Medway Council
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Health and Adult Social Care Overview and Scrutiny Committee

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NHS Kent and Medway ICB Change-25: ICB Transition Programme

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Summary:

This report briefs the Committee on changes underway within NHS Kent and Medway Integrated Care Board (ICB), as part of structural reform to the NHS across England. In particular, the briefing updates on the requirement for ICBs to make a circa 50% reduction in their operating costs by the end of this calendar year (2025).

1. Recommendation

1.1. The Committee is asked to note this report.

2. Budget and policy framework

2.1. Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health service in Medway. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it, and in particular, relevant information provided to it by a local Healthwatch. The Council has delegated responsibility for discharging this function to this Committee and to the Children and Young People's Overview and Scrutiny Committee as set out in the Council's Constitution.

3. Background

3.1. In March 2025, the Secretary of State for Health and Social Care announced reforms to the way the NHS is managed nationally, with the abolition of NHS England by April 2027 and the transfer of its functions to the Department of Health and Social Care (DHSC), with a total reduction in the combined workforce of 50%.

3.2. At the same time, it was less widely reported that the 42 Integrated Care Boards (ICBs) in England, who commission local health and care services, would also have their operating costs – i.e. the cost to run each organisation - reduced by 50%, albeit at a faster pace, i.e. by December of this year. This reduction is in addition to the 30% running cost savings required of ICBs over the previous two

years, making a 65% total reduction in operating costs since ICBs were established in July 2022.

3.3. For assurance, reductions in ICB operating costs do not impact on the commissioning budgets which pay for local health and care services, and as such there is no direct impact on patient care.

3.4. This briefing note outlines how NHS Kent and Medway ICB is preparing to make these savings. The briefing provides an update on current implementation plans, highlights the opportunities and key risks, and explains the impact and support available to ICB staff during the transition process and for those who will be made redundant.

Context

3.5. Following the Secretary of State's announcement in March, a preliminary national model blueprint for Integrated Care Boards was published at the beginning of May. This emphasised a change in the future role of these organisations, with a greater focus as system convenors and 'strategic commissioners' of healthcare services under a new operating model, to be described in the 10 Year Health Plan. The expectation is that the model ICB blueprint will, in future, sit alongside a model blueprint for NHSE/DHSC regional teams and a model blueprint for local neighbourhood health.

The NHS 10 Year Plan

3.6. The NHS 10 Year Plan was published on 3 July 2025[1]. It includes the vision and expectation of how health and care services will be improved and delivered over the next decade. It describes a new operating model with a leaner and simpler way of working, where every part of the NHS is clear on its purpose, what it is accountable for, and to whom.

3.7. With regard to ICBs, the Plan emphasises the on-going importance of these organisations. It notes: *"ICBs will be strategic commissioners of local health services, responsible for all but the most specialised commissioning, using multi-year budgets. This means ensuring that the money available to each local care system is put to the best possible use: to improve their population's health, reduce health inequalities and improve access to consistently high-quality services.*

3.8. *"They [ICBs] will be expected to draw on a deep understanding of population need, and to make long-term decisions in the interests of improved outcomes and financial sustainability. They will need to shape commissioning plans through deep engagement with patients and the public; and to use competitive processes where helpful, alongside clear contracting and contract management to drive change and ensure delivery.*

3.9. The 10 Year Plan goes on to say that over the coming months, the number of ICBs will reduce from the existing 42 organisations, and all will be required to work

[1] https://www.england.nhs.uk/long-term-plan/

within a total operating budget capped at the equivalent of £19.00 per head of GP registered population from the end of this year.

3.10. It notes that the ICB model blueprint describes in greater detail the expectations around what ICBs should focus their efforts on in the future, and those functions that they should stop doing and, over time, transfer to other organisations.

Darzi Review and the model blueprint for ICBs

3.11. The preliminary model blueprint acknowledges that when ICBs were established in July 2022, they had - and still have today – statutory functions around planning, arranging and oversight of local healthcare services, and a range of delivery functions, including emergency planning, engagement, safeguarding, continuing healthcare services, medicines management, etc.

3.12. A report by Lord Darzi in November 2024[2], noted that since 2022, there had been differing interpretations of the role of ICBs, with some leaning towards tackling the social determinants of health, some focused on working at a local level to encourage services to work more effectively together, and some focused on supporting their providers to improve financial and operational performance. The Darzi report notes that the broad agenda of ICBs has resulted in many finding it hard to use their powers to commission services in line with the four national objectives for integrated care systems. *"This has largely resulted in the status quo with increasing resources directed to acute providers, when the four objectives should have instead led to the opposite outcome."*

3.13. The recently published ICB blueprint therefore confirms that the future role and responsibilities of ICBs will be much clearer and provide greater consistency, to better enable the strategic objectives of redistributing resource out of hospital and into integrating care.

3.14. Three strategic shifts form the foundation of the ICB's approach (and the NHS Ten Year Plan) to transform and redesign health and care:

- **From treatment to prevention**: A stronger emphasis on preventative health and wellbeing, addressing the causes of ill health before they require costly medical intervention and reducing inequalities in health.

- **From hospital to community**: Moving care closer to home by building more joined-up, person-centred care in local neighbourhoods, reducing reliance on acute care.

- **From analogue to digital**: Harnessing technology and data to transform care delivery and decision-making.

3.15. The blueprint notes that these shifts set the direction for how ICBs need to operate going forward. *"The NHS needs strong commissioners who can better understand the health and care needs of their local populations, who can work with users and wider communities to develop strategies to improve health and tackle inequalities*

[2] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-health-and-social-care

and who can contract with providers to ensure consistently high-quality and efficient care, in line with best practice."

3.16. The refreshed role of ICBs has been developed as part of a refreshed NHS system landscape as outlined below:

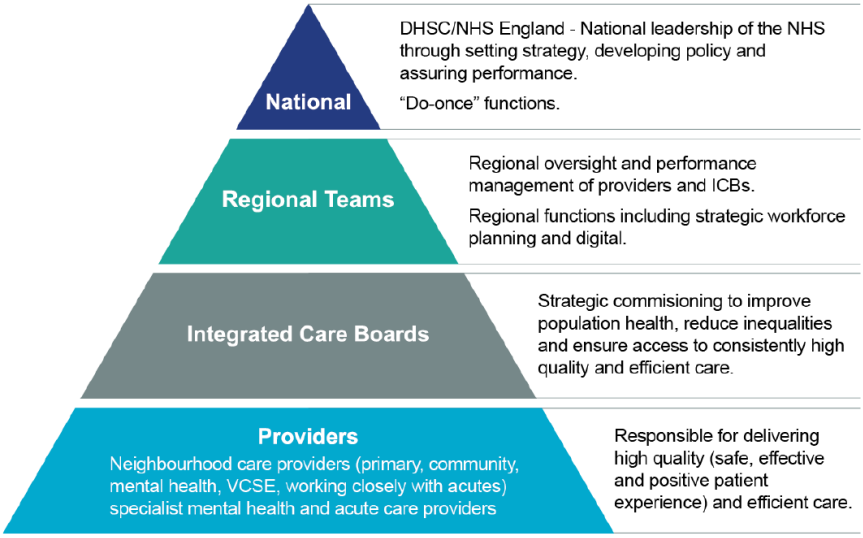

Figure 1 – NHS operating landscape

3.17. In order to deliver this more defined purpose in the future, ICBs will need to focus on the following core functions:

Figure 2 – Model ICB operating model

3.18. The blueprint for ICBs therefore lists functions that it proposes are retained and grown over time, could be shared with other partners, and or transferred out of ICBs. These include:

Functions that ICBs should retain and invest in over time:

- Assessing population need, and assessing quality, performance and productivity of existing provision
- Developing long term population health strategy and end-to-end care pathway redesign and commissioning
- Market shaping and management, and strategic contracting
- Evaluating outcomes and the day-to-day oversight of healthcare utilisation
- Engaging with service users, ensuring effective feedback and co-design
- Ensuring the organisation is compliant, accountable and safe

Retain and adapt, with potential to deliver at scale *(with local partners of pan-ICBs)*

- Quality management
- Clinical and corporate governance and core organisational operations
- Development of clinical policy effectiveness and local funding decisions

Functions and activities to transfer over time

Transfer to regions/national:

- Provider performance oversight – performance management and regulatory oversight
- Strategic workforce planning – ICBs to retain limited commissioning overview, with other aspects transferring to regions
- National data and digital infrastructure
- Emergency preparedness, resilience and response

Transfer to providers:

- Local workforce development
- Sustainability
- Local digital and technology leadership and transformation
- Development of neighbourhood and place-based partnerships

Test and explore to streamline and transfer or share at greater scale

- Infection prevention and control
- Safeguarding [3]
- SEND [3]
- NHS continuing health care [3]
- Strategic estate and infrastructure

3.19. Further work is underway nationally to test assumptions around those functions earmarked for potential transfer and where they may best sit in the future to deliver optimum benefit. In the meantime, ICBs are working on the basis that until there is readiness to transfer services and corresponding resource, these functions will remain the responsibility of ICBs and as such should be played in to operating cost reductions.

[3] Would require legislative change – expected circa April 2027

Planning for the changes in NHS Kent and Medway

3.20. It has recently been confirmed that the number of ICBs in England will reduce from 42 to 26 by April 2027. The number of ICBs in the southeast region will reduce from six to four[4], NHS Kent and Medway is not affected by these mergers or boundary changes.

Local context

3.21. Kent and Medway currently has a registered GP population over just over two million people. The ICB has a total commissioning budget of circa £4.7 billion per annum, which it spends on commissioning services including:

- Community and rehabilitation healthcare
- Elective care including diagnostics, outpatient, day-case and elective inpatient care
- GP primary care
- Children's services including those with complex needs
- Learning disabilities and autism
- Mental health services for adults and children and younger people
- Maternity and neonatal services
- NHS continuing healthcare
- Pharmacy, optometry and dentistry services
- Specialist services provided by tertiary centres in London and the southeast
- Urgent and emergency care including accident and emergency, ambulance and out- of-hours services

3.22. The ICB has an operating budget of £73.5 million (circa 1.5% of the total budget), which in effect is the cost of running the ICB and managing the commissioning of the above services.

The 'Change-25' Kent and Medway ICB transition programme

3.23. The ICB programme to reduce our operating costs is locally known as the 'Change-25' programme. The programme requires ICBs to reduce operating costs by circa 50% nationally, to operate within a maximum running cost budget of £19.00 per head of (registered GP) population, by 31 December 2025.

3.24. For NHS Kent and Medway, this means further reducing our current operating costs, from £73.5 million to £38.3 million within what remains of a seven-month period. To deliver this reduction the ICB will need to reduce its current workforce establishment of 770 by circa 49% whole time equivalent staff. This will be achieved through vacancy control and voluntary and compulsory redundancies. The estimated redundancy cost is expected to be circa £21m, which is a similar scale to the other ICBs in the region.

3.25. This is an extremely challenging timescale and task, given the complexity of the programme, and critically, the need to continue delivering the significant

[4] The four south-east ICBs will be: NHS Kent and Medway, NHS Surrey and Sussex, NHS Hampshire and the Isle of Wight and NHS Thames Valley ICBs.

operational and financial agenda, which includes overseeing the largest system financial savings programme in the country and delivering on-going improvements in primary care, elective and non-elective access.

3.26. The Change-25 programme is also dependent on a number of external factors, such as:

- confirmation of funding arrangements that will enable the ICB to proceed to staff consultation and redundancy;
- publication of the 'model regional blueprint' due July 2025, which we expect to confirm arrangements for functions expected to transfer to regions from ICBs;
- confirming the impact on ICBs of the recent announcement in the Ten Year Plan to dissolve commission support units (which provide back-office functions to ICBs); and
- securing wider agreements with other ICBs and partners to maximise the opportunity for shared working, similar to the current joint commissioning arrangements with Medway Council.

3.27. The ICB has appointed the ICB Executive Director of Corporate Governance as the programme's Transition Director and a programme management team (PMO) has been put in place. A Transition Committee has also been established as a formal sub-committee of the ICB Board. The work of the PMO reports via the Transition Director into the Executive Management Team on a weekly basis and on to the Transition Committee.

3.28. An NHS Kent and Medway Insight and Involvement Group has also been established to support the development of the new Kent and Medway ICB Operating Model. The group is made up of staff from each of our existing divisions and every staff grade across the organisation, and also includes representation from our unions and staff networks. A communications and engagement plan is in place and details how we will effectively involve our staff and engage with our partners.

3.29. At a regional level, south east ICB transition directors meet on a weekly basis and chief executives meet fortnightly. Transition directors oversee the development of plans for those functions which could be shared across multiple ICBs, and also act as the coordination group to choreograph and align ICB plans including staff consultation timetables, recognising the considerable interdependencies across the organisations.

<u>Progress to date</u>

3.30. Over the course of the past five months the following key pieces of work have progressed, outside of establishing the governance and programme management arrangements:

- Progression of a new Kent and Medway ICB Operating Model, through the staff Insight and Involvement Group: the 'front-end' of the Operating Model has now been developed. This details the role, responsibilities, values and behaviours we expect to see within the new organisation with a much-reduced

workforce. Work is now underway to outline the governance and decision-making framework that the organisation will operate within.

- A key piece of work to define the 'practical application' of strategic commissioning in Kent and Medway, i.e. what does it practically mean to commission strategically, and what will be different from what we do now.
- Completion of a 'do, share, transfer, stop' model, that informs both the ICB Operating Model and long-term programmes of work. This outlines which functions could be shared across organisations over a longer timeframe, which could be transferred and to whom, and what we will stop doing.
- Developing pan-ICB functional models that would see some functions provided through a single hosted model across the south-east, rather than undertaken by individual ICBs. Further work is progressing on this at pace to finalise proposals to inform the Operating Model and staffing structures.
- Significant development of staff support packages, both to assist colleagues and line managers during the Change-25 programme, and also preparing individuals for seeking new roles and alternative employment post-reorganisation (see more on this later).
- Running an 'expressions of interest' initiative for voluntary redundancy to understand the level of interest should a national VR programme be announced. Over 100 members of staff have expressed an interest in VR and if the ICB is allowed to run a scheme, this could significantly reduce the number of people we have to make compulsory redundant.
- Undertaking an NHS Kent and Medway system partnership review to consider the current partnership arrangements in place between provider collaboratives, health and care partnerships and the numerous NHS system programme boards. The outcome of this review is to be presented to the Joint Committee of NHS organisations in September, with an expectation that it will condense the number of system groups in place, providing greater clarity and removing duplication/inefficiency.
- Proposals for a new ICB executive team structure, and the divisional model that will sit underneath this, with corresponding mapping of new functions to new divisions. In addition, review of the make-up of the ICB Board, which is also expected to reduce in size.
- Modelling of indicative financial allocations for each of the functions, with an average staffing reduction of 49% across the organisation. Staffing structures have started to be developed, in anticipation of going out to consultation from the autumn.

3.31. With regard to timetable, this remains a dynamic and complex programme. We have a detailed Change-25 programme plan that enables us to work to the December deadline, but a number of uncertainties remain including issues outside of the ICBs control. As such the timetable currently remains rather fluid.

<u>Opportunities, risk and challenges</u>

3.32. Whilst challenging, the Change-25 programme offers l long-term opportunities locally. These include:

- driving greater focus on *commissioning strategically* to improve population health rather than managing provider performance;

- targeting resource and expertise on assessing need and co-developing and commissioning effective end-to-end care pathways with clearer expected outcomes;
- maximising opportunities for collaboration and reducing duplication, for example through greater joint commissioning and sharing of expertise; and
- shaping and managing provider delivery markets, that optimise patient experience and care outcomes, for example through the development of neighbourhood delivery models.

3.33. However, this will take time to achieve, will require a number of functions to be transferred out of the ICB, and importantly require a change in both mind- and skill-set with investment (time and resource) needed in areas such as developing healthcare data and analytics, strategic contracting and market development, system leadership for population health, and developing proactive involvement of communities and users to co-design services.

3.34. The pace of addressing the more immediate challenges and risks will determine the ability of the organisation and wider system to reap the benefits of these opportunities. In terms of material challenges, there are a number:

a. **Funding**: the funding of redundancies has not yet been agreed. We understand that the Treasury has stated that redundancies are to be funded from current local budgets, but there are strict rules that prevent ICBs from exceeding their operating costs. In addition, ICBs are required to obtain approval from NHS England to make staff redundant, and it is unlikely that the ICB will be given approval to proceed this financial year, given the current difficult financial situation locally. Therefore, whilst there is a requirement for ICBs to make the £19.00 per head saving by December 2025, it is increasingly likely that approval to make the majority of staff redundant will not be provided until the new financial year. We are working closely with other ICBs and our regional team in NHS England to clarify the situation as soon as possible, and following this, we will be able to finalise the timetable and confirm consultation arrangements with our staff.

b. **Voluntary Redundancy**. It remains unclear whether a national voluntary redundancy programme will be made available: staff are not able to apply or volunteer for compulsory redundancy, and there are strict rules on running compulsory redundancy programmes where organisations expect to make more than 20 people redundant. An early voluntary redundancy programme would allow staff who wish to leave the organisation, to exit (subject to specific criteria), and reduce the number of required compulsory redundancies.

c. **Living within our means**. In order for the ICB to effectively reduce its operating costs by 49% to achieve the £19.00 per head cap, those functions which should no longer be provided by an ICB need to transfer out of the organisation. Otherwise, the ICB will be required to hold on to these functions whilst still having to live within the operating cost cap. Some efficiencies can obviously be made whilst retaining these functions, but it significantly restricts what the ICB is able to do whilst living with a circa fifty percent reduced workforce.

At the time of reporting, the model regional blueprint has not yet been published. Expected updates to the ICB blueprint are also still awaited. In addition, a number of functions will require a change in statutory legislation before they can transfer out.

Current planning assumptions are that many of these functions will likely need to be retained by the ICB until 2026/early 2027. If this is correct, the ICB will find it difficult to live within the operating cost envelope in the meantime and effectively deliver its core responsibilities. Again, we are working closely with our ICB partners in the southeast, NHS England and other partners, to maximise opportunities for joint working and creating greater efficiency in order to deliver the 'ask'.

d. **Delivering in-year priorities**. As previously noted, NHS Kent and Medway is this year required to deliver the largest efficiency programme in the country (circa £470m / 10%). This is alongside also needing to deliver continued progress of our annual operating plan, which includes reducing waiting lists and improving patient care and experience. The Change-25 programme understandably puts greater stress on delivering this, with on-going staff uncertainty about their futures.

e. **Our workforce**. The impact of the Change-25 programme on our workforce, alongside similar programmes for back-office staff in our providers, cannot be understated. Our staff are resilient, but a protracted transition programme with uncertainty about timescales and outcomes, significantly increases anxiety levels. Currently, staff sickness levels and turnover are low and staff satisfaction with the ICB Change-25 programme is reassuringly better than previous reorganisations. However, the inevitable silent anxiety amongst many of our colleagues will quickly turn to disquiet if confidence in the process is lost. We are working hard to ensure all staff are kept up to date, involved where they can be, and have the necessary support arrangements in place during this difficult time.

<u>Supporting our staff</u>

3.35. Alongside our regular employee support programme, our People and Culture Team have developed a comprehensive colleague support package to help staff and line managers during the Change-25 programme. This includes providing support to prepare individuals for potentially seeking alternative employment outside of NHS Kent and Medway.

3.36. We are working closely with a number of external organisations to help staff with personalised career coaching and job searching support, alongside guidance on education and training opportunities. Appendix A to this paper provides further information on this.

3.37. We are also extremely grateful to a number of organisations, including Medway Council, who are offering guaranteed consideration during short-listing and interviews for individuals who are displaced or a risk within the ICB.

Summary

3.38. The Change-25 programme presents real opportunities to align with the new strategic commissioning model outlined in the NHS 10 Year Plan. This change comes amid broader structural reforms to the NHS landscape and involves considerable operational and cultural shifts. Despite the significantly challenging timelines, legislative uncertainties, and reliance on external decisions, such as the timing of function transfers and redundancy funding availability, we have made considerable progress towards delivering the requirements of the programme, all while continuing to focus on delivery of the critical priorities in our annual operating plan.

3.39. Recognising the scale and impact of these changes on our workforce, the ICB is placing strong emphasis on supporting our colleagues throughout this difficult period. A comprehensive staff support package has been launched, in addition to our core employee wellbeing services. Meaningful staff engagement and involvement is central to the Change-25 programme, with the Insight and Involvement Group ensuring colleagues from across the organisation help shape the future ICB model. While uncertainty remains, our commitment to open, honest communication and staff wellbeing remains unwavering.

4. Risk management

4.1. There are no material risks to Medway Council arising directly from this report. The implementation of the model ICB blueprint and reduction in ICB operating costs primarily impacts on the internal business of the ICB. There may be some indirect consequences as a result, in terms of how the ICB works with the Council, but there are no material risks.

5. Financial implications

5.1. There are no financial implications to Medway Council arising directly from this report.

6. Legal implications

6.1. There are no legal implications to Medway Council arising directly from this report.

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Appendices

Appendix A – ICB colleague support offer

Background papers

None