, including organisational change policy harmonisation, staff networks and union arrangements.

Board Implications

Boards should note the interim provider solution, the shared investment required and the opportunity to develop a broader collaborative People Services model.

8. Corporate Services Programme

The Committee reviewed a revised operating model and transition plan covering Procurement and Estates for the Corporate Services programme recognizing the significant efficiency opportunities.

Key Points

- The programme has been recast to reflect the evolving roles of national, regional, ICB and provider collaborative levels.
- The transition plan runs from July to October 2026 to allow provider collaborative arrangements to mature.
- The operating model has been tested with the regional team and the Executive Sponsor.

Decision

The Joint Committee approved the revised operating model, roles and responsibilities, and transition plan.

Board Implications

Boards should note the phased transfer of operational responsibilities and the need for continuing engagement with provider collaboratives.

9. Principal Risks

- CSU closure and transition readiness, including loss of critical workforce and capability.
- Unresolved GPIT infrastructure and Bristol Data Centre hosting arrangements.
- Procurement service fragility and the pace required to establish a hosted solution.

- People Services transition and the need to maintain service continuity.
- Business continuity and governance during transfer to new operating models.
- The affordability and capacity required to deliver multiple regional transitions concurrently.

Recommendations

ICB Boards are asked to:

- Note the key decisions and approvals made by the South East ICBs Joint Committee on 14 July 2026.
- Note the principal programme and transition risks and the mitigating actions underway.
- Support continued collaborative commissioning and shared service transition arrangements.
- Receive further assurance through subsequent Joint Committee reports.

Report from South East Integrated Commissioning Boards' Chief Executive Officers Joint Committee held on 11 August 2026

Office of the South East ICBs

Report to: South East ICBs Joint Committee / ICB Boards
Report sponsor: Adam Doyle, Chief Executive, Kent and Medway ICB / Committee Chair
Report author: Sumona Chatterjee, Executive Programme Director, Office of the SE ICBs
Meeting date: 11 August 2026
Report type: Board Assurance and Programme Oversight Report
Classification: Part 1: Assurance Report

Purpose

To provide ICB Boards with an update on key decisions, approvals, risks and collaborative programmes considered by the South East ICBs Joint Committee at its meeting on 11 August 2026.

Executive summary

The Joint Committee continues to oversee the development of collaborative arrangements across the four South East ICBs, with a particular focus on CSU transition, hosted service arrangements, delegated commissioning and regional transformation programmes. At the August meeting, the Committee received assurance on progress across the Office of the South East ICBs portfolio, OPIC mobilisation, transition arrangements for the Digital, Data and Intelligence (DDI) programme, and the transition arrangements for the regional transformation programmes.

The Committee approved the August programme update and latest highlight reports. It noted significant progress in stabilising transition arrangements, including confirmation of an interim Bristol data centre hosting arrangement for GPIT infrastructure, continued progress with Procurement, People Services and Clinical Policy Unit transition plans, and the need to define and standardise decision-making criteria for future regional transformation programmes.

Key matters for Board attention: Part A

1. OPIC Programme update

The Committee received an update on mobilisation of the Office of Pan ICB Commissioning, including workforce and affordability risks, staff engagement, governance development and resourcing requirements for the next six months.

Key points

- The programme is tracking to plan against voluntary redundancy assumptions and is expected to remain within the affordability plans.
- Staff engagement with regional commissioning staff is progressing, with vacancies from indirect commissioning being considered through the stage two filling of posts process.
- The shadow OPIC Sub-Committee is being refreshed to focus on service areas not yet delegated, including health and justice commissioning and vaccination and screening.

- Stakeholder engagement remains strong, with an OPIC introduction event attended by more than 400 people and further engagement sessions planned.
- Resourcing requirements for the next six months are being reviewed, with additional support to be sought from ICBs, CSUs and NHS England as workstreams increase in activity.

Board implications: Boards should note continued progress in OPIC mobilisation and the importance of maintaining organisational readiness for delegated commissioning arrangements ahead of April 2027.

2. Office of the South East ICBs Programme report

The Committee reviewed the August programme report and latest highlight reports covering tranche one CSU transition programmes and tranche two regional transformation programmes.

Key points

- The Procurement programme Memorandum of Understanding is now in place, with Kent and Medway continuing as host while further service options and delivery models are developed.
- The first phase of the Clinical Effectiveness transfer is complete, with the second phase of the Clinical Policy Unit for Clinical Policy Implementation scheduled to go live in October.
- Further work is required on Clinical Policy Unit funding arrangements, including the proposed fair-shares population-based methodology.
- The People Services programme remains on track, with contract arrangements progressing with DELT as interim provider.
- The Aseptic programme will return in October, with a need to identify an ICB Chief Finance Officer to support the programme.
- Corporate Services transition discussions with Provider Collaboratives are progressing, and the Ambulance Transformation and ADHD programmes continue to move forward.

Decision: The Joint Committee approved the August programme update report, latest highlight reports and associated plans.

Board implications: Boards should note continued progress across the portfolio, alongside the requirement for active oversight of transition risks, workforce capacity, funding alignment and the leadership arrangements needed to sustain delivery.

3. Digital, Data and Intelligence Programme

The Committee received a detailed verbal update on the DDI programme, including Kent and Medway staff transfer, GPIT and Corporate IT transition, consultation arrangements, workforce eligibility review, financial liabilities and GPIT infrastructure hosting.

Key points

- All Kent and Medway staff transferred to Surrey and Sussex ICB on 1 August 2026, supported by a data protection agreement to maintain continuity pending consultation outcomes and post-filling processes.

- The potential staff cohort for transfer from CSU has increased from 170 to 197 whole-time equivalents, requiring an extension of consultation to the end of August to clarify eligibility, roles and structures.
- Surrey and Sussex ICB remain in discussion with the CSU regarding COSOP transfers, with a proposed 1 October transfer date being considered against a CSU position of 1 December.
- Weekly transition meetings continue between Thames Valley, Kent and Medway, and Surrey and Sussex colleagues to coordinate GPIT and Corporate IT transition plans.
- Redundancy liabilities remain under discussion, with NHS England funding to be explored and any residual liability to be shared proportionately across ICBs if required.
- Bristol NHS Trust has confirmed an interim two-year data centre hosting arrangement, with further due diligence required on service levels and costs and a potential future move to national hosting not yet confirmed.

Board implications: Boards should note that substantial progress has been made in stabilising GPIT infrastructure hosting and DDI transition arrangements. However, the programme remains complex, and delays to staff and service transfer could create material business continuity and patient service risks, particularly ahead of winter and early January 2027. This is a risk that is currently being assessed for mitigation.

Part B

4. Regional Transformation programmes and developmental pipeline

The Committee considered the outcome of a desktop review of four regional transformation programmes in discussion with Chief Medical Officers: ADHD and neurodiversity, risk stratification for frailty, cardiovascular disease and palliative and end-of-life care. The review used the previously agreed decision framework to determine whether each programme should continue as a pan-ICB regional programme, align to another regional route, or be delivered locally.

Key points

- The ADHD and neurodiversity programme will progress to delivery phase, led by Surrey and Sussex ICB, with NHS England resources aligned to support the programme.
- Risk stratification for frailty was considered better aligned to neighbourhood programme arrangements and will not progress as a separate Regionally led pan-ICB programme.
- The cardiovascular disease programme will continue at regional level, led through existing regional arrangements.
- Palliative and end-of-life care programme whilst a key pillar of Neighbourhood delivery plans for each ICB in discussion with Chief Medical Officers the value added for an at scale programme at this stage could not be identified. Following the publication of the Modern Service Framework there may be value in a standardised reporting dashboard on advance care planning etc. Therefore, the decision was not to set up a pan ICB programme.

The Committee recognised the value of having a decision framework and agreed that there was need to codify principles and criteria for determining when programmes should be

undertaken Region once, Four ICBs once, Region with four ICBs, Region with Provider Collaboratives and Region with ICBs and Provider. **Board implications:** Boards should note the agreed direction of travel for the regional transformation pipeline and the intention to strengthen decision-making discipline by codifying the principles for future regional programme selection and ownership.

Principal Risks

- CSU closure and transition readiness, including workforce eligibility, consultation, service continuity and transfer timing.
- DDI and GPIT transition complexity, including the need to maintain safe service provision during winter and into early January 2027.
- Residual uncertainty over long-term GPIT infrastructure hosting beyond the interim two-year Bristol arrangement.
- Financial liabilities associated with staff transfer, including potential redundancy costs and the need to confirm NHS England funding routes.

Recommendations

ICB Boards are asked to:

- Note the key decisions and approvals made by the South East ICBs Joint Committee on 11 August 2026.
- Note the principal programme and transition risks and the mitigating actions underway.
- Support continued collaborative commissioning and shared service transition arrangements across the four South East ICBs.
- Note the confirmation of the interim Bristol GPIT infrastructure hosting arrangement and the continued need for assurance on long-term hosting, service levels and costs.
- Support the development of clear regional programme decision-making criteria to guide future programme selection and ownership.
- Receive further assurance through subsequent Joint Committee reports.

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	Tuesday, 22 September 2026
Report Title	Governance Handbook and Board Committee Terms of Reference
Key question	Does the Board approve the refreshed Governance Handbook and the updated Terms of Reference for the Quality, Safeguarding and Patient Experience Committee, Remuneration and People Committee, and Finance and Performance Committee as providing a clear and effective framework for governance, accountability, and assurance?
Executive Lead	Claire Robson, Company Secretary and Director of Corporate Affairs
Author	Claire Robson, Company Secretary and Director of Corporate Affairs

Which of the organisation's strategic objectives does the report support:	
☐ Commission the right services each year	☐ To ensure financial sustainability over three years
☐ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☐ Seek assurance ☒ Decision/approval required ☐ For noting/information

Recommendation(s) to the Meeting:

The Board is asked to:

1. **NOTE** the contents of this report
2. **APPROVE** the refreshed Governance Handbook.
3. **APPROVE** the updated Terms of Reference for the Quality, Safeguarding and Patient Experience Committee
4. **APPROVE** the updated Terms of Reference for the Remuneration and People Committee

5. **APPROVE** the updated Terms of Reference for the Finance and Performance Committee
6. **AUTHORISE** the Company Secretary and Director of Corporate Affairs to make any final non-material drafting, formatting or cross-referencing amendments required before publication

Executive summary:

The Governance Handbook was last comprehensively reviewed in 2024. The review undertaken during 2026 identified significant duplication between the Handbook and the individual constitutional and governance documents maintained separately by the ICB. The refreshed Handbook has therefore been repositioned as an overarching governance framework, explaining how accountability, decision-making, assurance, and organisational oversight operate, while directing users to separately controlled source documents through a governance document library. This approach reduces duplication, strengthens document control, and allows individual governance documents to be updated through their appropriate approval routes without requiring the entire Handbook to be reproduced or revised.

Following implementation of the revised governance arrangements in April 2026, the Terms of Reference for the Quality, Safeguarding and Patient Experience Committee, Remuneration and People Committee, and Finance and Performance Committee have also been reviewed to ensure they remain clear, fit for purpose and aligned with the practical operation of the Committees.

The revised Committee Terms of Reference clarify the respective assurance remits, membership and attendance arrangements, quorum, reporting responsibilities, risk escalation, and accountability to the Board. The Remuneration and People Committee Terms of Reference formalise the Committee's operation through separate People Business and Remuneration Business sections while preserving a single Committee and assurance route to the Board. The Quality, Safeguarding and Patient Experience Committee Terms of Reference clarify the Committee's role as an assurance body rather than a provider regulator or operational delivery forum and include a responsibilities matrix to support clarity across Committee and commissioning arrangements. The Finance and Performance Committee Terms of Reference clarify its responsibilities for financial sustainability, system performance, productivity, resource use, contracting, and commissioning oversight. Each Committee has reviewed these changes and endorses the proposal to put these to the Board for approval.

The Board is invited to approve the refreshed Governance Handbook and the three updated Committee Terms of Reference.

Proposed next steps:

Following Board approval:

- the Governance Handbook and updated Committee Terms of Reference will be finalised and published;
- the Terms of Reference will be included within the governance document library as the authoritative controlled versions;
- Committee forward plans, reporting arrangements and associated governance documentation will be updated where required; and
- the arrangements will continue to be monitored through the annual Committee effectiveness and Terms of Reference review processes.

Governance pathway to date:		
Meeting name:	Date:	Outcome:
Executive Committee	12 August 2026	Reviewed the proposed refresh and modernisation of the Governance Handbook and provided feedback on the structure, content, and direction of travel.
Quality, Safeguarding and Patient Experience Committee	1 September 2026	Reviewed the Terms of Reference and approved their presentation to the Board for approval
Finance and Performance Committee	24 August 2026	Reviewed the Terms of Reference and approved their presentation to the Board for approval
Remuneration and People Committee	8 September 2026	Reviewed the Terms of Reference and approved their presentation to the Board for approval

Contact for further information	Claire Robson, claire.robson24@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities, and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

This paper relates to the ICB's governance framework and the responsibilities and operating arrangements of Board Committees. The proposed changes do not themselves

COMPLIANCE NOTES:

alter commissioned services, employment policies, or the delivery of patient care. Equality, health inequalities, and quality impacts arising from substantive decisions considered through the governance framework will continue to be assessed through the relevant organisational processes.

Conflicts of Interest

Are there any conflicts associated with authors or reporting officers?

☐ Yes ☒ No

If yes, please confirm how the conflict has been managed.

FOI Status

Is this report disclosable under FOI?

☒ Yes ☐ No

If no, please specify why:

Financial Implications

Are there financial implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Legal Implications

Are there legal implications associated with this report?

☒ Yes ☐ No

If yes, please describe:

The Governance Handbook and Committee Terms of Reference support the ICB in discharging its statutory governance responsibilities and should be read alongside the ICB Constitution, Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions. The Terms of Reference specify that the Committees are established by, accountable to and may have their Terms of Reference amended only with the approval of the Board.

Quality and Safety Implications

Are there quality or safety implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Patient and Public Engagement

Are there patient and public engagement implications associated with this report?

☐ Yes ☒ No

If yes, please describe. If no, please specify why:

COMPLIANCE NOTES:
The paper concerns the internal governance and assurance arrangements of the ICB and does not directly change commissioned services or patient care. No specific patient or public engagement activity has therefore been undertaken. The revised Quality, Safeguarding and Patient Experience Committee Terms of Reference retain requirements relating to patient voice, lived experience, complaints, concerns, and engagement intelligence.

GOVERNANCE HANDBOOK AND BOARD COMMITTEE TERMS OF REFERENCE

1. INTRODUCTION

1.1 The Governance Handbook forms an important part of the ICB's overarching governance framework. It provides a point of reference for understanding how accountability, decision-making, assurance, and oversight operate across the organisation.

1.2 The Handbook was last comprehensively reviewed in 2024. The review undertaken during 2026 identified extensive duplication between the Handbook and individual constitutional and governance documents maintained separately across the organisation. This meant that changes to governance arrangements could require updates in several places, increasing administrative burden and creating a risk of inconsistent versions.

1.3 A working draft of the refreshed Governance Handbook was presented to Executive Committee on 12 August 2026. The proposed approach repositioned the Handbook from a repository containing reproduced governance documents to an overarching framework explaining the organisation's governance architecture and directing users to separate, controlled source documents.

1.4 In April 2026, the ICB implemented revised governance arrangements, including new Committee structures and responsibilities. Following the initial period of operation, the Terms of Reference for the Quality, Safeguarding and Patient Experience Committee, Remuneration and People Committee, and Finance and Performance Committee have been reviewed to incorporate learning, clarify responsibilities and ensure that the documented arrangements reflect how the Committees are intended to operate.

1.5 The refreshed Governance Handbook and updated Committee Terms of Reference are now presented to the Board for approval.

2. STRATEGIC ALIGNMENT

2.1 A clear and effective governance framework is fundamental to the delivery of the ICB's strategic objectives. It supports transparent accountability, effective decision-making, appropriate delegation, risk management, and clear assurance to the Board.

2.2 The refreshed Handbook and Committee Terms of Reference support the ICB's development as a high-performing strategic commissioning organisation by clarifying how governance and assurance operate and by improving the relationship between executive delivery, Committee scrutiny, and Board accountability.

2.3 The revised arrangements support:

- clear lines of accountability from executive management and commissioned service oversight through to Board assurance;
- effective financial, quality, performance, and workforce governance;
- proportionate escalation of risks and concerns;

- clearer distinction between executive responsibility, Committee assurance and matters reserved to the Board; and
- more efficient maintenance and control of governance documents.

3. REFRESHED GOVERNANCE HANDBOOK

3.1 The refreshed Governance Handbook explains how governance operates across the ICB rather than reproducing each constitutional and governance document in full.

3.2 Its structure focuses on:

- governance overview and principles;
- leadership and accountability;
- governance, assurance, and decision-making arrangements;
- risk management and organisational oversight;
- transparency and public accountability; and
- the governance document library.

3.3 The Constitution, Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions, Board and Committee Terms of Reference and governance policies will remain separate controlled documents. The Handbook will signpost users to their current authoritative versions.

3.4 This approach provides the following benefits:

- **Improved clarity:** the Handbook explains the governance framework and how its components relate to one another.
- **Reduced duplication:** source documents are maintained once rather than reproduced across several documents.
- **Improved document control:** individual documents retain clear ownership, approval routes, and review cycles.
- **Greater flexibility:** individual governance documents can be updated through the appropriate route without requiring wholesale revision of the Handbook.
- **A clearer source of authority:** users can identify the current approved source document rather than relying on reproduced content.

3.5 The decision to maintain the Committee Terms of Reference separately is particularly relevant while the new Committee arrangements continue to mature. It allows amendments to be approved and implemented through established governance routes while keeping the overarching Handbook stable.

4. QUALITY, SAFEGUARDING, AND PATIENT EXPERIENCE COMMITTEE TERMS OF REFERENCE

4.1 The Quality, Safeguarding and Patient Experience Committee Terms of Reference have been reviewed following the first period of operation under the revised governance framework implemented in April 2026.

4.2 The amendments are intended to improve clarity regarding the Committee's assurance role, responsibilities, reporting arrangements and relationship with wider commissioning and governance structures. A Committee responsibilities matrix has also been incorporated to support clarity of accountability and avoid duplication across governance forums.

5. REMUNERATION AND PEOPLE COMMITTEE

5.1 The Remuneration and People Committee Terms of Reference have been reviewed following Quarter 1 of operation under the revised governance arrangements.

5.2 The amendments provide greater clarity regarding the Committee's remit, membership, attendance arrangements, management of conflicts of interest and reporting responsibilities. They also formalise the operation of the Committee through separate People Business and Remuneration Business sections whilst maintaining a single assurance route to the Board.

6. FINANCE AND PERFORMANCE COMMITTEE

6.1 The Finance and Performance Committee Terms of Reference have been reviewed to ensure they appropriately reflect the Committee's role in providing assurance to the Board regarding financial sustainability, performance, productivity, and effective use of resources.

6.2 The amendments strengthen clarity regarding the Committee's responsibilities, governance arrangements, reporting relationships, and accountability to the Board, whilst reflecting the Committee's role within the ICB's revised governance framework

7. KEY RISKS, MITIGATIONS, AND CONTROLS

7.1 There is a risk that the Governance Handbook and Committee Terms of Reference become inconsistent if governance documents are reproduced in several locations. This is mitigated by maintaining each substantive governance document as a separate controlled source and using the Handbook to explain and signpost the framework.

7.2 There is a risk of ambiguity or duplication across Board Committees and executive arrangements if Committee responsibilities are not clearly defined. This is mitigated through clearer descriptions of Committee purpose, responsibility, assurance and escalation, supported in the case of QSPE by the responsibility's matrix.

7.3 There is a risk that Committee documentation does not reflect practical operation or learning from implementation. This has been mitigated through review following the

initial period of operation under the revised governance arrangements and through the continued requirement for annual effectiveness and Terms of Reference reviews.

7.4 There is a risk that the QSPE Committee's role in population health, inequalities and prevention could be interpreted as including detailed executive or strategy delivery responsibilities. Removing the detailed bullets beneath section 3.7.1 mitigates this risk while retaining appropriate Board assurance within the Committee's quality, patient experience, and commissioned services remit.

7.5 There is a risk that sensitive remuneration business is not managed with sufficient clarity regarding attendance, confidentiality, and conflicts of interest. The revised Remuneration and People Committee Terms of Reference mitigate this by formalising the two-part operating model and strengthening conflict-management arrangements.

8. OTHER CONSIDERATIONS

8.1 Approval of the Governance Handbook does not supersede the Constitution, Standing Orders, Scheme of Reservation and Delegation, Standing Financial Instructions or any other document requiring separate approval. Where there is any inconsistency, the relevant formally approved source document will take precedence.

8.2 The Committee Terms of Reference do not transfer executive delivery responsibility to the Committees. Their primary purpose is to enable effective oversight, scrutiny, assurance, and escalation to the Board.

8.3 Any material future amendments to Board Committee Terms of Reference will continue to require Board approval. Minor administrative or formatting changes may be made through document control arrangements provided they do not alter the substance of the approved remit, authority, membership, quorum, or delegations

9. REQUIRED OUTCOMES AND NEXT STEPS

9.1 The Board is asked to:

- **NOTE** the development and review undertaken following implementation of the revised governance arrangements.
- **APPROVE** the refreshed Governance Handbook.
- **APPROVE** the updated Quality, Safeguarding and Patient Experience Committee Terms of Reference, including the further amendment to section 3.7.1.
- **APPROVE** the updated Remuneration and People Committee Terms of Reference.
- **APPROVE** the updated Finance and Performance Committee Terms of Reference.
- **AUTHORISE** the Company Secretary and Director of Corporate Affairs to make final non-material drafting, formatting, and cross-referencing amendments before publication.

9.2 Following approval:

- the documents will be finalised and published;

- the approved Committee Terms of Reference will be held as separate controlled documents within the governance document library;
- the Governance Handbook will reference the authoritative versions;
- associated Committee forward plans and governance documentation will be updated; and
- operation of the arrangements will be monitored through annual Committee effectiveness and document review processes.

10. SUPPORTING DOCUMENTATION

9.1 There are no supporting documents relevant to this report.

Appendices

Appendix 1: Governance Handbook
Appendix 2: Quality, Safeguarding and Patient Experience Committee Terms of Reference
Appendix 3: Remuneration and People Committee Terms of Reference
Appendix 4: Finance and Performance Committee Terms of Reference

NHS Kent and Medway

NHS KENT AND MEDWAY

INTEGRATED CARE BOARD

GOVERNANCE HANDBOOK

August 2026

NHS
Kent and Medway

Version: 05:

August 2026

Version	Notes	Date
01	Original Version	July 2022
02	Updated following changes to SFI's	March 2023
03	Update to SoRD and Schedule 1 of SoRD	May 2024
04	Update following Governance Review actions and review of all Committee Terms of Reference	November 2024
05	Restructured Governance Handbook to reduce duplication, strengthen governance clarity and establish a single source of truth for governance documents.	August 2026

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SECTION 1: OVERVIEW

1. Purpose of the Governance Handbook

The Governance Handbook provides the overarching framework through which NHS Kent and Medway Integrated Care Board (ICB) exercises effective governance, accountability and decision-making. It explains how the organisation is directed and controlled, how statutory and delegated responsibilities are discharged, and how assurance is obtained regarding the delivery of strategic objectives.

The Handbook is intended to support Board Members, Committee Members, executives, colleagues and system partners in understanding how governance operates across the organisation and where accountability sits for key decisions. It provides a single point of reference for the governance arrangements that underpin the discharge of the ICB's statutory responsibilities and stewardship of public resources.

This Handbook should be read alongside the ICB Constitution and associated governance documents. Detailed constitutional and supporting governance documents are maintained separately as controlled documents and incorporated within this Handbook by reference. Where any inconsistency exists between this Handbook and an approved governance document, the approved governance document shall take precedence.

2. What Good Governance Means

Good governance is fundamental to the successful delivery of the ICB's statutory duties and strategic objectives. It provides clarity regarding responsibilities, promotes transparency, supports evidence-based decision-making, and ensures the organisation remains accountable for its actions and the use of public resources.

Effective governance should not be viewed solely as a compliance requirement. It is a strategic enabler which supports delivery, facilitates partnership working and provides confidence that decisions are being taken in an informed, transparent and consistent manner.

The ICB's governance framework is designed to support:

- Delivery of statutory functions.
- Accountability for public resources.
- Effective management of risk.
- Continuous improvement in quality and outcomes.
- Collaboration across the Kent and Medway health and care system.
- Transparency and public confidence in decision-making.

3. Governance Framework

The governance framework consists of:

- Integrated Care Board
- Board Committees
- Executive Committee

- Executive-led groups and programme boards
- System partnerships and collaborative arrangements
- Delegated decision-making arrangements
- Risk management and assurance mechanisms

The relationship between these bodies is illustrated within the ICB Governance Structure diagram contained at Appendix 1. The framework has been designed to ensure clear accountability, minimise duplication and support effective oversight of quality, performance, workforce, finance and transformation activities.

SECTION 2: LEADERSHIP AND ACCOUNTABILITY

4. Integrated Care Board

The Board is the principal decision-making body of NHS Kent and Medway ICB and is collectively responsible for the effective stewardship of the organisation. The Board establishes the strategic direction of the organisation, determines priorities, oversees organisational performance and ensures compliance with statutory requirements.

The Board maintains oversight of quality, patient safety, financial performance, workforce, delivery of strategic objectives and organisational risk. It is responsible for establishing appropriate governance arrangements and obtaining assurance that these arrangements are operating effectively.

Whilst certain responsibilities may be delegated to Committees, officers or other bodies, accountability for the discharge of statutory responsibilities remains with the Board.

5. Chair and Non-Executive Directors

The Chair leads the Board and is responsible for ensuring its effectiveness in directing the organisation. The Chair promotes a culture of openness, constructive challenge and collective responsibility, ensuring that Board Members receive the information and support required to undertake their duties effectively.

Non-Executive Directors bring independence, scrutiny and objective challenge to Board discussions and decisions. They provide assurance regarding the performance of the organisation and play a key role in holding the Executive to account.

6. Chief Executive

The Chief Executive is the Accountable Officer for the organisation and has responsibility for the day-to-day management of the ICB. This includes implementation of Board strategy, delivery of organisational objectives and ensuring compliance with statutory, regulatory and financial requirements.

The Chief Executive exercises delegated authority on behalf of the Board and is supported by the Executive Committee and executive leadership team.

7. Executive Directors

Executive Directors are collectively responsible for supporting the Chief Executive in the leadership, management and delivery of the ICB's strategic objectives and statutory functions. As members of the Board, Executive Directors share corporate responsibility for all Board decisions and are accountable for ensuring that decisions are implemented effectively across their areas of responsibility.

The Executive Directors comprise the senior executive leadership of the organisation and provide Board-level leadership across the following key areas:

- Commissioning and strategic planning
- Nursing, quality and patient experience
- Medical leadership, outcomes and clinical effectiveness
- Finance
- Workforce, organisational development and culture

The specific executive portfolio structure is determined by the Chief Executive and may change from time to time to reflect organisational requirements.

8. Partner Members

Partner Members bring the perspectives and expertise of key health and care partners and communities across Kent and Medway. They support the Board in understanding system-wide impacts, promoting collaboration and ensuring that decisions are informed by a broad understanding of the needs of the population and the wider health and care system.

Partner Members are full members of the Board and share collective responsibility for Board decisions. They are expected to contribute independent judgement and expertise whilst acting in the interests of the ICB and the population it serves, rather than as representatives of individual organisations or stakeholder groups.

The Partner Member roles include representation and expertise across:

- Acute, community and ambulance services
- Mental health services
- Primary care
- Local government
- People and communities
- Voluntary, community and social enterprise (VCSE) organisations

The specific Partner Member roles and appointments are determined in accordance with the Constitution and relevant appointment processes and may be reviewed periodically to ensure they continue to support effective system leadership and engagement**.**

9. Company Secretary and Director of Corporate Affairs

The Company Secretary and Director of Corporate Affairs supports the Board, Committees and Executive Committee in the effective operation of governance arrangements. The role provides independent advice on governance matters, promotes compliance with constitutional requirements and supports continuous improvement in governance practice.

The Company Secretary and Director of Corporate Affairs is responsible for ensuring governance arrangements remain effective, proportionate and aligned to organisational needs.

10. Executive Committee

Executive Committee provides collective leadership for the management of the organisation and supports delivery of the Board's strategic objectives.

Executive Committee is responsible for:

- Monitoring delivery of organisational priorities.
- Exercising delegated decision-making authority.
- Managing organisational performance.
- Overseeing delivery of strategic programmes.
- Reviewing corporate risks.
- Escalating matters requiring Board or Committee consideration.

11. Board Committees

Board Committees support the Board through the exercise of delegated authority and provision of assurance within defined areas of responsibility.

Each Committee operates in accordance with approved Terms of Reference and contributes to the Board's overall assurance framework through oversight of performance, risk and delivery within its respective remit.

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SECTION 3: GOVERNANCE, ASSURANCE AND DECISION-MAKING FRAMEWORK

12. Governance Principles

The ICB is committed to ensuring that decisions are taken at the appropriate organisational level by the body best placed to consider the issue. Decisions should be proportionate, evidence-based and transparent, supported by appropriate consideration of quality, finance, workforce, equality and risk implications.

Governance arrangements are intended to facilitate timely decision-making whilst ensuring significant matters receive appropriate scrutiny and oversight.

13. The Delegation Framework

A clear delegation framework exists to support effective governance and organisational accountability.

Authority is exercised through:

- Constitution.
- Standing Orders.
- Scheme of Reservation and Delegation.
- Standing Financial Instructions.
- Committee Terms of Reference.
- Executive Officer Scheme of Authority.

Together these documents establish which decisions are reserved to the Board, delegated to Committees, delegated to officers or managed through Executive Committee and supporting governance structures.

14. Governance Routes

The governance framework operates on the principle that matters should be considered at the lowest appropriate level whilst maintaining effective oversight.

Operational matters should normally be managed by Executive Directors, delegated officers, and executive-led groups. Matters with significant strategic, financial, quality, workforce or reputational implications should be considered through the relevant governance route before being escalated where necessary.

The Governance, Assurance and Escalation Framework (see Appendix 2) sets out the principal governance routes across the organisation and demonstrates:

- Operational decision-making routes.
- Strategic decision-making routes.
- Assurance and reporting routes.
- Escalation arrangements.

- Board approval requirements.
- The relationship between Executive Committee, Board Committees and the Board.

The framework supports clear accountability, minimises duplication and ensures that risks, decisions and assurance are considered by the body best placed to discharge the relevant responsibility. It also provides a mechanism for the Board to receive assurance that appropriate oversight, challenge and scrutiny has taken place before matters are escalated for decision or assurance.

15. Assurance Framework

The Board requires assurance that the organisation is delivering its statutory duties and strategic objectives effectively, that risks are being appropriately managed and that controls are operating as intended.

Assurance is obtained through a range of governance mechanisms, including operational reporting, performance monitoring, risk management processes, Board Committees, internal audit, external audit and regulatory oversight. Together, these arrangements provide confidence regarding the effectiveness of decision-making, governance, internal control and organisational performance.

The assurance framework operates across all levels of the organisation and is designed to ensure that information is considered by the body best placed to provide challenge, scrutiny, oversight and assurance before matters are escalated where necessary.

The framework supports assurance in relation to:

- Delivery of strategic objectives.
- Compliance with statutory and regulatory responsibilities.
- Quality, safety and patient experience.
- Financial performance and sustainability.
- Workforce, leadership and culture.
- Risk management and internal control.
- Partnership working and system delivery.

Assurance should be evidence-based, proportionate to the significance of the matter being considered and derived from reliable sources of information.

16. Escalation Arrangements

Where risks exceed agreed tolerance levels, delegated authority is insufficient, or additional oversight is required, matters will be escalated through the governance structure.

Escalation routes should be clearly defined and may include referral from operational groups to Executive Committee, from Executive Committee to Board Committees, or from Board Committees to the Board.

The purpose of escalation is to support decision-making, manage risk and ensure appropriate organisational visibility.

17. Recording Decisions

All formal governance decisions should be accurately recorded through approved governance processes.

This includes:

- Minutes.
- Action logs.
- Decision notices.
- Delegated decision records.
- Governance reports.

These arrangements support transparency, accountability and organisational learning.

SECTION 4: ASSURANCE AND RISK

18. Board Assurance Framework

The Board Assurance Framework (BAF) provides the principal mechanism through which the Board gains oversight of strategic risks and assurance regarding delivery of organisational objectives.

The BAF supports Board discussion regarding:

- Strategic objectives.
- Principal risks.
- Key controls.
- Sources of assurance.
- Gaps in assurance.
- Planned mitigating actions.

The Framework supports Board decision-making and helps identify areas requiring additional oversight or intervention.

19. Risk Management Framework

The Board is responsible for establishing and maintaining an effective system of internal control and risk management. Risk management supports the achievement of organisational objectives by ensuring that threats and opportunities are identified, assessed and managed appropriately.

The organisation seeks to maintain a culture where risks are identified and managed proportionately and where accountability for managing risk is clearly understood.

20. Corporate Risk Register

The Corporate Risk Register provides a structured overview of significant operational and corporate risks which could impact delivery of organisational objectives.

Corporate risks are routinely monitored by Executive Committee and escalated to Board Committees and the Board where appropriate.

21. Three Lines Assurance Model

The ICB adopts a three-lines assurance approach.

The first line consists of operational management and delivery functions responsible for managing risk and maintaining controls.

The second line comprises oversight functions including governance, finance, quality, workforce, risk and compliance arrangements.

The third line consists of independent assurance functions such as Internal Audit, External Audit and regulatory review.

Together these arrangements provide the Board with confidence regarding the effectiveness of governance, control and risk management processes.

22. Committee Assurance

Board Committees play an essential role within the assurance framework.

Committees provide oversight of key risks within their delegated areas of responsibility, identify emerging concerns, monitor delivery and escalate matters requiring Board consideration. Committee assurance forms part of the overall assurance provided to the Board.

23. Continuous Improvement

The ICB is committed to continuous improvement in governance. Governance arrangements will be reviewed periodically to ensure they remain proportionate, efficient and effective.

This will include consideration of governance reviews, audit recommendations, Board and Committee effectiveness evaluations, lessons learned and emerging good practice.

SECTION 5: TRANSPARENCY AND STANDARDS

24. Public Accountability

As a statutory public body, the ICB is accountable to the public, patients, partners, NHS England and other stakeholders.

The organisation is committed to conducting its business openly and transparently whilst balancing requirements relating to confidentiality, information governance and the protection of personal data.

25. Standards of Conduct

The ICB expects the highest standards of integrity, probity and professionalism from all Board Members, Committee Members and employees.

Those acting on behalf of the organisation are expected to uphold:

- The Nolan Principles of Public Life.
- NHS values and behaviours.
- Organisational policies and procedures.
- Legislative and regulatory requirements.

26. Conflicts of Interest

Effective management of conflicts of interest is essential to maintaining confidence in decision-making.

All individuals participating within the governance framework are required to identify, declare and manage relevant interests in accordance with approved policies and procedures.

27. Information Governance and Confidentiality

The organisation is committed to ensuring information is managed appropriately, lawfully and securely.

Robust information governance arrangements support effective decision-making whilst ensuring compliance with legal and regulatory obligations relating to confidentiality, privacy and data protection.

28. Equality and Inclusion

The ICB is committed to promoting equality, diversity and inclusion and to reducing health inequalities across Kent and Medway.

Governance arrangements should ensure that equality impacts are considered appropriately and that decisions support fair access, improved outcomes and equitable treatment for the population and workforce.

29. Involvement and Engagement

The Board recognises the importance of involving patients, communities, partners and stakeholders in the development of services and decision-making.

Effective engagement supports better decisions, improved outcomes and stronger public confidence in the organisation.

SECTION 6: GOVERNANCE DOCUMENT LIBRARY

30. Controlled Governance Document Register

The governance documents listed below form part of the ICB's overall governance framework. They are maintained as separate controlled documents and should be read alongside this Governance Handbook. The Handbook provides an overview of how the governance framework operates; the documents listed in this register provide the detailed authority, rules, policies and procedures that support it.

Where there is any inconsistency between this Handbook and an approved governance document, the approved governance document will take precedence. This reflects the existing principle already included in the current Governance Handbook.

The purpose of maintaining a controlled register is to ensure that each governance document has a clear owner, approval route and review cycle. This supports version control, reduces duplication and enables individual documents to be updated when required without requiring a full review of the Governance Handbook.

Ref	Document	Purpose	Document owner	Approval body	Suggested review cycle	Publication / access	Update trigger
1	ICB Constitution	Sets out the statutory establishment, membership, governance arrangements and core rules of the ICB.	Company Secretary / Director of Corporate Affairs	Board and NHS England where required	As required, with formal review when constitutional changes are needed	ICB website and internal governance library	Legislative change, NHS England requirement, Board membership or governance model change
2	Standing Orders	Sets out the rules for the conduct of Board, committee and formal governance meetings. The current Handbook includes Standing Orders as part of the governance material.	Company Secretary / Director of Corporate Affairs	Board	Annual or as required	ICB website and internal governance library	Constitution change, meeting governance change, audit recommendation
3	Scheme of Reservation and Delegation	Defines which matters are reserved to the Board and which are delegated to committees, groups or officers. The current Handbook includes the Scheme of Reservation and Delegation as a core chapter.	Company Secretary / Director of Corporate Affairs	Board	Annual or as required	ICB website and internal governance library	Change to delegation, committee structure, statutory function or financial authority
4	Standing Financial Instructions	Sets out financial governance requirements, controls and responsibilities. The current Handbook includes Standing Financial	Chief Finance Officer	Board	Annual or as required	ICB website and internal governance library	Financial regime change, audit finding, procurement or delegation change

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Ref	Document	Purpose	Document owner	Approval body	Suggested review cycle	Publication / access	Update trigger
		Instructions as a core chapter.					
5	Board Terms of Reference / Board Governance Statement	Describes the role, remit and operating arrangements of the Board.	Company Secretary / Director of Corporate Affairs	Board	Annual	ICB website and internal governance library	Board composition, statutory remit or operating model change
6	Board Annual Cycle of Business	Sets out the planned annual schedule of Board business to ensure statutory, strategic and assurance items are considered at the right time.	Company Secretary / Director of Corporate Affairs	Board or Chair approval, depending on local practice	Annual, with in-year updates	Internal governance library / Board portal	New statutory requirement, Board development need, planning cycle change
7	Board Development Framework	Describes the approach to Board development, effectiveness and continuous improvement.	Company Secretary / Director of Corporate Affairs	Board	Annual	Internal governance library / Board portal	Board effectiveness review, development programme change
8	Board Member Role Profiles	Sets out the responsibilities and expectations of Board members, including executive, non-executive and partner members where applicable.	Company Secretary / Director of Corporate Affairs	Board or Remuneration / People Committee, depending on role	As required	Internal governance library	Board appointment, NHS England guidance or role change
9	Governance Structure Chart	Shows the current relationship between the Board, committees, Executive Committee and supporting groups. The	Company Secretary / Director of Corporate Affairs	Executive Committee / Board as appropriate	As required	Handbook, internal governance	Committee structure change, new forum, removal or renaming of group

Ref	Document	Purpose	Document owner	Approval body	Suggested review cycle	Publication / access	Update trigger
		current Handbook includes structure diagrams, although these will need updating.				library and Board portal	
10	Committee Structure Chart	Provides a summary of the Board committee structure and reporting lines.	Company Secretary / Director of Corporate Affairs	Board	As required	Handbook, internal governance library and Board portal	Committee change, delegation change, reporting route change
11	Audit and Risk Committee Terms of Reference	Defines the Committee's role, authority, membership, responsibilities and reporting arrangements in relation to governance, risk management, internal control, audit, counter fraud and assurance.	Company Secretary and Director of Corporate Affairs	Board	Annual	Website and governance document library	Committee effectiveness review, governance review, audit recommendation, regulatory change
12	Finance and Performance Committee Terms of Reference	Defines the Committee's role, authority, membership, responsibilities and reporting arrangements in relation to financial sustainability, financial planning, productivity, operational performance and delivery oversight.	Company Secretary and Director of Corporate Affairs / Chief Finance Officer	Board	Annual	Website and governance document library	Changes to financial governance, committee effectiveness review, governance review, statutory or regulatory change
13	Quality, Safeguarding and	Defines the Committee's role, authority, membership,	Company Secretary and	Board	Annual	Website and governance	Changes to quality governance

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Ref	Document	Purpose	Document owner	Approval body	Suggested review cycle	Publication / access	Update trigger
	Patient Experience Committee Terms of Reference	responsibilities and reporting arrangements in relation to quality, patient safety, safeguarding, patient experience and quality assurance.	Director of Corporate Affairs / Chief Nursing, Quality and Experience Officer			document library	requirements, committee effectiveness review, governance review, statutory or regulatory change
14	Remuneration and People Committee Terms of Reference	Defines the Committee's role, authority, membership, responsibilities and reporting arrangements in relation to remuneration, workforce, organisational development, leadership, culture and senior appointments.	Company Secretary and Director of Corporate Affairs / Chief People and Culture Officer	Board	Annual	Website and governance document library	Workforce governance changes, committee effectiveness review, governance review, statutory or regulatory change
15	Executive Committee Terms of Reference	Defines the Executive Committee's role, authority, membership, responsibilities, delegated powers, assurance responsibilities and reporting arrangements.	Company Secretary and Director of Corporate Affairs / Chief Executive Officer	Board	Annual	Governance document library	Executive operating model changes, governance review, delegation changes, organisational restructure
16	Risk Management Framework	Sets out the approach to identifying, assessing, managing, escalating and reporting risk.	Risk Lead / Director of Corporate Affairs	Board or Audit and Risk Committee	Annual	Internal governance library	Audit recommendation, risk process change, governance review

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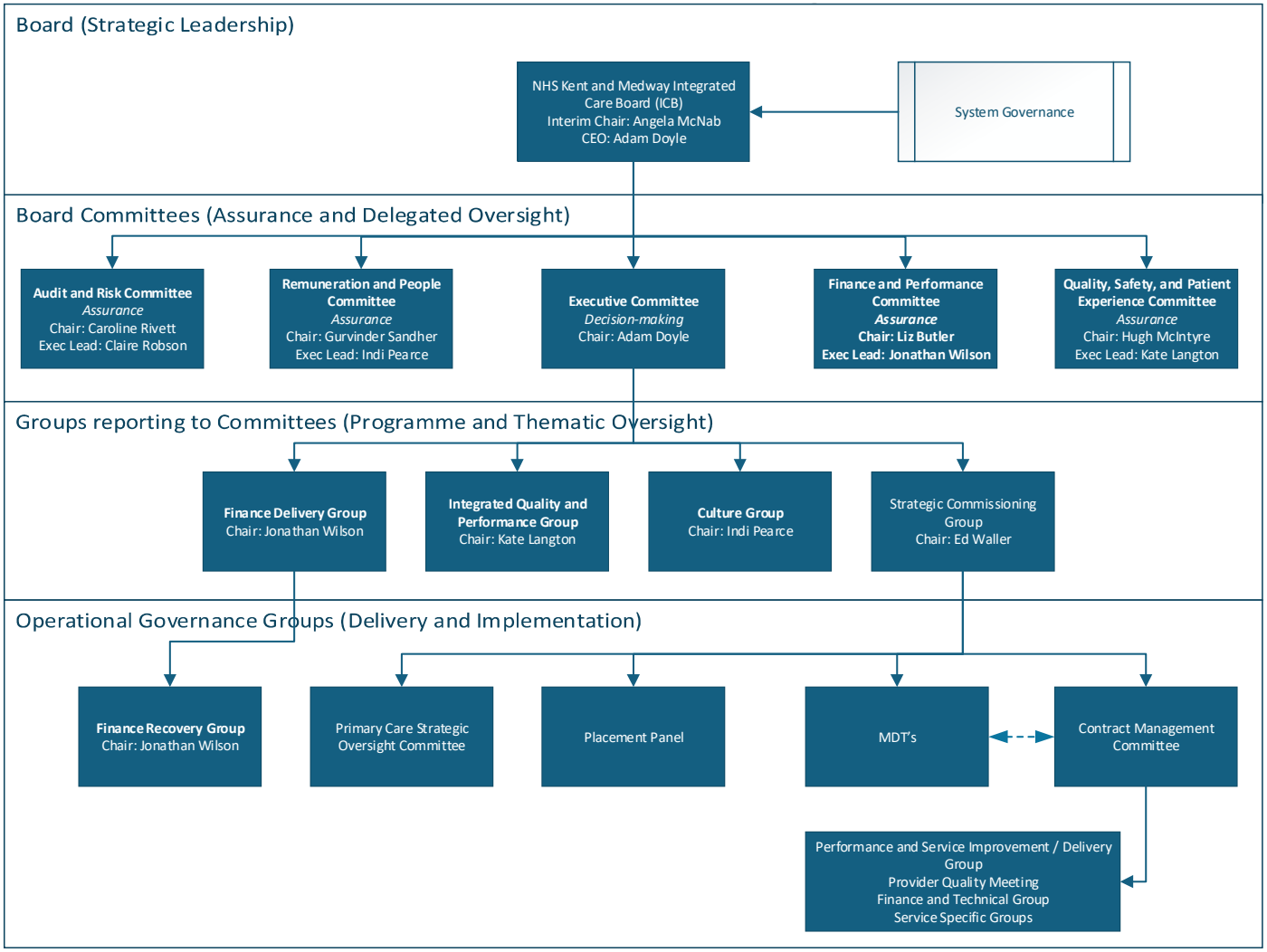
Ref	Document	Purpose	Document owner	Approval body	Suggested review cycle	Publication / access	Update trigger
17	Corporate Risk Register	Provides the register of significant organisational risks requiring executive and committee oversight.	Risk Lead	Executive Committee, with committee and Board escalation	Regular reporting cycle	Internal governance library / Board portal	New risk, change in score, control failure, escalation requirement
18	Standards of Business Conduct Policy	Sets out expected standards of conduct, including declarations, gifts, hospitality and probity requirements.	Company Secretary / Director of Corporate Affairs	Board or Audit and Risk Committee	Annual or as required	ICB website and internal governance library	National guidance, audit finding, policy review
19	Conflicts of Interest Policy	Sets out arrangements for declaring, managing and recording interests and conflicts.	Company Secretary / Director of Corporate Affairs	Board or Audit and Risk Committee	Annual or as required	ICB website and internal governance library	NHS England guidance, audit finding, governance issue
20	Fit and Proper Persons Framework	Sets out arrangements for compliance with Fit and Proper Persons requirements.	Company Secretary / Director of Corporate Affairs, with People function	Board or Remuneration / People Committee	Annual	Internal governance library	Regulatory change, NHS England guidance, appointment process change
21	Freedom of Information Policy	Sets out arrangements for compliance with Freedom of Information requirements.	Company Secretary and Director of Corporate Affairs	Executive Committee or relevant policy approval route	As required	ICB website and internal governance library	Legislative change, ICO guidance, process change
22	Annual Governance Statement	Provides the annual statement of governance,	Chief Executive / Director of Corporate Affairs /	Board, usually following Audit and Risk	Annual	Annual Report and Accounts / ICB website	Annual reporting cycle

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Ref	Document	Purpose	Document owner	Approval body	Suggested review cycle	Publication / access	Update trigger
		internal control and assurance arrangements.	Chief Finance Officer	Committee review			
23	Corporate Calendar	Sets out key Board, committee, reporting, planning and statutory deadlines.	Company Secretary / Director of Corporate Affairs	Executive Committee / Board as appropriate	Annual, with in-year updates	Internal governance library	Board cycle change, statutory deadline change
24	Committee Annual Cycles of Business	Sets out the recurring business for each Board Committee and supports agenda planning.	Committees Team, with Committee Chairs and Executive Leads	Each Committee	Annual, with in-year updates	Internal governance library / Board portal	Committee remit change, new assurance requirement
25	Board and Committee Paper Template and Guidance	Sets out expectations for the preparation of papers, including decisions, assurance, risk and equality considerations.	Company Secretary / Director of Corporate Affairs	Executive Committee	Annual or as required	Internal governance library	Feedback from Board, committee chairs, audit or paper quality review

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Appendix 1 – Governance Structure Chart



Appendix 2 – Governance, Assurance, and Escalation Framework

Domain / Responsibility	Executive Committee	Audit & Risk Committee	Finance & Performance Committee	Quality, Safeguarding & Patient Experience Committee	Remuneration & People Committee	ICB Board
Primary role	Operational leadership, coordination and delivery	Independent assurance on governance, risk and internal control	Oversight of financial sustainability and performance	Oversight of quality, safety, patient experience and non-financial performance	Oversight of workforce, remuneration and culture	Ultimate accountability and decision-making
Nature of role	First line of defence	Second line – assurance of assurance	Board assurance committee	Board assurance committee	Board assurance committee	Governing body
Risk identification	Identifies and manages operational risks	Assures risk framework and mitigations	Identifies and escalates financial and delivery risks	Identifies and escalates quality and safety risks	Identifies and escalates workforce risks	Owns principal risks (BAF)
Risk escalation route	To Board Committees / Board	To Board	To Board; to Audit & Risk for assurance	To Board; to Audit & Risk for assurance	To Board; to Audit & Risk if required	Board Assurance Framework
Quality & safety	Delivery – management	Assures risk management processes	Input where financial impact	Primary oversight and assurance	Input where workforce impact	Receives assurance

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Domain / Responsibility	Executive Committee	Audit & Risk Committee	Finance & Performance Committee	Quality, Safeguarding & Patient Experience Committee	Remuneration & People Committee	ICB Board
Financial governance	Delivery – management	Assures controls	Primary oversight and assurance	Input on quality impact	Input on workforce cost	Approves plans
Internal control and governance	Operation – management	Primary assurance	Input only	Input only	Input only	Receives assurance
Patient experience / voice	Implementation – management	Not in remit	Not in remit	Primary oversight and assurance	Not in remit	Receives assurance
Safeguarding, IPC, medicines safety	Delivery – management	Assures controls only	Not in remit	Primary oversight and assurance	Not in remit	Receives assurance
Population health and inequalities	Delivery – management	Not in remit	Financial impact only	Strategic oversight (quality/outcomes lens)	Workforce implications only	System leadership
Clinical priorities and pathways	Delivery – management	Not in remit	Affordability only	Oversight and recommendations	Not in remit	Final approval
Workforce, pay and culture	Manages workforce	Assures governance	Workforce cost input	Quality impact input	Primary oversight and assurance	Approves senior decisions
Senior appointments and remuneration	Implementation – management	Not in remit	Not in remit	Not in remit	Primary oversight and assurance	Ratifies / approves where required

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Domain / Responsibility	Executive Committee	Audit & Risk Committee	Finance & Performance Committee	Quality, Safeguarding & Patient Experience Committee	Remuneration & People Committee	ICB Board
Cross-committee working	Co-ordination – management	Relationship clarity only	Works laterally where required	Works laterally where required	Not required	Integrates assurance

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QUALITY, SAFEGUARDING, AND PATIENT EXPERIENCE COMMITTEE

Terms of Reference

1. Purpose

1.1 The Quality, Safeguarding, and Patient Experience Committee (the Committee) supports the delivery of the Integrated Care Board's (the ICB's) objectives by providing oversight and assurance in relation to the quality, safety, performance and outcomes of commissioned health and care services. The Committee seeks assurance that the ICB is discharging its functions in a way that secures continuous improvement across the dimensions of quality, and that statutory, mandatory, and strategic obligations relating to quality, safety, safeguarding, patient experience and non-financial performance are being met, in support of agreed system outcomes and plans.

2. Authority

2.1 The Committee is established as a standing Committee of the Board of the ICB. These Terms of Reference set out the Committee's membership, remit, responsibilities, and reporting arrangements and may only be amended with the approval of the Board.

2.2 The Committee is authorised by the ICB Board to take all necessary actions to fulfil the remit set out in these Terms of Reference. This includes authority to investigate any activity within its remit and to seek any information it requires from any officer or member of staff of the ICB, all of whom are required to co-operate with any reasonable request made by the Committee.

2.3 The Committee is authorised to commission any report it considers necessary to support the discharge of its responsibilities and to obtain independent professional advice, including legal advice, in accordance with procedures established by the ICB. The Committee may also secure the attendance of individuals with relevant experience and expertise where it considers this necessary.

2.4 The Committee may establish task and finish sub-groups to take forward specific pieces of work where appropriate. The Committee shall determine the membership

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and terms of reference of any such sub-groups but shall not delegate decision-making authority to such groups.

2.5 In exercising its authority, and discharging its responsibilities, the Committee shall operate in accordance with applicable statutory requirements, relevant national guidance and benchmarking, and the ICB's Constitution, Standing Orders, Scheme of Reservation and Delegation, and associated policies, and shall have regard to quality, safety, and patient experience governance frameworks, and applicable information governance and confidentiality requirements.

3. Responsibilities

3.1 *Core assurance* responsibilities

3.1.1 The Committee supports the ICB Board by providing oversight and assurance in relation to the quality, safety, safeguarding, patient experience and non-financial performance of commissioned health and care services in accordance with the responsibilities set out below.

3.1.2 The Committee's role is to provide assurance to the Board regarding the effectiveness of the ICB's arrangements for commissioning, oversight, quality governance, safeguarding, patient experience, escalation and assurance. The Committee does not act as a regulator of providers, and does not assume accountability for the operational delivery of services by provider organisations. The Committee's role is to seek assurance that the ICS has appropriate mechanisms in place to monitor, challenge, support, and escalate concerns regarding commissioned services.

3.2 *Quality, Safety and Performance Assurance*

3.2.1 The Committee shall oversee and seek assurance regarding the effectiveness of the ICB's arrangements to monitor, commission, and assure quality, safety, safeguarding, patient experience, and non-financial performance outcomes ~~delivery of outcomes relating to quality, safety, safeguarding, patient experience and non-financial performance of commissioned services~~, including performance against:

- applicable statutory and mandatory standards and requirements;
- Kent and Medway health and care plans and agreed system outcome measures, including relevant elements of the Integrated Care Strategy and the System Oversight Framework;
- the NHS Constitution, NHS Long Term Plan and other relevant national plans; and
- Kent and Medway commissioning and operational delivery plans.

3.2.2 The Committee shall seek assurance that the patient voice and lived experience are systematically captured and reflected within the quality, safety, and performance reporting and are used to inform scrutiny, learning, improvement and escalation.

3.3 *Assurance frameworks and reporting*

3.3.1 The Committee shall seek assurance that effective quality, safety and performance reporting, oversight and escalation frameworks are in place and operating effectively across:

- ~~health and care partnerships and provider collaboratives~~relevant provider oversight, quality governance and commissioning assurance arrangements established by the ICB and system partners;
- ~~system service and enabling programme boards;~~
- primary care commissioned services, including delegated functions; and
- safeguarding, looked after children, continuing healthcare, funded nursing care and personal health budgets.

3.4 *System and regulatory assurance*

3.4.1 The Committee shall:

- agree and oversee quality and performance assurance arrangements between the ICB and NHS England, recognising the ambition for the system to become increasingly self-assuring as delegation matures;
- scrutinise compliance with relevant national directives, regulations, standards, policies and best practice issued by regulatory and oversight bodies; and
- provide assurance to the Board and regulators that the ICB has the capability and capacity to discharge its statutory responsibilities in relation to quality, safety, safeguarding and patient experience.

3.5 *Quality improvement and learning*

3.5.1 The Committee shall seek assurance that:

- effective quality improvement programmes are in place and delivering sustained improvement;
- robust arrangements exist for identifying, investigating and learning from incidents, serious incidents, never events, complaints and other intelligence; and
- learning is shared appropriately across system partners to support improvement and prevent recurrence.

3.5.2 The Committee shall receive regular assurance regarding patient experience, complaints, concerns, compliments, engagement activity and lived experience, and seek assurance that learning arising from these intelligence sources is incorporated into quality improvement, service development, commissioning activity, and organisational learning.

3.6 *Safeguarding, medicines and infection control*

3.6.1 The Committee shall seek assurance that:

- commissioned services meet statutory safeguarding responsibilities for children, young people, adults at risk and looked after children;
- statutory responsibilities for infection prevention and control and medicines optimisation and safety are being discharged; and
- commissioned services meet Care Quality Commission registration requirements, NHS standard contracts and relevant professional and legislative standards.

3.7 *Population health, inequalities and prevention*

3.7.1 The Committee shall receive assurance that appropriate arrangements are in place to address population health outcomes, prevention and health inequalities as they relate to quality, patient experience and commissioned services. ~~provide strategic oversight of population health, prevention and health inequality priorities insofar as they relate to quality, safety, patient experience and outcomes, including:~~

- ~~supporting the ICP Joint Committee in the development and oversight of the Integrated Care Strategy and associated outcome measures;~~
- ~~overseeing the development and delivery of health and care plans aligned to system priorities;~~
- ~~ensuring plans are informed by population health management intelligence, JSNAs and local assessments of need; and~~
- ~~providing oversight of system approaches to reducing unwarranted variation, addressing inequalities and embedding prevention.~~

3.8 *Clinical priorities and pathways*

3.8.1 Within its delegated authority, the Committee shall:

- ~~consider and approve recommendations from relevant clinical advisory and policy groups where these are not delegated elsewhere;~~
- review and comment on proposals for clinical service developments, pathway changes and commissioning decisions; and

- ~~make recommendations to the Board on the commissioning or de-commissioning of services where required; and~~

- oversee delivery of agreed clinical priorities and associated outcomes.

3.9 *Risk and escalation*

3.9.1 The Committee shall focus on risks relating to the ICB's ability to discharge its responsibilities effectively and shall receive assurance regarding the effectiveness of oversight and mitigation arrangements in place across commissioned services.

3.9.2 The Committee shall review such risks within its remit, including the adequacy of mitigations, identify emerging risks, and recommend the addition or escalation of risks to the ICB Board including escalation to the Audit and Risk Committee where risks have implications for the Board Assurance Framework, organisational controls or wider governance arrangements. ~~and, where appropriate, the Audit and Risk Committee.~~

3.10 *Cross-committee and system working*

3.10.1 The Committee shall work alongside other ICB Committees, system groups and partners, and provide quality, safety and performance assurance input where matters fall within its remit or require specialist oversight.

3.10.2 To support clarity of accountability and avoid duplication of responsibility across the Board and its Committees, the Committee's areas of lead oversight, assurance and escalation are set out in Appendix 1 to these Terms of Reference.

4. Membership and Attendance

4.1 *Membership*

4.1.1 The members of the Committee, including the Chair, shall be appointed by the Board.

4.1.2 The Committee shall consist of not fewer than five members:

- Non-Executive Member (Chair)
- Non-Executive Member
- Chief Nursing, Experience and Quality Officer
- Chief Medical and Outcomes Officer
- Deputy Chief Commissioning Officer

4.1.3 The Chair of the ICB Board and Chair of the Audit and Risk Committee may not be a member of the Committee but may attend meetings by invitation of the Committee Chair.

4.1.4 The Chair of the Committee shall be appointed by the Board from amongst the Non-Executive Directors. In appointing the Chair of the Committee, the Board shall

have regard to the importance of maintaining the independence and objectivity of the Committee, including the overall portfolio of committee roles held by the individual.

4.1.5 The Committee may appoint a Vice Chair of the Committee from among the Committee's members. The Vice Chair shall act in place of the Chair of the Committee in the Chair's absence or as otherwise required.

~~4.1.6 No individual shall be present during any discussion relating to any aspect of their own pay or any aspect of the pay of others when it has, or could reasonably be perceived to have, an impact on them.~~ 4.1.6 Committee members may not nominate deputies to attend or act in their place. Where a member is unable to attend, the meeting may proceed provided it remains quorate.

4.1.~~5~~7 Members of the Committee shall, collectively, possess an appropriate balance of skills, knowledge, and experience relating to quality, patient safety, safeguarding, clinical governance, patient experience, performance, commissioning and population health. ~~in accounting, risk management, internal audit, external audit, and other technical or specialist areas, relevant to the ICB's business. At least one member shall have recent and relevant financial experience.~~ In considering appointments to the Committee, due regard shall be given to diversity and equality.

4.2 *Standing Invitations*

4.2.1 The Director of Quality (Safety, Effectiveness, Experience), Director of Safeguarding, Director of Performance and Regulation, and Company Secretary shall have a standing invitation to attend all meetings of the Committee.

4.2.2 Meetings of the Committee may also be attended by the Chief Executive Officer, or their nominated deputy, as and when appropriate.

4.3 *Attendance by Others*

4.3.1 Attendance at Committee meetings is restricted to Committee members.

4.3.2 The Chair may, at their discretion, invite officers, staff, or other individuals to attend meetings, or specific items or parts thereof, where their attendance is required to support the Committee's consideration of business. Such attendees shall have no voting rights.

4.3.3 The Chair may require any attendee who is not a Committee member to withdraw from the meeting for any item where this is considered necessary to facilitate open and frank discussion or to manage conflicts of interest.

5. Proceedings of Meetings

5.1 The Committee shall meet six times each year scheduled to support the business cycle of the ICB. The timing and frequency of meetings shall be agreed by the Chair of the Committee.

5.2 The Chair of the Committee, acting on their own authority, or at the request of a Committee member, the Chair of the ICB Board or the Chief Executive Officer, may convene additional meetings of the Committee at any time to consider matters requiring urgent attention.

5.3 The quorum for any meeting of the Committee shall be three members, including at least two ~~one~~ Non-Executive Members, one of whom shall be ~~Director and/or~~ the Chair ~~(~~or their formally nominated deputy~~)~~.

5.4 Where a Committee member is disqualified from participating in an item of business by reason of a conflict of interest, that member shall not be counted towards the quorum for that item.

5.5 Where a meeting is not quorate, the meeting may proceed for the purposes of discussion and information-sharing only, but no decisions or recommendations may be made.

5.6 Attendance by members via virtual means shall be permitted and shall count towards the quorum, provided that such attendance is by audio-visual link which enables all participants to see and hear one another, that the member has access to all meeting papers, and is able to participate fully in the meeting as if present in person.

6. Decision-Making and Voting

6.1 The Committee shall seek to reach its conclusions and recommendations by consensus wherever possible.

6.2 Where a consensus cannot be reached, a decision may be taken by a formal vote. Each Committee member present at the meeting shall have one vote. No member may vote by proxy.

6.3 Only Committee members shall be entitled to vote. Attendees who are not members of the Committee shall not have voting rights.

6.4 A decision shall be carried if a simple majority of those members present and voting are in favour. In the event of an equality of votes, the Chair of the Committee, or in their absence, the member presiding, shall have a second and casting vote.

6.5 In exceptional circumstances, where a decision is required before the next scheduled meeting, the Committee may consider and agree matters via correspondence, including electronic circulation. All eligible voting members must be provided with sufficient information and a reasonable opportunity to comment or indicate their agreement. Any decision taken through correspondence shall be

recorded by the Chair and formally reported to, and ratified at, the next quorate meeting. This approach shall not be used for matters requiring substantive discussion unless delay would adversely affect the discharge of the ICB's statutory or delegated responsibilities.

7. Reporting

7.1 The Committee is accountable to the ICB Board.

7.2 The Committee shall report to the ICB Board on the discharge of its responsibilities. The Chair of the Committee shall provide a summary report to the next scheduled meeting of the ICB Board following each Committee meeting, setting out the key matters considered, actions agreed, and any issues requiring escalation to or decision by the Board.

8. Governance and Resources

8.1 The Committee shall be supported by the Chief Nursing, Experience and Quality Officer, who is the nominated Executive Team lead for governance.

8.2 Secretariat support shall be provided by the ICB Committees Team. The duties of the secretariat include, but are not limited to:

- agreeing the agenda with the Chief Nursing, Experience and Quality Officer and the Chair of the Committee, and collating and circulating papers at least five working days in advance of meeting;
- taking minutes of meetings and maintaining a record of actions and matters arising; and
- providing administrative and governance support to the Chair of the Committee and Committee members as required.

8.3 The Committee shall have access to such resources and information as it reasonably requires to discharge its responsibilities effectively.

9. Monitoring Effectiveness and Compliance with Terms of Reference

9.1 The Committee shall undertake an annual review of its effectiveness and shall provide an annual report to the ICB Board on how it has discharged its responsibilities, delivered its objectives and complied with these terms of reference, including commentary on relevant aspects of the Board Assurance Framework and applicable regulatory requirements.

9.2 These Terms of Reference shall be reviewed at least annually by the Committee and approved by the ICB Board.

Date approved:	*7 April 2026*
Approved by:	ICB Board
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Appendix 1 – Committee Responsibilities Matrix

The Committee's role is to provide assurance to the Board regarding the effectiveness of the ICB's arrangements for commissioning, quality governance, safeguarding, patient experience, oversight and escalation. The Committee does not act as a regulator of providers, nor does it assume accountability for the operational delivery of services by provider organisations. Accountability for service delivery remains with provider organisations and relevant statutory bodies. The Committee seeks assurance that the ICB has appropriate mechanisms in place to monitor, challenge, support and escalate concerns relating to commissioned services.

Area	Role of QSPE Committee
Quality of commissioned services	**Lead assurance** – seeks assurance that the ICB has appropriate arrangements in place to commission, monitor, oversee and escalate concerns relating to quality.
Patient safety	**Lead assurance** – seeks assurance regarding the effectiveness of the ICB's patient safety oversight and escalation arrangements.
Safeguarding	**Lead assurance** – seeks assurance regarding discharge of the ICB's statutory safeguarding responsibilities and oversight arrangements.
Patient experience and lived experience	**Lead assurance** – receives assurance regarding complaints, concerns, engagement activity, patient stories, lived experience and organisational learning arising from these sources.
Health inequalities and quality impact	**Lead assurance** – receives assurance regarding the impact of commissioned services and commissioning decisions on health inequalities and protected groups.
Population health and prevention	**Oversight and assurance** – receives assurance that commissioning plans appropriately reflect population health intelligence, prevention and inequality objectives.
Strategic Commissioning Performance Report	**Lead assurance** – scrutinises performance information to assess whether the ICB is achieving intended outcomes through its commissioning arrangements.

Area	Role of QSPE Committee
Quality elements of commissioning and contracting	**Lead assurance** – seeks assurance that quality, safety and patient experience requirements are incorporated into commissioning intentions, contracts and oversight arrangements.
Provider quality concerns	**Receive assurance** – seeks assurance that the ICB has appropriate monitoring, escalation and intervention arrangements in place. Does not assume responsibility for managing provider operations.
Provider operational performance	**Not responsible** – receives assurance regarding the effectiveness of ICB oversight arrangements where quality, safety or patient experience implications arise.
Provider governance arrangements	**Not responsible** – receives assurance that the ICB is appropriately responding to concerns identified through provider governance mechanisms.
Quality risks and Committee Risk Register	**Lead assurance** – reviews risks within remit and recommends escalation where appropriate.
Board Assurance Framework risks within remit	**Lead assurance** – reviews and provides assurance on Board Assurance Framework risks allocated to the Committee.
Escalation to NHS England, regulators or partner organisations	**Receives assurance** that appropriate escalation and intervention processes have been followed where concerns are identified.
Clinical service developments and pathway changes	**Receive assurance and provide advice** regarding quality, safety and patient experience implications.
Commissioning intentions	**Receive assurance only** – considers whether quality, safety, safeguarding and patient experience requirements have been appropriately reflected.
Clinical Advisory Groups and Clinical Policy Groups	**Not responsible** – approval and decision-making sit within commissioning arrangements unless specifically delegated by the Board.

Area	**Role of QSPE Committee**
Service commissioning or decommissioning decisions	**Advisory role only** – may provide assurance or recommendations regarding quality, safety and patient experience considerations but does not approve such decisions unless specifically delegated.
Financial performance	**Receive assurance where quality, safety or patient experience implications arise.**
Audit reports relating to quality, safeguarding or patient experience	**Lead assurance** – reviews findings and seeks assurance regarding implementation of recommendations.
Quality improvement programmes	**Lead assurance** – seeks assurance that improvement programmes are in place and delivering measurable improvement.
Complaints, incidents, PSIRF and organisational learning	**Lead assurance** – seeks assurance that learning is identified, acted upon and embedded appropriately.

REMUNERATION AND PEOPLE COMMITTEE

Terms of Reference

1. Purpose

1.1 The Remuneration and People Committee (the Committee) supports the delivery of the Integrated Care Board's (the ICB's) objectives by providing oversight and assurance to the Board on the ICB's arrangements for remuneration, people leadership and workforce governance. In doing so, the Committee exercises oversight of the ICB's approach to executive remuneration, senior appointments, succession planning and the delivery of the ICB's people priorities.

2. Authority

2.1 The Committee is established as a standing Committee of the Board of the ICB. These Terms of Reference set out the Committee's membership, remit, responsibilities, and reporting arrangements and may only be amended with the approval of the Board.

2.2 The Committee is authorised by the ICB Board to take all necessary actions to fulfil the remit set out in these Terms of Reference. This includes authority to investigate any activity within its remit and to seek any information it requires from any officer or member of staff of the ICB, all of whom are required to co-operate with any reasonable request made by the Committee.

2.3 The Committee is authorised to commission any report it considers necessary to support the discharge of its responsibilities and to obtain independent professional advice, including legal advice, in accordance with procedures established by the ICB. The Committee may also secure the attendance of individuals with relevant experience and expertise where it considers this necessary.

2.4 The Committee may establish task and finish sub-groups to take forward specific pieces of work where appropriate. The Committee shall determine the membership and terms of reference of any such sub-groups but shall not delegate decision-making authority to such groups.

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2.5 Decisions relating to the remuneration and conditions of service of Committee Members shall be determined by the Chair of the Board, with the agreement of the Chief Executive Officer and Chief Finance Officer, based on the recommendation of the Joint Chief People and Culture Officer, with any unresolved matters referred to non-conflicted Board Members.

2.6 In exercising its authority, and discharging its responsibilities, the Committee shall operate in accordance with applicable statutory requirements, national terms and conditions, relevant national guidance and appropriate benchmarking, applicable information governance and confidentiality requirements, and the ICB's Constitution, Standing Orders, Scheme of Reservation and Delegation, and associated policies and governance frameworks.

3. Responsibilities

3.1 The Committee shall provide oversight to the ICB Board on matters relating to remuneration, people, culture, and organisational development, and provide assurance to the Board on the ICB's statutory and regulatory duties in relation to its workforce.

3.2 In doing so, the Committee shall oversee:

- remuneration and contractual matters relating to the Chief Executive, Directors, and very Senior Managers;
- pay, reward and workforce matters for all staff;
- appointment, performance and succession planning; and
- assurance, compliance and statutory duties.

3.3 *Operating Arrangements*

3.3.1 The Committee shall operate as a single standing Committee of the Board, with business structured in two parts:

Part 1: People Business

This part of the meeting shall consider matters relating to workforce strategy and planning, culture and organisational development, equality, diversity and inclusion, workforce governance and assurance, and delivery of the People Plan and People Promise.

Part 2: Remuneration Business

This part of the meeting shall consider matters relating to executive and very senior manager remuneration, senior appointments and contractual arrangements,

executive performance and succession planning, and termination, severance and other contractual matters requiring confidential consideration.

The Committee shall remain a single Board Committee and shall provide a single source of assurance to the Board on matters within its remit. The agenda, papers, attendance records and minutes shall clearly identify whether items are considered under Part 1 or Part 2.

3.4 *Remuneration and contractual matters – Chief Executive, Directors and Very Senior Managers*

3.4.1 Determine and approve all aspects of remuneration for the Chief Executive, Executive Directors and other Very Senior Managers, including but not limited to:

- salary (including any performance-related elements);
- bonuses or incentive payments (where applicable);
- pension arrangements; and
- benefits in kind.

3.4.2 Determine and approve contractual terms, including arrangements for termination of employment, severance, and other contractual or non-contractual payments for the Chief Executive, Directors and other Very Senior Managers, ensuring compliance with relevant legislation, national guidance and contractual requirements.

3..5 Pay, reward and workforce matters – all staff

3.5.1 Oversee the development, delivery and effectiveness of the ICB's People Plan and workforce strategic objectives, ensuring alignment with the ICB's strategy and system workforce priorities.

3.5.2 Approve and keep under review the ICB's pay policy, including the adoption and application of national pay frameworks such as Agenda for Change.

3.5.3 Oversee the ICB's contractual arrangements for staff, ensuring that these are fair, lawful and consistent with national and local requirements.

3.5.4 Oversee the ICB's approach to delivering the NHS People Plan and NHS People Promise and receive assurance on progress against national workforce priorities and commitments.

3.5.5 Determine and approve arrangements for termination payments and any special payments for staff, following scrutiny of their proper calculation and taking account of relevant national guidance and approvals.

3.5.6 Approve the workforce development plan, ensuring alignment with the ICB's strategic objectives and system priorities.

3.5.7 Approve the organisational talent management programme, including approaches to talent identification, development and retention.

3.5.8 Approve the culture and organisational development plan and oversee delivery against agreed objectives.

3.6 Appointments, performance and succession

3.6.1 Exercise the Board's delegated functions in relation to the nomination and appointment of some or all Board members, as set out in the ICB's Constitution and Standing Orders.

3.6.2 Oversee arrangements for the performance review and appraisal of the Chief Executive, Executive Directors, and other senior leaders, and provide assurance to the Board that robust and effective processes are in place.

3.6.3 Oversee succession planning arrangements for the Board and senior leadership roles, ensuring continuity of leadership and capability.

3.7 Assurance, compliance and statutory duties

3.7.1 Provide assurance to the Board on the ICB's compliance with its statutory duties and regulatory requirements relating to people, including but not limited to:

- employment legislation;
- the Fit and Proper Persons Regulations; and
- relevant NHS England guidance.

3.7.2 Oversee and provide assurance to the Board on the ICB's compliance with its statutory equality duties and the effectiveness of its approach to advancing equality, diversity, and inclusion, including monitoring progress and outcomes.

3.7.3 Receive and consider reports, as appropriate, to enable the Committee to discharge its responsibilities and provide assurance to the Board.

3.8 Risk and escalation

3.8.1 The Committee shall review risks within its remit, including the adequacy of mitigations, identify emerging risks, and recommend the addition or escalation of risks to the ICB Board and, where appropriate, the Audit and Risk Committee.

4. Membership and Attendance

4.1 *Membership*

4.1.1 The members of the Committee, including the Chair, shall be appointed by the Board.

4.1.2 The Committee shall consist of not fewer than five~~our~~ members:

- Non-Executive Member (Chair)
- Non-Executive Member
- Chair of the ICB
- Joint Chief People and Culture Officer
- Deputy Chief Executive Officer

4.1.3 The Chair of the Board shall ~~may~~ be a member of the Committee but may not be appointed as Chair of the Committee. The Chair of the Board shall be expected to attend Part 2, except where they are conflicted or where the matter relates to their own appointment, appraisal, remuneration, reappointment, succession, terms and conditions, or any other matter where their participation would give rise to an actual or perceived conflict of interest. For Part 1, the Chair of the ICB shall remain a member of the Committee but attendance will ordinarily be by exception and where required to support quoracy, continuity of governance, or consideration of a specific matter within the Chair's role.

4.1.4 Whilst the Deputy Chief Executive Officer is a member of the Committee, they shall not ordinarily attend, participate in, or receive papers relating to Part 2 Remuneration Business items. The Committee Chair may exceptionally invite the Deputy Chief Executive Officer to attend a specific Remuneration Business item where their advice is required and where no actual or perceived conflict of interest exists.

4.1.4~~5~~ The Chair of the Audit and Risk Committee may not be a member of the Remuneration and People Committee.

4.1.5~~6~~ The Chair of the Committee shall be appointed by the Board from amongst the Non-Executive Directors. In appointing the Chair of the Committee, the Board shall have regard to the importance of maintaining the independence and objectivity of the Committee, including the overall portfolio of committee roles held by the individual.

4.1.~~6~~7 The Committee may appoint a Vice Chair of the Committee from among the Committee's members. The Vice Chair shall act in place of the Chair of the Committee in the Chair's absence or as otherwise required.

4.1.~~7~~8 Members of the Committee may not nominate deputies to attend or act in their place. Where a member is unable to attend, the meeting may proceed provided that it remains quorate.

~~No individual shall be present during any discussion relating to any aspect of their own pay or any aspect of the pay of others when it has, or could reasonably be perceived to have, an impact on them.~~

4.1.~~8~~9 Members of the Committee shall, collectively, possess an appropriate balance of skills, knowledge, and experience relevant to the Committee's remit, including remuneration workforce strategy, people and culture, organisational development, employment law, equality, diversity and inclusion, and public sector governance. In considering appointments to the Committee, due regard shall be given to diversity and equality.

~~4.1.9 No member of the Committee shall be present for, or participate in, any discussion or decision relating to any aspect of their own remuneration, terms and conditions of service, or those of others where this has, or could reasonably be perceived to have, an impact on them.~~

4.2 *Attendance*

4.2.1 No member of the Committee shall be present for, participate in, or receive papers relating to any discussion or decision concerning their own remuneration, terms and conditions of service, performance, succession planning, appointment, reappointment or any matter where this has, or could reasonably be perceived to have, an impact on them.

4.2.2 In addition to the requirements set out in 4.2.1 above, the Chair of the ICB shall not be present for, participate in, receive papers relating to, or be counted towards the quorum for any item concerning the appointment, appraisal, remuneration, reappointment, succession or terms and conditions of the Chair of the ICB.

4.2.3 Attendance arrangements shall reflect the Committee's business. Part 1 People Committee Business will ordinarily be attended by those members and standing attendees required to support discussion and assurance on people, culture, and workforce matters. The Chair of the ICB may attend Part 1 where required, including to support quoracy, but routine attendance is not expected. Part 2 Remuneration Business will ordinarily be attended by Committee members eligible to participate in the business under consideration. The Chair of the ICB will be expected to attend Part 2, except where conflict or where required to withdraw under these Terms of Reference.

4.3 *Standing Invitations*

4.~~2~~3.1 The Deputy Chief People and Culture Officer and Director of People shall have a standing invitation to attend ~~all~~ meetings of the Committee, subject to the attendance arrangements for Remuneration Business set out in these Terms of Reference. .

4.~~2~~3.2 The Chief Finance Officer, or their nominated deputy, shall have a standing invitation to attend meetings of the Committee and shall be invited to attend Remuneration Business and any other items with material financial, workforce, or organisational implications.

4.3.3 The Chief Executive Officer may also attend meetings of the Committee, or specific items, as and when appropriate. ~~Meetings of the Committee may also be attended by the Chief Executive Officer or the Chief Finance Officer, or their nominated deputies, as and when appropriate.~~

4.3.4 Attendance at Part 2 Remuneration Business shall be restricted to Committee members and attendees who are eligible to participate in the item under consideration, together with those individuals specifically invited by the Committee Chair for a particular item. The Committee Chair may require any attendee or member to withdraw from an item to manage actual or perceived conflicts of interest or to preserve confidentiality.

4.~~3~~4 *Attendance by Others*

4.~~3~~4.1 Attendance at Committee meetings shall be limited to Committee members, individuals holding a standing invitation, and such other attendees as may be invited by the Chair. ~~is restricted to Committee members.~~

4.~~3~~4.2 The Chair may, at their discretion, invite officers, staff, or other individuals to attend meetings, or specific items or parts thereof, where their attendance is required to support the Committee's consideration of business. Such attendees shall have no voting rights.

4.~~3~~4.3 The Chair may require any attendee who is not a Committee member to withdraw from the meeting for any item where this is considered necessary to facilitate open and frank discussion or to manage conflicts of interest.

5. Proceedings of Meetings

5.1 The Committee shall meet four times each year scheduled to support the business cycle of the ICB. The timing and frequency of meetings shall be agreed by the Chair of the Committee.

5.2 The Chair of the Committee, acting on their own authority, or at the request of a Committee member, the Chair of the ICB Board or the Chief Executive Officer, may

convene additional meetings of the Committee at any time to consider matters requiring urgent attention.

5.3 The quorum for any meeting of the Committee shall be three members and shall include at least two Non-Executive Members, one of whom shall be the Committee Chair or Vice Chair.

5.4 Where a Committee member is required to withdraw from a Part 2 Remuneration Business item due to a conflict of interest, or by virtue of the attendance arrangements set out in these Terms of Reference, that member shall not participate in discussion or decision-making on that item and shall not be counted towards the quorum for that item. Where this would render the Committee inquorate, the matter shall be deferred or referred to appropriately constituted non-conflicted members of the Committee. For Part 1 People Committee Business, the Chair of the ICB may be counted towards the quorum where they are in attendance and are not conflicted in relation to the item under consideration.

~~5.4 Where a Committee member is disqualified from participating in an item of business by reason of a conflict of interest, that member shall not be counted towards the quorum for that item.~~

5.5 Where a meeting is not quorate, the meeting may proceed for the purposes of discussion and information-sharing only, but no decisions or recommendations may be made.

5.6 Attendance by members via virtual means shall be permitted and shall count towards the quorum, provided that such attendance is by audio-visual link which enables all participants to see and hear one another, that the member has access to all meeting papers, and is able to participate fully in the meeting as if present in person.

a. Decision-Making and Voting

6.1 The Committee shall seek to reach its conclusions and recommendations by consensus wherever possible.

6.2 Where a consensus cannot be reached, a decision may be taken by a formal vote. Each Committee member present at the meeting shall have one vote. No member may vote by proxy.

6.3 Only Committee members shall be entitled to vote. Attendees who are not members of the Committee shall not have voting rights.

6.4 A decision shall be carried if a simple majority of those members present and voting are in favour. In the event of an equality of votes, the Chair of the Committee, or in their absence, the member presiding, shall have a second and casting vote.

6.5 In exceptional circumstances, where a decision is required before the next scheduled meeting, the Committee may consider and agree matters via correspondence, including electronic circulation. All eligible voting members must be provided with sufficient information and a reasonable opportunity to comment or indicate their agreement. Any decision taken through correspondence shall be recorded by the Chair and formally reported to, and ratified at, the next quorate meeting. This approach shall not be used for matters requiring substantive discussion unless delay would adversely affect the discharge of the ICB's statutory or delegated responsibilities.

7. Reporting

7.1 The Committee is accountable to the ICB Board.

7.2 The Committee shall report to the ICB Board on the discharge of its responsibilities. The Chair of the Committee shall provide a summary report to the next scheduled meeting of the ICB Board following each Committee meeting, setting out the key matters considered, actions agreed, and any issues requiring escalation to or decision by the Board.

8. Governance and Resources

8.1 The Committee shall be supported by the Joint Chief People and Culture Officer, who is the nominated Executive Team lead for remuneration and people.

8.2 Secretariat support shall be provided by the ICB Committees Team. The duties of the secretariat include, but are not limited to:

- agreeing the agenda with the Joint Chief People and Culture Officer and the Chair of the Committee, and collating and circulating papers at least five working days in advance of meeting;
- taking minutes of meetings and maintaining a record of actions and matters arising; and
- providing administrative and governance support to the Chair of the Committee and Committee members as required.

8.3 The Committee shall have access to such resources and information as it reasonably requires to discharge its responsibilities effectively.

9. Monitoring Effectiveness and Compliance with Terms of Reference

9.1 The Committee shall undertake an annual review of its effectiveness and shall provide an annual report to the ICB Board on how it has discharged its responsibilities, delivered its objectives and complied with these terms of reference,

including commentary on relevant aspects of the Board Assurance Framework and applicable regulatory requirements.

9.2 These Terms of Reference shall be reviewed at least annually by the Committee and approved by the ICB Board.

Date approved:	*7 April 2026*
Approved by:	ICB Board
Next review date:	*April 2027*
Version Control:	v2.0

Kent and Medway

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

1. Purpose

1.1 The Finance and Performance Committee (the Committee) supports the delivery of the Integrated Care Board's (the ICB's) objectives by providing oversight and assurance to the Board in relation to financial sustainability, system performance, productivity and the effective use of resources. The Committee provides assurance that appropriate financial frameworks, operating models, and contractual arrangements are in place across the Kent and Medway system to enable the efficient, sustainable, and transparent allocation and management of resources, consistent with the agreed system priorities, financial duties and obligations.

2. Authority

2.1 The Committee is established as a standing Committee of the Board of the ICB. These Terms of Reference set out the Committee's membership, remit, responsibilities, and reporting arrangements and may only be amended with the approval of the Board.

2.2 The Committee is authorised by the ICB Board to take all necessary actions to fulfil the remit set out in these Terms of Reference. This includes authority to investigate any activity within its remit and to seek any information it requires from any officer or member of staff of the ICB, all of whom are required to co-operate with any reasonable request made by the Committee.

2.3 The Committee is authorised to commission any report it considers necessary to support the discharge of its responsibilities and to obtain independent professional advice, including legal advice, in accordance with procedures established by the ICB. The Committee may also secure the attendance of individuals with relevant experience and expertise where it considers this necessary.

2.4 The Committee may establish task and finish sub-groups to take forward specific pieces of work where appropriate. The Committee shall determine the membership

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and terms of reference of any such sub-groups but shall not delegate decision-making authority to such groups.

2.5 In exercising its authority, and discharging its responsibilities, the Committee shall operate in accordance with applicable statutory financial duties and requirements, relevant national guidance and benchmarking, applicable information governance and confidentiality requirements, and the ICB's Constitution, Standing Orders, Scheme of Reservation and Delegation, financial policies, and associated system and performance governance frameworks.

3. Responsibilities

3.1 *Core assurance responsibilities*

3.1.1 The Committee shall provide oversight and assurance to the ICB Board in relation to financial sustainability, system performance, productivity and the effective use of resources, in accordance with its responsibilities set out below.

3.2 *Financial duties and system assurance*

3.2.1 The Committee shall provide assurance to the Board that the ICB and the wider Kent and Medway system are meeting applicable statutory and mandatory financial duties and requirements, and that financial plans, performance and delivery are aligned to:

- agreed system and organisational financial duties and obligations;
- the Kent and Medway Integrated Care Strategy and associated commissioning and operational delivery plans, including Financial Recovery Plans;
- the NHS Constitution and the NHS Long Term Plan, where relevant to financial and performance delivery.

3.3 *System financial framework and operating model*

3.3.1 The Committee shall oversee and seek assurance that an effective system financial framework and operating model is in place for the collective management and distribution of capital and revenue resources across Kent and Medway.
This includes assurance that:

- the framework supports effective accountability for service delivery within available resources;
- appropriate flexibilities are applied at system and place level in line with agreed arrangements; and

- partner organisations remain accountable for delivery within their respective allocations and responsibilities.

3.4 *Financial planning and resource allocation*

3.4.1 The Committee shall:

- oversee the development of annual, medium-term and longer-term financial plans, including the allocation of resources to enable the ICB to discharge its functions;
- ensure that financial plans are robust, evidence-based and developed using appropriate local data and intelligence; and
- recommend financial plans to the Board for approval, where required.

3.5 *Performance, productivity and efficiency oversight*

3.5.1 The Committee shall monitor and oversee:

- delivery against agreed financial plans and control totals;
- system, place and organisational performance against agreed financial, productivity and efficiency objectives;
- the design, implementation and delivery of agreed system productivity and efficiency programmes.

3.5.2 This assurance shall be obtained through the receipt of written and verbal reports, dashboards and briefings at a system, place, collaborative, programme or organisational level, as the Committee considers appropriate.

3.6 *Investment, business cases and use of resources*

3.6.1 The Committee shall:

- review and comment on proposed business cases and investment proposals, and make recommendations to the Board, other Committees or the ICB Executive as appropriate;
- where requested, retain oversight of approved business cases in relation to financial planning, affordability and delivery.

3.7 *Contracting and commissioning oversight*

3.7.1 The Committee shall:

- oversee the effective use of contractual levers, incentives and remedial actions in relation to commissioned services;

- receive assurance on the application of contractual remedies where appropriate, or explanations where such remedies have not been applied;
- consider and comment on the development of new contractual forms and approaches that support system partnership working;
- review contractual obligations and arrangements linked to national procurement and provider selection regimes; and
- where authorised, scrutinise the implementation and mobilisation of new tenders and contract awards.

3.8 *Risk and escalation*

3.8.1 The Committee shall review risks within its remit, including the adequacy of mitigations, identify emerging risks, and recommend the addition or escalation of risks to the ICB Board and, where appropriate, the Audit and Risk Committee.

3.9 *Cross-committee and system working*

3.9.1 The Committee shall work alongside other ICB Committees and system groups and partners, and provide financial and contractual input where matters fall within its remit or require specialist oversight.

4. Membership and Attendance

4.1 *Membership*

4.1.1 The members of the Committee, including the Chair, shall be appointed by the Board.

4.1.2 The Committee shall consist of not fewer than four members:

- Non-Executive Member (Chair)
- Non-Executive Member
- Chief Finance Officer
- Deputy Chief Executive Officer

4.1.3 The Chair of the Board may be a member of the Committee but shall not be appointed as Chair of the Committee.

4.1.4 The Chair of the Audit and Risk Committee shall not be a member of the Committee but may attend meetings by invitation of the Committee Chair.

4.1.5 The Chair of the Committee shall be appointed by the Board from amongst the Non-Executive Directors. In appointing the Chair of the Committee, the Board shall have regard to the importance of maintaining the independence and objectivity of

the Committee, including the overall portfolio of committee roles held by the individual.

4.1.6 The Committee may appoint a Vice Chair of the Committee from among the Committee's members. The Vice Chair shall act in place of the Chair of the Committee in the Chair's absence or as otherwise required.

4.1.7 Members of the Committee shall, collectively, possess an appropriate balance of skills, knowledge, and experience in financial management, budgeting and planning, performance management, value for money in the use of resources, productivity, commissioning, and other technical or specialist areas relevant to the ICB's functions. At least one member shall have recent and relevant financial experience. In considering appointments to the Committee, due regard shall be given to diversity and equality.

4.1.8 Members of the Committee may not nominate deputies to attend or act in their place. Where a member is unable to attend, the Committee may proceed provided that the meeting remains quorate.

4.2 *Standing Invitations*

4.2.1 The Deputy Chief Commissioning Officer, Chief Nursing, Experience and Quality Officer, and Director of Performance and Regulation shall have a standing invitation to attend all meetings of the Committee.

4.2.2 Meetings of the Committee may also be attended by the Chief Executive Officer, or exceptionally their nominated deputy, as and when appropriate. Such attendees shall not be members of the Committee and shall not count towards quorum.

4.3 *Attendance by Others*

4.3.1 Attendance at Committee meetings is restricted to Committee members.

4.3.2 The Chair may, at their discretion, invite officers, staff, or other individuals to attend meetings, or specific items or parts thereof, where their attendance is required to support the Committee's consideration of business. Such attendees shall have no voting rights.

4.3.3 The Chair may require any attendee who is not a Committee member to withdraw from the meeting for any item where this is considered necessary to facilitate open and frank discussion or to manage conflicts of interest.

5. Proceedings of Meetings

5.1 The Committee shall meet six times each year scheduled to support the business cycle of the ICB. The timing and frequency of meetings shall be agreed by the Chair of the Committee.

5.2 The Chair of the Committee, acting on their own authority, or at the request of a Committee member, the Chair of the ICB Board or the Chief Executive Officer, may convene additional meetings of the Committee at any time to consider matters requiring urgent attention.

5.3 The quorum for any meeting of the Committee shall be three members, including at least two Non-Executive Members, one of whom shall be the Chair or Vice Chair of the Committee.

5.4 Where a Committee member is disqualified from participating in an item of business by reason of a conflict of interest, that member shall not be counted towards the quorum for that item.

5.5 Where a meeting is not quorate, the meeting may proceed for the purposes of discussion and information-sharing only, but no decisions or recommendations may be made.

5.6 Attendance by members via virtual means shall be permitted and shall count towards the quorum, provided that such attendance is by audio-visual link which enables all participants to see and hear one another, that the member has access to all meeting papers, and is able to participate fully in the meeting as if present in person.

6. Decision-Making and Voting

6.1 The Committee shall seek to reach its conclusions and recommendations by consensus wherever possible.

6.2 Where a consensus cannot be reached, a decision may be taken by a formal vote. Each Committee member present at the meeting shall have one vote. No member may vote by proxy.

6.3 Only Committee members shall be entitled to vote. Attendees who are not members of the Committee shall not have voting rights.

6.4 A decision shall be carried if a simple majority of those members present and voting are in favour. In the event of an equality of votes, the Chair of the Committee, or in their absence, the member presiding, shall have a second and casting vote.

6.5 In exceptional circumstances, where a decision is required before the next scheduled meeting, the Committee may consider and agree matters via correspondence, including electronic circulation. All eligible voting members must be provided with sufficient information and a reasonable opportunity to comment or indicate their agreement. Any decision taken through correspondence shall be recorded by the Chair and formally reported to, and ratified at, the next quorate meeting. This approach shall not be used for matters requiring substantive

discussion unless delay would adversely affect the discharge of the ICB's statutory or delegated responsibilities.

7. Reporting

7.1 The Committee is accountable to the ICB Board.

7.2 The Committee shall report to the ICB Board on the discharge of its responsibilities. The Chair of the Committee shall provide a summary report to the next scheduled meeting of the ICB Board following each Committee meeting, setting out the key matters considered, actions agreed, and any issues requiring escalation to or decision by the Board.

8. Governance and Resources

8.1 The Committee shall be supported by the Chief Finance Officer, who is the nominated Executive Team lead for governance.

8.2 Secretariat support shall be provided by the ICB Committees Team. The duties of the secretariat include, but are not limited to:

- agreeing the agenda with the Chief Finance Officer and the Chair of the Committee, and collating and circulating papers at least five working days in advance of meeting;
- taking minutes of meetings and maintaining a record of actions and matters arising; and
- providing administrative and governance support to the Chair of the Committee and Committee members as required.

8.3 The Committee shall have access to such resources and information as it reasonably requires to discharge its responsibilities effectively.

9. Monitoring Effectiveness and Compliance with Terms of Reference

9.1 The Committee shall undertake an annual review of its effectiveness and shall provide an annual report to the ICB Board on how it has discharged its responsibilities, delivered its objectives and complied with these terms of reference, including commentary on relevant aspects of the Board Assurance Framework and applicable regulatory requirements.

9.2 These Terms of Reference shall be reviewed at least annually by the Committee and approved by the ICB Board.

Date approved:	22 September ~~7 April~~ 2026
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