

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 7th October, 2026

10.00 am

**Council Chamber, Sessions House, County Hall,
Maidstone**





AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 7th October, 2026, at 10.00 am Ask for: **Gaetano Romagnuolo**
Council Chamber, Sessions House, County Telephone: **03000 416624**
Hall, Maidstone

Membership

Reform UK (9):	Mr R Mayall (Chair), Mr T Mole (Vice-Chair), Mr J Baker, Miss D Morton, Mrs B Porter, Mrs S Roots, Mr T L Shonk and Dr G Sturley
Liberal Democrat (2):	Mr M Brice and Mr A Ricketts
Conservative (1):	Ms C Russell
Green (1):	Mr S Jeffery
Restore Britain Kent (1):	Mr O Bradshaw
District/Borough Representatives (4):	Councillor P Cole, Councillor H Keen, Councillor K Moses and Councillor S Mochrie-Cox

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item

1. Election of Vice-Chair
2. Apologies and Substitutes
3. Declarations of Interests by Members in items on the Agenda for this meeting.
4. Minutes of the meeting held on 3 June 2026 (Pages 1 - 14)
5. Intensive Recovery Programme Update (Pages 15 - 22)
6. Update on the proposed bed reductions on Whatman Ward, Maidstone

Hospital (Pages 23 - 28)

7. Commissioning Intentions 2027/28: Engagement Findings and Finalisation (Pages 29 - 146)
8. Overview of the Kent and Medway ICB Maternity Services Transformation Programme (Pages 147 - 154)
9. Work Programme (Pages 155 - 158)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Benjamin Watts
General Counsel
03000 416814

29 September 2026

KENT COUNTY COUNCIL

Health Overview and Scrutiny Committee

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 3 June 2026.

PRESENT:

Mr R Mayall (Chair), Mr T Mole (Vice-Chair), Mr MJ Baker, Mr A Hook, Mr O Bradshaw, Mr H Rayner, Mr S Jeffery, Mr D Sian, Mrs B Porter, Mr A Ricketts, Mr Roots, Mr T Shonk, Mr S Mochrie-Cox, Mr M Paul and Mr P Cole.

ALSO PRESENT:

Mr R Yates.

IN ATTENDANCE:

Mr Dominic Cox (Deputy Chief Commissioning Officer), Mrs Claire Robson (The Company Secretary of the Kent and Medway Integrated Care Board) Mrs Rebecca Fox (Director of Quality and Deputy Chief Nurse), Mrs Rose Waters (Service Director for Forensic and Specialist Directorate) Mrs A Taylor,

UNRESTRICTED ITEMS

Apologies and Substitutes

(Item 1)

1. Apologies were received from Mrs C Russell (substituted by Mr H Rayner), Dr G Sturley (substituted by Mr M Paul), Mr A Kibble (substituted by Mr D Sian) and Mr M Brice (Substituted by Mr A Hook) and Mrs Keen.
2. Mr R Gotham (Healthwatch) was in virtual attendance.

RESOLVED that the apologies and substitutions be noted.

Declarations of Interest by Members in items on the agenda

(Item 2)

1. Mr Mochrie-Cox declared that he was Gravesham Borough Council's representative at the Integrated Care Partnership that oversees the Integrated Care Board (ICB) work.
2. During Item 6 Mr Hook declared that his professional work occasionally involved individuals receiving mental health care and he would therefore not participate in the debate.

RESOLVED that the declarations of interest be noted.

Minutes of the meeting held on 2 April 2026

(Item 3)

RESOLVED that the minutes of the meeting held on 2 April 2026 were a correct record and that they be signed by the Chairman.

Structural Changes to NHS Kent and Medway Integrated Care Board (ICB)

(Item 4)

Mr Dominic Cox (Deputy Chief Commissioning Officer), Mrs Claire Robson (The Company Secretary of the Kent and Medway Integrated Care Board) and Mrs Rebecca Fox (Director of Quality and Deputy Chief Nurse),

- 1) The Committee received the report outlining the structural changes to the NHS Kent and Medway ICB Mr Cox introduced the item, which included the following key points:
 - a) The purpose of the structural change was to enable a more strategic approach to commissioning services at both national and local levels. The revised structure would aim to support a more proactive and outcome-focused approach in the future.
 - b) A greater consideration would be given to inequalities and population needs, and how these would be addressed with the move towards a more clinically led model of commissioning. There would be increased engagement with partners.
 - c) The new model created more opportunities for joint working between the NHS and councils, including commissioning arrangements.
 - d) The transition involved organisational and restructuring changes providing opportunities for staff to move to different organisations, supporting an

improved integration of services, staff would be supported throughout the changes.

- e) Members were advised that some elements of the transition (including shared services such as procurement and digital) would not be fully established by 1 July.
- f) The programme had operated as a transitional initiative but would now become the general operating model. Appropriate oversight would be maintained through the Integrated Care Board governance arrangements.

2) In response to questions and comments from Members, the following points were noted:

- a) Further clarification was sought regarding the extent to which integration with local authorities had been considered within the proposals, as the report had referenced only limited collaboration.
- b) Members discussed issues relating to inequalities, noting that in addition to health inequalities, there were wider inequalities that required consideration. Clarification was sought on how the organisation intended to manage and reduce these inequalities.
- c) Additional questions discussed the approach to collaborative working with local authorities. Concerns were expressed about the current approach, including previous experiences of joint working, the pooling of budgets, and instances where there had been a lack of clarity over responsibilities. Additional points raised discussed how accountability would be maintained and whether sufficient safeguards would be in place before progressing further pooled budget arrangements.
- d) Mr Cox acknowledged the points raised and outlined that partnership working with local authorities remained an important priority. Work would be ongoing to address inequalities through collaboration, although the specific approaches and arrangements discussed would continue to develop over time.
- e) Referring to the development of neighbourhood health arrangements across Kent and Medway, Mr Cox outlined a proposed model and how it would be structured around different layers of care of delivery.
- f) Mr Cox outlined the proposed commissioning structure within the model, noting that this would include arrangements for primary care. He explained that single neighbourhoods would comprise groups of general practices operating within defined geographical areas, while multi-neighbourhood arrangements would cover larger populations of approximately 250,000

residents or more. It was further discussed that the final tier of the model related to acute care services.

- g) In response to further Members questions, aspects such as neighbourhood working would be central to tackling health inequalities and wider determinants, with local authorities already progressing related work and collaboration essential for effective delivery.
- h) The approach aimed to shift services towards prevention, early intervention and community-based provision, in line with longstanding ambitions to reduce reliance on acute care. In response to earlier queries, the Mr Cox confirmed that a commissioning policy had been developed with a renewed emphasis on joint commissioning.
- i) Members were advised that partners would review previous arrangements to identify effective practice, improve future joint working and any potential opportunities through the Better Care Fund. The importance of maximising the impact of shared resources and the commitment to ongoing partnership working to support delivery of the strategic approach was discussed as a priority.
- j) Mr Cox acknowledged that, historically, some processes had not been undertaken as effectively as intended, particularly in relation to engagement and commissioning timelines. Members were advised that a revised approach would be implemented to ensure earlier and more proactive engagement with partners, providers, local authorities and communities took place.
- k) In addition, Mr Cox explained that the new approach would enable commissioning discussions to begin significantly earlier and allow greater opportunity for collective input and challenge. It was further highlighted that this represented the clear expectations from senior leadership and the Board.
- l) In response to concerns regarding governance and accountability, Mr Cox clarified that the Integrated Care Board operated within a formal accountability framework, with oversight from NHS England and, following national changes, continuing accountability to the Department of Health. He emphasised that the organisation was subject to clear lines of scrutiny and could not act independently without accountability.
- j) Mr Cox acknowledged that neighbourhood plans had been submitted to meet national deadlines before full engagement had taken place, noting that these were not final and would continue to develop. Presenters confirmed that there would be further opportunities for collaboration and that the improvement of engagement with partners and communities remained a priority as the plans would continue to develop.

- k) Members raised concerns regarding the scale of historic financial pressures and referred to previous discussions where deficits in excess of £40 million had been identified. It was questioned how the current report addressed the prevention of any similar financial positions arising in the future.
- l) It was acknowledged that the financial position had related to previous historic discussions and Members were assured that work was underway between the Integrated Care Board and the Council to resolve and rectify the situation. It was agreed that the comments and concerns raised would be recorded in the minutes as was the request that future reports for greater financial clarity.
- m) Questions were raised on the lack of patient experiences captured within the paper with additional concerns raised on the benefits and dis-benefits that could possibly occur. Mr Cox responded that the changes had been driven by national requirements and would result in a reduction in headcount however, the primary intention would be to change the way services operated in the future, with a focus towards a more integrated delivery withing teams.
- n) Additionally, Mrs Fox highlighted that the move to a more strategic commissioner model would enable an improved and greater understanding of the patient's experience, including accessibility and the quality of care provided.
- o) A key role of the quality team would be to monitor the experience of individuals accessing the service and to ensure providers would be held to account for delivering high-quality care and Mrs Fox confirmed that the current process for assessing patient experience and holding providers accountable would continue.
- p) Mrs Fox confirmed that, while there had been a requirement to reduce headcount within the ICB, staff who had been transferred out of the organisation had done so under protected employment arrangements and would not be at risk of redundancy. It was highlighted that individual provider organisations would manage their own workforce processes separately.

RESOLVED that the Committee note the report.

Changes made to Commissioning Fertility Treatments in Kent and Medway

(Item 5)

Mr Dominic Cox (Deputy Chief Commissioning Officer) and Mrs Rebecca Fox (Director of Quality and Deputy Chief Nurse) were in attendance of the item:

- 1) The Committee received the report outlining the changes to commissioning fertility treatments in Kent and Medway.
 - a) NHS Kent and Medway had reviewed its policy on NHS-funded treatment and implemented changes on 1 April, 2026. The Committee was advised that the revised policy was based on clinical evidence and had been subject to public engagement, with feedback considered as part of the process.
 - b) It was discussed that the changes aligned with national trends, with approximately 69% of all Integrated Care Boards having introduced similar amendments.
 - c) Mr Cox acknowledged that planned communication with Members prior to the decision had not taken place and confirmed that engagement had been intended but did not occur and expressed regret for the oversight.
 - d) The changes to the Policy would deviate further away from the current NICE (National Institute for Health and Care Excellence) guidelines. Mrs Fox outlined the rationale for the changes, noting that they were made within an established commissioning framework and based on evidence relating to clinical effectiveness, outcomes and equality impact.
 - e) Members were advised of the key changes to NHS-funded fertility treatment policy:
 - i) reduction in the upper age limit for eligibility from 40 to 38
 - ii) reduction in the number of funded treatment cycles
 - iii) reduction in the number of embryo transfers. .
- 2) Members raised the following points:
 - a) Concerns were raised on the lack of information depth captured in the papers provided. Members expressed alarm regarding the process by which the changes had been implemented, noting that the decision appeared to have been taken following engagement and was contrary to any feedback received from the public.
 - b) Members commented on the perceived imbalance between clinically led decision-making and community input, noting that the impact of the changes on residents was substantial and that the revised policy did not align with NICE guidelines, representing a significant departure from recommended standards.

- c) The reduction of both the age threshold and the number of funded cycles /transfers went beyond what would be expected if based solely on clinical evidence. Members suggested that the combined changes could limit access to treatment and create a negative perception that the decision had been driven by cost-saving measures rather than clinical needs.
- d) Members questioned if changes to the IVF treatment impacted individuals on lower incomes disproportionately, potentially increasing inequality and suggested that the combined changes to eligibility and treatment offer should be subjected to greater scrutiny. Additional clarification on adequacy of consultation and the consideration of impacts on affected families was also raised.
- e) Presenters acknowledged the concerns raised and discussed the fertility effectiveness data had indicated that there was a significant decline in IVF success rates due to increasing age, measured by live births per embryo transfer. It was discussed that success rates were approximately 40% at age 35, reducing to around 20% at age 40, and less than 10% at age 42, which was within the age ranges referenced by NICE guidance.
- f) Members challenged the clinical justification for the revised age threshold, noting that the data presented did not clearly demonstrate a significant drop-off in outcomes specifically at age 37. Members raised that available evidence had typically grouped outcomes into broader age cohorts, making it difficult to validate the rationale provided, particularly given the limited supporting detail in the submitted report to the Committee.
- g) Other concerns included that the report, which had been issued shortly after implementation of the decision, did not provide sufficient detail to support effective scrutiny. Members suggested that future reports should more clearly set out the basis for decision-making. Members also queried the extent to which decisions were informed by patient need, clinical evidence, or financial considerations.
- h) It was suggested that the report lacked detail on the financial considerations underpinning the decision and that this had not been clarified in responses. Clarification was sought on the estimated impact and whether this related to specific eligibility changes or the wider policy. The report did not clearly quantify or communicate the anticipated savings and had limited the Committee's ability to fully scrutinise the basis for the decision.

- i) Members also requested that more comprehensive data be captured, including previous birth figures, projected impacts on future births, and the associated financial implications.
- j) Mrs Fox clarified that an engagement activity with service users was undertaken in advance of the change, rather than a formal public consultation. Mr Cox confirmed that this had been conducted in line with the relevant requirements, but apologised again for not notifying the Committee in advance.
- k) Members of the Committee raised concerns that the decision introduced three substantive reductions in service, relating to age eligibility, number of cycles and number of embryo transfers. They also remained unclear on the impact on low-income families and same sex couples whose eligibility was already significantly challenging in terms of criteria and cost.
- l) Mr Cox confirmed that feedback from the Committee would be reflected upon and emphasised that, while engagement could be strengthened, the decision had been based on available evidence and was not taken with adverse intent, reaffirming a commitment to working constructively with Members going forward

3) Mr Jeffery proposed, and Mr Hook seconded, the motion that:

The Committee submit a call-in request to the Secretary of State for Health and Social Care about the decision to change the NHS funded IVF fertility treatment offer for Kent and Medway residents.

The motion was put to the vote and was carried.

RESOLVED that the Committee submit a call-in request to the Secretary of State for Health and Social Care about the decision to change the NHS funded IVF fertility treatment offer for Kent and Medway residents.

Bedgebury Ward and Proposed Service Redesign

(Item 6)

Mr Dominic Cox (Deputy Chief Commissioning Officer) and Mrs Rose Waters (Service Director for Forensic and Specialist Directorate) presented the item:

- 1) Mr Cox introduced the item, which was about a proposed pathway redesign which would see Bedgebury Ward in Maidstone decommissioned. The officer

explained that a recent review had identified that the existing model was not aligned with national expectations for rehabilitation and was not delivering the most appropriate outcomes for service users and their families.

- 2) Mrs Waters provided further detail, noting that Bedgebury Ward was a 10-bed unit located within a medium secure setting, which limited its effectiveness as a rehabilitation environment.
- 3) Members were advised that:
 - a) The proposal was to redirect resources towards a more proactive, community-based model of care, including assertive outreach and more intensive multidisciplinary support, in line with recognised best practice.
 - b) The unit had opened in 2016 but had not been fully utilised as part of a typical rehabilitation pathway and was not regarded as a high-quality setting. Admissions and transfers to the unit had already been paused, reflecting concerns about its suitability.
 - c) Additionally, the unit's location had limited opportunities for patients to reintegrate into the community, including maintaining contact with family and social networks, which were key components of a successful and effective rehabilitation.
 - d) The established Forensic Outreach and Liaison Services (FOLS) would be supporting patients on discharge pathways from secure settings. Discharge planning had involved partnership working with local authorities, including care needs assessments and panel considerations, with a range of outcomes identified based on individual need, such as supported or independent living, rehabilitation units, or residential care options.
 - e) There were currently five patients within the Bedgebury unit. All five patients were on established discharge pathways and would not require the new assertive outreach provision. Discharge planning was progressing appropriately. It was anticipated that all patients would be discharged by early 2027.
 - f) The Committee was informed that the proposal was to reinvest resources into community-based support, including the development of an assertive outreach service to support patients transitioning from secure settings to the community.
 - g) The new model aimed to:
 - i) provide care closer to home

- ii) improve rehabilitation outcomes
- iii) reduce reliance on inpatient step-down beds
- iv) better align with national clinical models and best practice.

4) In response to questions and comments from Members, the following points were noted:

- a) Members queried how patients would be supported during the interim period between the cessation of admissions to the Bedgebury unit and the implementation of the new community-based arrangements in the Autumn, seeking assurance that appropriate care would be maintained during this transition. Mrs waters confirmed the individuals would continue to be supported by the FOLS team.
- b) In response, Members were advised that that resources would be reinvested into a community-based model, including multidisciplinary and assertive outreach support, as the current service was not aligned with best practice.
- c) Officers emphasised that this represented a redesign rather than a reduction in service, aimed at improving integration and patient outcomes. The number of patients affected was small and issues with the current model, including its suitability and location, had informed the proposed changes.
- d) Additional queries were raised on the assessment of impacts arising from the proposed change. Further clarification was sought on the potential impact on local authorities, referencing earlier comments in the meeting.
- e) Members expressed concerns that insufficient information was available to fully assess the implications and that the proposal should be treated as a substantial variation due to the current uncertainty regarding its impacts. They asked for clearer and more definitive information on resources and finances.
- f) Officers responded to concerns that the specific areas may become disenfranchised by the removal of specific provisions and explained that multiple sites of rehabilitation were present throughout the County.
- g) Members considered that there was a lack of patient experience and engagement in the presented paper. Officers acknowledged the concern and suggested this aspect be presented in a returning paper.
- h) The Committee discussed patient outcomes and transition arrangements, a number of patients had already been discharged over recent months and years with positive outcomes.

- i) Remaining patients had been progressing well, and many were already on extended trial leave and benefiting from community placements. Currently there was no indication that remaining patients would need to return to inpatient care.
 - j) Officers responded to questions from Members regarding how a redistribution of resources and investment into community resources could be an overall better model. Officers referred to national evidence which indicated that such approaches could lead to improved outcomes for individuals' rehabilitation and recovery and that the intention was to utilise existing investment more effectively by reallocating resources to areas where they could have a greater impact.
 - k) The importance of strengthening community-based services was highlighted. The officer acknowledged that, as services shifted further into the community, there would be a need to ensure sufficient capacity and capability to manage increased demand. It was noted that this consideration would form a key part of the ongoing work to implement the model.
 - l) A Member questioned the proportion of bed discharges that had required rapid readmission within 12 to 24 months, including through crisis team interventions or Accident and Emergency attendance, and sought clarification on how these outcomes would be monitored in the context of any decommissioning. Officers acknowledged that the data was not available at this time.
- 5) Mr Rayner proposed, and Mr Jeffery seconded, the motion that:
- a) the Committee deem the Bedgebury Ward pathway redesign as a substantial variation of service, and
 - b) that the NHS, Kent and Medway representatives be invited to attend the Committee and present an update at an appropriate time, including the information requested regarding the proportion of bed discharges that had required rapid readmission within 12 to 24 months, including through crisis team interventions or Accident and Emergency attendance, and sought clarification on how these outcomes would be monitored in the context of any decommissioning

The motion was carried by majority vote.

RESOLVED that:

- a) the Committee deem the Bedgebury Ward pathway redesign as a substantial variation of service, and

- b) that the NHS, Kent and Medway representatives be invited to attend the Committee and present an update at an appropriate time, including the information requested regarding the proportion of bed discharges that had required rapid readmission within 12 to 24 months, including through crisis team interventions or Accident and Emergency attendance, and sought clarification on how these outcomes would be monitored in the context of any decommissioning.
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Meningitis B Outbreak Response

(Item 7)

Mr Dominic Cox (Deputy Chief Commissioning Officer) and Mrs Claire Robson (The Company Secretary of the Kent and Medway Integrated Care Board)

- 1) The Committee received a report about the response to the recent Meningitis B outbreak, and Mr Cox highlighted the following aspects of the report:
 - a) a coordinated local response had been delivered in March 2026 involving Kent County Council, the NHS, UK Health Security Agency, education providers and the venue concerned. It was highlighted that strong collaboration had enabled effective management of the incident.
 - b) A declaration of a major incident and activation of the NHS's role as a Category 1 emergency responder and had resulted in the swift implementation of a mass antibiotic prophylaxis programme and vaccination response.
 - c) Responses had been clinically led with strong joint leadership from the Council and NHS, ensuring it was safe and evidence based. Additionally, the response had been rapid, well-coordinated and supported by proactive communication. Approximately 13,500 antibiotic treatments and 12,000 vaccinations delivered across multiple sites, and the overall scale and effectiveness of the mobilisation were highlighted as positive, proactive and organised.
 - d) Officers discussed areas for improvement, including the need to strengthen coordination between local and national partners in the event of a future incident. Further discussion raised that workforce resilience required further consideration, as responses of a large scale could place significant pressure on a small number of staff. Ongoing reflections were being undertaken across the NHS and partner organisations to address the challenges encountered.
- 2) Members responded to the report with the following:

- c) They raised concerns that the East Kent Hospitals University Foundation Trust was not present at the Committee to discuss the incident. Concerns on how long it took the organisation to flag the incident and how other organisations were also not present to discuss their role in the incident.
- d) Members raised that awareness of the meningitis outbreak among students appeared to have arisen only after a video circulated showing an emergency response, rather than through formal communication and expressed worries regarding the timeliness and urgency of the University's response and if there had been shortcomings on how the incident was communicated.
- e) Conversely, Members praised the speed in which KCC and the administration had dealt with the incident and it was discussed that the recommendation go beyond noting the report by formally recognising the efforts of those involved in delivering the response, and by recording the Committee's sympathies for the friends and families of the individuals who had died, as well as those affected by the incident
- f) Following a question, officers confirmed that a formal debrief was either underway or pending to identify lessons learned and address gaps, noting the complexity of multi-agency coordination and information-sharing constraints.
- g) Additionally, it was discussed that social media had supported the official response through community awareness, and that Members sought reassurance on whether the overall outcome reflected system effectiveness or favourable circumstances.
- h) In response Mr Cox explained that the UK Health Security Agency (UKHSA) review was understood to be in progress, though its status was not yet confirmed.
- i) It was discussed that factors such as the timing of the incident during the academic term and the movement of students between campus and home had been considered as part of the response and had presented additional challenges for managing and communicating the situation.
- j) A motion was proposed by the Chair that the Committee's recommendation be amended to formally thank the teams who delivered the response and to record the Committee's sympathies with the friends and families of the two individuals who had died, as well as those who had suffered as a result of the incident.

RESOLVED that the Committee:

- a) note the report
 - b) formally thank the teams who delivered the response,
 - c) express its sympathy with the families and friends of the two people who had died and all those affected by the incident.
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END

Item 5: Intensive Recovery Programme Update

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 7 October 2026

Subject: Intensive Recovery Programme Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the East Kent Hospitals University NHS Foundation Trust.

1) Introduction

- a) In March 2026, the Health and Social Care Secretary placed EKHUFT into the NHS Intensive Recovery Programme (IRP), whose aim is to deliver sustainable step change.
- b) EKHUFT is one of only five trusts in the IRP, reflecting the seriousness of the challenges it faces. The Trust has delivered several improvement but more needs to be done to achieve the progress required.

2) Recommendation

- a) RECOMMENDED that the Committee consider and note the report.

Background Documents

None.

Contact Details

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East Kent Hospitals Update for Health Overview and Scrutiny Committee
Intensive Recovery Programme: October 2026

1. Purpose

- 1.1 To provide an update to HOSC on the Trust's actions after being placed in the NHS England Intensive Recovery Programme (IRP).

2. Background

- 2.1. East Kent Hospitals University NHS Foundation Trust (EKHUFT) has five hospitals: three Acute Hospital sites (William Harvey, Ashford; Queen Elizabeth The Queen Mother, Margate; Kent and Canterbury, Canterbury), and two Community Hospitals (Buckland Hospital, Dover; Royal Victoria, Folkestone).
- 2.2. In March 2026, Health and Social Care Secretary Wes Streeting placed EKHUFT into the NHS Intensive Recovery Programme (IRP). EKHUFT is one of only five trusts in the IRP, reflecting the seriousness of the challenges it faces. The Trust has undergone many improvement initiatives over the past decade, and delivered many improvements. Yet challenges remain and the Trust needs to go further to deliver the sustainable improvement required.
- 2.3. The aim of the IRP is to deliver sustainable step-change, informed by lessons from previous improvement work, that's trust-owned – and with aligned and streamlined support and oversight.
- 2.4. The IRP began with a statement of the Trust's challenges and their causes, informed by existing reviews and diagnostic work, covering all aspects of its work to provide high quality, safe, effective care for the people it serves, while being financially sustainable.
- 2.5. The next step is to develop – then deliver – an integrated IRP recovery programme and improvement plan that covers immediate stabilisation work, in-year recovery, and wider/long-term system strategic change – with short-term, 26/27 year-end and 27/28 year-end milestones and metrics.
- 2.6. It is important to identify and resolve long-standing issues sustainably in the Trust, and also as part of the wider Kent and Medway system. Partnership working as an alliance and through collaboratives is a key element of the improvement plan.

- 2.7. An integrated improvement plan that addresses these challenges is being developed. In the meantime, four short term improvement priorities have been agreed, with senior responsible officers – an executive director and a non-executive director - in place and leading each one. They comprise:
- Maternity and neo-natal improvement programme
 - Emergency Department pressure reduction
 - Financial performance and Cost Improvement Plan development
 - Strategy development

3. Governance and leadership

- 3.1 In April, NHS England imposed additional conditions on the Trust's licence under section 111 of the Health and Social Care Act, which particularly focus on the stability of the Trust's Board of Directors at a time when so much needs to be delivered. This means tighter scrutiny from regulators so they, partners and patients, can be assured that the Trust is working effectively to improve patient care in East Kent.
- 3.2 The Trust's Board is working even more closely with its regulators, particularly NHS England, and its commissioners to ensure it is leading well and its governance (practices, rules and performance) is as robust as possible; something all organisations need, particularly large ones with multiple sites and complexity.
- 3.3 We have appointed a substantive chair, and the process to recruiting a substantive Chief Executive is also being progressed. We are also recruiting substantive Non-Executive Director posts, having recently appointed three interim Non-Executive Directors. The Trust is also receiving support on leadership including a Board development programme.

4. Maternity and neo-natal improvement programme

- 4.1 The Trust is one of the 12 trusts that were chosen to take part in the Baroness Amos review, as a trust where a previous investigation had taken place. The report identified a number of positive changes within our maternity service since the publication of Dr Bill Kirkup's 'Reading the signals' investigation in 2022 – this included the CQC to rate services as 'good' at both William Harvey Hospital and QEQM Hospital, in 2025. It also describes concerns raised by families and staff that the Trust fully acknowledges and is responding to.
- 4.2 There were extensive improvements made during the first three years of the Maternity and Neonatal Improvement Programme (MNIP) and this current phase ends in October 2026. MNIP phase 2 has been coproduced and agreed and will begin in October 2026, carrying over any unfinished actions from the first programme. The recommendations for recent reviews and concerns underpin the four workstreams (People and Culture; Quality and Safety; Clinical pathways and person centred care; Infrastructure and digital) to ensure improvements required are captured.
- 4.3 The Trust has commissioned an external independent review of intrauterine deaths and early learning has already informed actions to improve awareness of reduced



foetal movements, access to care and triage responsiveness. A report is due to be published shortly.

- 4.4 Workforce recruitment is improving, there has been significant progress in midwifery recruitment and a strong pipeline of applicants. Wider system issues have affected the workforce, including changes to bank rates, and the Trust is reviewing this while also maintaining constructive engagement with staff.
- 4.5 Estates and service development issues have been identified, including delays to antenatal education provision, completion of CQC environmental actions and reconfiguration of the William Harvey Hospital triage area. These are expected to be resolved later in year.

5. Emergency Department pressure reduction

- 5.1 Corridor care is defined by NHS England as patients receiving clinical care for 45 minutes or more in non-designated, inappropriate areas (e.g., hallways, waiting rooms) of emergency departments or acute wards. It compromises safety, lacks dignity for patients and is demoralising for staff. We recognise that it is a challenge across our hospitals and not just our Emergency Departments – for example, strengthening the support to wards and discharging teams, in discharging patients who no longer need to be in an acute hospital to free up more beds.
- 5.2 The Trust has been working with NHS England's Getting it Right First Time (GIRFT) team at QEQM and William Harvey (WHH) hospitals for some months - the focus includes improving our four-hour, 12-hour and 24-hour performance. Improvement work has seen a range of operational and cultural changes embedded, plus positive system working across partners, including collaboration between acute, community and mental health teams.
- 5.3 In January, an average of almost 46 people a day were cared for in non-care spaces within our emergency departments, for a total of almost 20,700 hours throughout the month. By May, this had reduced to an average of 38 patients a day across both WHH and QEQM, and the total hours they spent in non-care spaces was down more than 70 per cent to a total of 6,130. The teams have broadly maintained those numbers throughout June and July, and into August.
- 5.4 The new Same Day Emergency Care (SDEC) units at QEQM and WHH are opening to patients this month. The SDEC units allow acute specialists to assess, diagnose and treat patients on the same day of arrival who would otherwise have been admitted to hospital. Under this care model, patients attending hospital with certain conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.
- 5.5 Further progress is dependent on support from system partners, particularly local authority services, community and mental health partners, and the Trust is preparing for winter pressures by continuing to focus on this area and work with key commissioners, partners and providers.



6. Financial performance

- 6.1 The short-term improvement priority is improving grip and control, particularly in relation to pay expenditure, and in developing and delivering the necessary savings required through the Cost Improvement Programme, including through productivity improvements. Enhanced pay controls have been implemented, including a vacancy freeze and measures to reduce reliance on temporary staffing, to support delivery of the financial plan.
- 6.2 The Trust has a CIP target of £76m for 2026/27 but is working to an internal stretch target of £90m to provide some headroom for the associated costs of delivering the programme and support delivery of the overall financial plan. The Trust has developed risk-adjusted plans covering the full £76m. The current focus is on delivery with progress and risks being closely monitored through established financial governance arrangements.
- 6.3 Medium term planning is also underway, with the objective of returning the Trust to financial balance by 2029/30. This will require sustained financial discipline, robust financial governance, effective cost control and delivery of recurrent efficiencies over the medium term.

7. Strategy development

- 7.1. The Trust is developing an organisational strategy to set out what our long-term future will look like and how we will continue to improve our services, including a clinical strategy. The key aims and priorities of the strategy include:
- **Improve quality, safety and access to care** – Safer, higher-quality care with better outcomes and more timely, reliable access.
 - **Reduce health inequalities** – More equitable access, experience and outcomes, with greater focus on communities facing the greatest inequalities.
 - **Transform how and where care is delivered** – More joined-up care, with prevention and care closer to home alongside strong acute and specialist services.
 - **Build sustainable services and workforce** – Resilient services and workforce, enabled by technology, innovation, infrastructure and financial sustainability.
 - **Strengthen partnership working** – Working with partners to improve pathways, reduce inequalities and deliver wider benefits for East Kent and Kent & Medway.
- 7.2. The strategy will support delivery of the Trust's Integrated Improvement Plan, and the ambitions set out in the NHS 10 Year Health Plan and the Kent and Medway five-year strategy. This includes working with system partners to redesign pathways, strengthen prevention and deliver more care closer to home and in community settings where appropriate.



- 7.3. The Trust will also develop supporting clinical, digital, workforce and estates transformation plans, alongside its Green Plan. Together, these will underpin delivery of the Trust Strategy and set out the longer-term direction for these key areas over the next five to 10 years.
- 7.4. Any future proposals arising from the strategy will be subject to the appropriate engagement and consultation processes, where required.

8. Recommendation

It is recommended that the Committee consider and note the report.

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Item 6: Update on the proposed bed reductions on Whatman Ward, Maidstone Hospital

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny
To: Health Overview and Scrutiny Committee, 7 October 2026
Subject: Update on the proposed bed reductions on Whatman Ward, Maidstone Hospital

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Maidstone and Tunbridge Wells NHS Trust.

1) Introduction

- a) The purpose of this report is to provide an update on the proposed bed reductions on Whatman Ward at Maidstone Hospital, and the impact upon potentially affected staff. Whatman Ward is a 21-bedded facility which provides geriatric and acute frailty care.
- b) The current plan has delayed the reduction in bed capacity by two weeks and is designed to proceed in several phases. The first bay closure is planned for the end of week commencing 12th October 2026. It is expected that one bay per week will be closed thereafter, with a scheduled full closure of Whatman Ward by 6 November 2026.

2) Recommendation

- a) RECOMMENDED that the Committee note and comment on the report.

Background Documents

None.

Contact Details

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**Kent County Council
Health Overview and Scrutiny Committee**

7th October 2026

**Maidstone and Tunbridge Wells NHS Trust
Update on the proposed bed reductions on Whatman Ward,
Maidstone Hospital.**

Report from: Rachel Jones, Director Strategy, Planning & Partnerships
Dr Nick Bagley, Deputy Chief of Service, Medicine & Emergency
Care.

1. Summary

1.1 The purpose of this report is to provide an update on the proposed bed reductions on of Whatman Ward, Maidstone Hospital, and the impact upon potentially affected staff.

2. Recommendations

2.1 The Committee is asked to note and comment upon the update provided.

3. Context and Policy Framework

3.1 The NHS 10-Year Plan was a national document which set out the government's vision for the future of health and care in England. Its aim was to respond to rising demand, widening health inequalities and financial pressures by committing to a fundamental transformation of how services were delivered. The Plan also set the context in which all health care organisations had to operate.

3.2 A central tenant of the 10-Year plan was that care would move out of hospitals and into communities. Instead of relying on large acute centres for most services, the future model provided for neighbourhood health to become the focal point for care, and a shift from reactive to proactive care.

4. Acute and Community Care Provision

4.1 Whatman Ward is a 21 bedded facility at Maidstone Hospital, which provides geriatric and acute frailty care. These are two cohorts of patients that are a specific focus of the national policy framework.

4.2 Each day, between 120 and 150 patients in our hospitals are medically ready to leave (no criteria to reside) but remain in a hospital bed while waiting for the next stage of their care, which is often older and frail people. This has a significant impact on in-patient care, patient experience and patient flow across our hospitals.

4.3 Working with partners across Kent and Medway, we are focusing on a range of improvements designed to reduce the amount of time spent in hospital once patients no longer meet the criteria to reside and ensure patients receive care in the most appropriate setting for their needs.

4.4 This includes strengthening discharge planning via daily board rounds, senior decision making, a daily focus on what is required to support discharge for all patients who no longer meet the criteria to reside, expanding Same Day Emergency Care services and increasing the use of our virtual ward, all of which improve how patients move through hospital services.

4.5 Community service models are improved to better meet the needs of patients. Specific examples include provision of a West Kent community-based frailty service, an award-winning virtual ward service, and proactive identification and case management of the frailest patients through primary care led neighbourhood multidisciplinary teams. The work described above is making increasing use of these services and forms a core plank of ensuring patients receive the right care, in the right place at the right time in line with the national policy direction.

4.6 These models of care are a proactive move to strengthen patient care, ensure sustainable services, and build a more resilient system across health and care.

4.7 Our focus remains on providing safe, high-quality care while ensuring patients receive the right care, in the right place, at the right time. A Quality Impact Assessment has been undertaken, with several mitigation measures put into place, including a delay to the implementation of bed reductions.

4.8 Any changes to capacity are being carefully assessed and clinically led, with patient safety and quality of care remaining our priorities.

5. Proposed Closure Update

5.1 The current plan has delayed the reduction in bed capacity by 2 weeks and is planned to proceed in several phases which allows us to assess the impact and maintain safety.

5.2 The first bay closure will be planned for the end of week commencing 12th October 2026. It is expected that we will then close one bay per week thereafter, with a full closure of Whatman Ward planned by Friday 6th November 2026.

5.3 This will be reviewed and impacts monitored as each bay closes and is therefore subject to change to ensure we maintain safety and quality of service provision.

6. Staffing Implications

6.1 A 30-day formal staff consultation commenced on 24th July and closed on 22nd August.

6.2 As part of the consultation; and without prejudice of the outcome, staff were asked to submit an Expression of Interest form which details their ward and site preferences.

6.3 A 2-week extension was added to the end of the consultation to give time to review the staff feedback. Following this, the bed reduction plans have been put back until the middle of October and will be phased to assess the impact on patient safety and with quality indicators being reviewed as each bay is closed.

6.4 The formal outcome was communicated to staff on 14th September 2026.

6.4 All affected staff will be offered re-deployment, with our primary goal to accommodate their preferred option.

6.5 Redeploying staff will improve our staffing rates across our beds and will support safer staffing and staff well-being.

Lead officer contact

Rachel Jones Executive Director Strategy Planning & Partnerships
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Item 7: Commissioning Intentions 2027/28: Engagement Findings and Finalisation

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 7 October 2026

Subject: Commissioning Intentions 2027/28: Engagement Findings and Finalisation

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the NHS Kent and Medway Integrated Care Board (ICB).

1) Introduction

- a) The NHS Kent and Medway Commissioning Intentions 2027/28 set out the ICB's strategic, commissioning priorities for local health and care service provision, and represent a key mechanism for translating the Five-Year Strategy and Three-Year Commissioning Plan into delivery.
- b) The Commissioning Intentions describe a planned shift towards prevention, population health, neighbourhood-based care and strategic commissioning. This system is supported by the Kent and Medway 'four layers of care' model which describes a single, coherent healthcare offer organised across four interdependent layers: primary care, single neighbourhood care, multi neighbourhood care and acute hospital care.
- c) The purpose of this report is to provide HOSC with an overview of the engagement undertaken, and to seek the Committee's support for the direction of travel from strategy to the delivery of local health and care services in 2027/28.

2) Recommendation

- a) RECOMMENDED that the Committee:
 - 1. Note the findings from the engagement undertaken on the draft Commissioning Intentions 2027/28, including the priorities, conditions and commissioning recommendations arising from the feedback received.
 - 2. Note that the engagement findings have informed the development of the final Commissioning Intentions.
 - 3. Note that the final Commissioning Intentions 2027/28 have now been approved by the ICB Board and system partners.
 - 4. Support the final Commissioning Intentions as the basis for delivery in 2027/28.

Background Documents

None.

Contact Details

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Report to	Health Overview and Scrutiny Committee
Meeting date	7 October 2026
Report Title	Commissioning Intentions 2027/28: Engagement Findings & Finalisation
Key question	Does the Overview and Scrutiny Committee note the findings from engagement on the finalised Commissioning Intentions 2027/28 and agree them as the basis for delivery in 2027/28?
Executive Lead	Adam Doyle, CEO NHS Kent and Medway
Author	Chris Neill, Chief Commissioning Officer NHS Kent and Medway

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 meeting is asked to: NOTE the findings from the engagement undertaken on the draft Commissioning Intentions 2027/28, including the priorities, conditions and commissioning recommendations arising from the feedback received. NOTE that the engagement findings have informed the development of the final Commissioning Intentions. NOTE that the final Commissioning Intentions 2027/28 have now been approved by the ICB Board and system partners. SUPPORT the final Commissioning Intentions as the basis for delivery in 2027/28.

Executive summary:

The NHS Kent and Medway Commissioning Intentions 2027/28 set out the ICB's strategic commissioning priorities and represent a key mechanism for translating the Five-Year Strategy and three-year commissioning plan into delivery. The Commissioning Intentions describe a planned shift towards prevention, population health, neighbourhood-based care and strategic commissioning, supported by the four-layer model of care.

The Commissioning Intentions were approved by the ICB Board on 21 July 2026 for engagement. Engagement remained open until 1 September 2026 and included online surveys, independent market research, community outreach, stakeholder submissions and direct engagement with providers, partners, voluntary, community, faith and social enterprise organisations, members of the public and patient representatives. In total, 3,343 survey responses were received, including 533 from people working in health and care or for an NHS organisation. A further 33 written responses were received from provider organisations, partners, VCFSE organisations and members of the public.

The engagement demonstrated broad support for the overall strategic direction set out within the draft Commissioning Intentions, including the focus on prevention, neighbourhood health, integrated care, care closer to home and a progressive move towards outcome-based commissioning. Feedback also identified a number of important issues which stakeholders wished to see reflected in implementation and delivery. The strongest themes included improving access to general practice and hospital services, strengthening urgent and emergency care, improving mental health support, ensuring non-digital routes remain available, supporting carers, strengthening partnership working with local authorities and the VCFSE sector, and ensuring that activity is not transferred between settings without appropriate workforce, capacity and resource.

The engagement findings also highlighted strong support for prevention and earlier intervention, greater integration across health and care services, improved communication and continuity of care, and a focus on outcomes and patient experience rather than performance measures alone. Whilst respondents were broadly supportive of transformation and care closer to home, they consistently emphasised that any changes must deliver demonstrably better care, be accessible to local communities, and be supported by sufficient workforce, infrastructure and community capacity.

The findings have informed the development of the final Commissioning Intentions and are continuing to shape subsequent implementation planning. The engagement findings and proposed changes to the final document were considered and endorsed by the ICB Board on 22 September 2026.

The purpose of this report is to provide the Overview and Scrutiny Committee with visibility of the engagement undertaken, the key themes arising from the engagement and to seek the Committee's support for the direction of travel going into the 2027/28 financial year.

Proposed next steps:

The Commissioning Intentions will form the basis for the forward plan from here.

Governance pathway to date:		
Meeting name:	Date:	Outcome:
System Leadership Group	24 th July 2026	Noted/Shared Intentions
System Leadership Group	28 th August 2026	Noted
Joint Committee	21 st September 2026	Engagement outcome and system response presented for information.
ICB Board	22 nd September 2026	Final Commissioning Intentions approved by the Board.

Contact for further information	Chris Neill, chris.neill4@nhs.net
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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 report provides an update on engagement and the development of the strategic Commissioning Intentions. Equality, quality and health inequalities assessments will be undertaken at the appropriate stage for individual commissioning decisions, pathway changes and specific service proposals arising from the Commissioning Intentions.
Conflicts of Interest
Are there any conflicts associated with authors or reporting officers? ☐ Yes ☒ No <i>If yes, please confirm how the conflict has been managed.</i>
FOI Status
Is this report disclosable under FOI? ☒ Yes ☐ No <i>If no, please specify why:</i>
Financial Implications
Are there financial implications associated with this report?

COMPLIANCE NOTES:

☐ Yes

☒ No

If yes, please describe: None arising directly from the contents of this report.

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 Commissioning Intentions are intended to support improved outcomes, reduced unwarranted variation and more preventative and integrated models of care. Quality, patient safety, safeguarding, clinical governance and the safe management of service or pathway transitions will need to be addressed through detailed implementation plans and relevant impact assessments.

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:

Extensive public, staff and stakeholder engagement has informed the development of the Commissioning Intentions. This included three survey approaches and responses from provider organisations, partners, VCSEF organisations, members of the public and patient representatives. Further involvement will be required as individual pathways, service proposals and implementation plans are developed.

A photograph of two people, a woman and a man, sitting on a blue sofa and smiling. The woman is wearing a colorful patterned hijab and a blue patterned top. The man is wearing a light blue checkered shirt. They are in a room with large windows in the background. The image is overlaid with a purple gradient at the bottom.

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

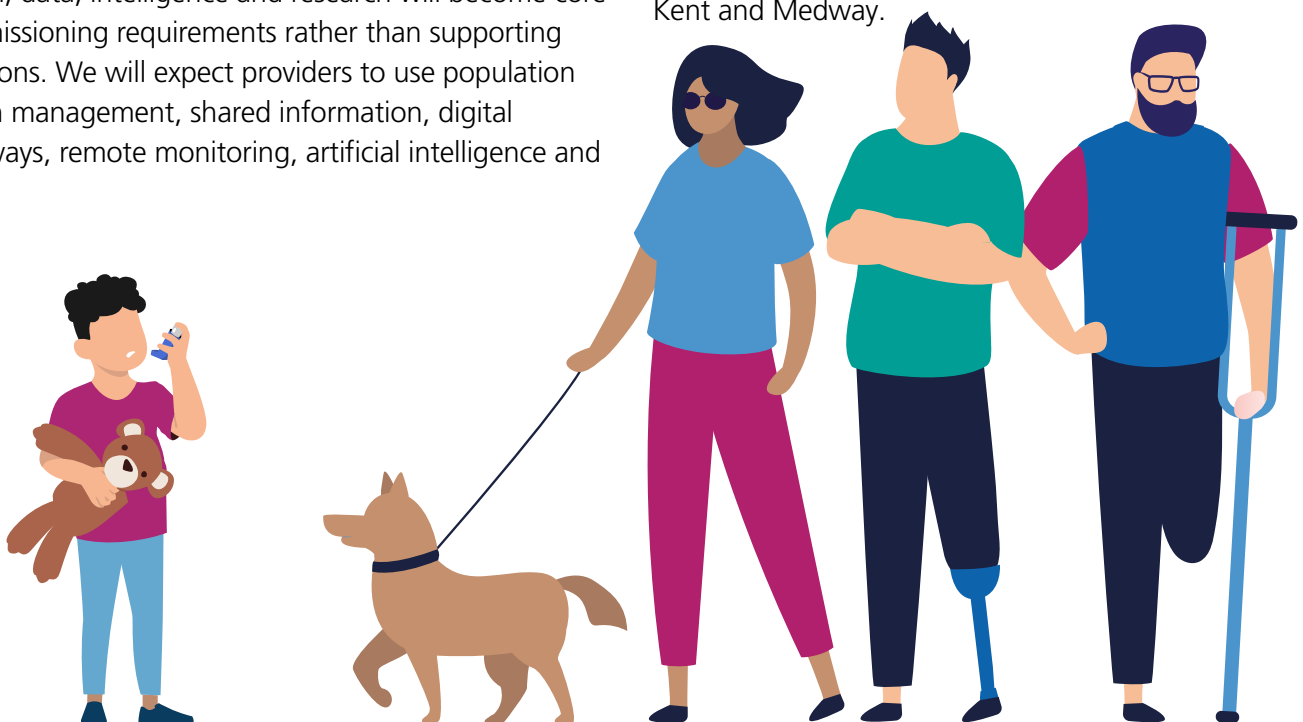
Maternity and Neonatal Investigation and wider system reviews. Commissioning will increasingly take place jointly with our local authority partners. Providers will increasingly be expected to work through the Acute and Neighbourhood Collaboratives, with greater emphasis placed on pathway performance, 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

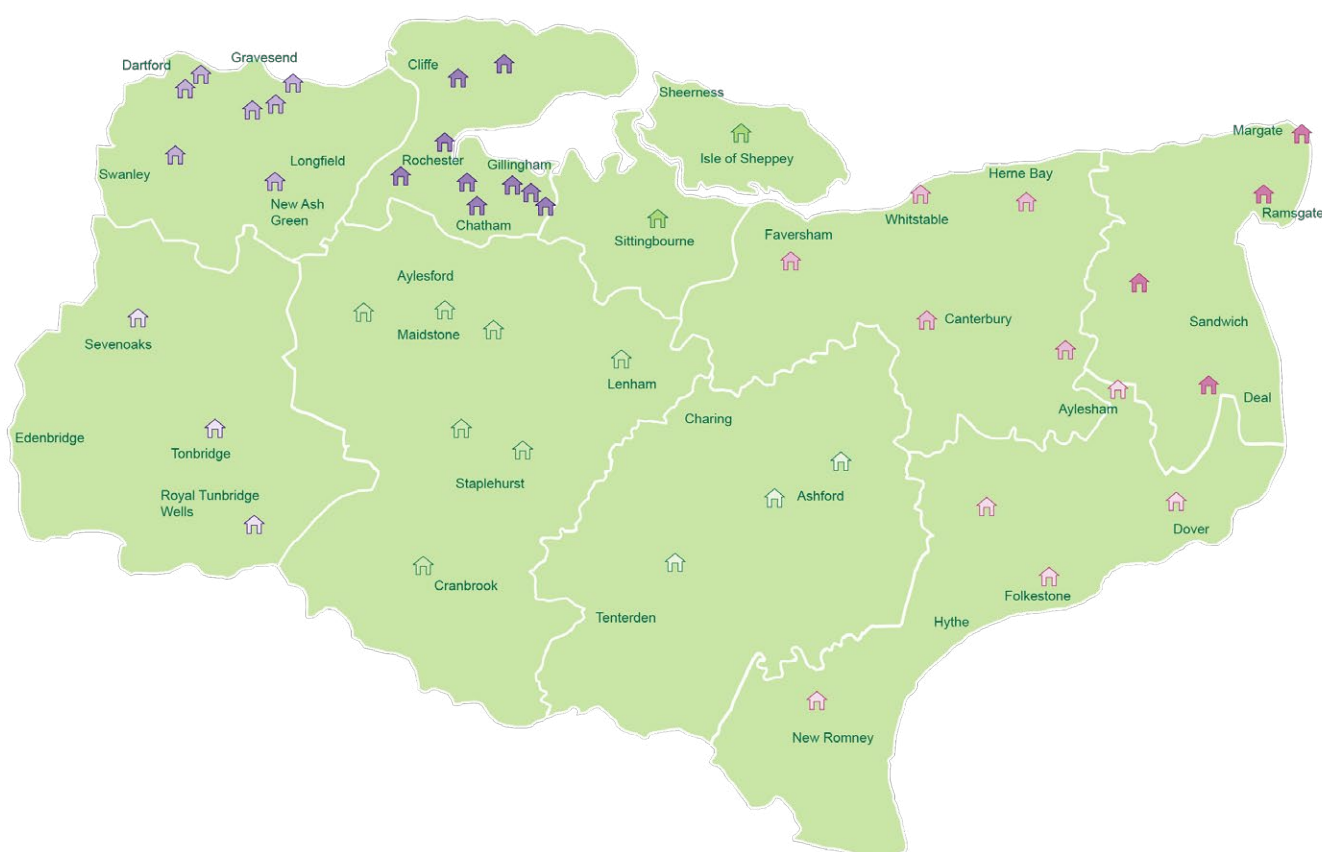
Neighbourhood health will become the principal model for proactive, integrated and preventative care delivery. 45 neighbourhoods have been identified across Kent and Medway, each broadly aligned to primary care network footprints and serving populations of approximately 30,000 to 50,000 residents.

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

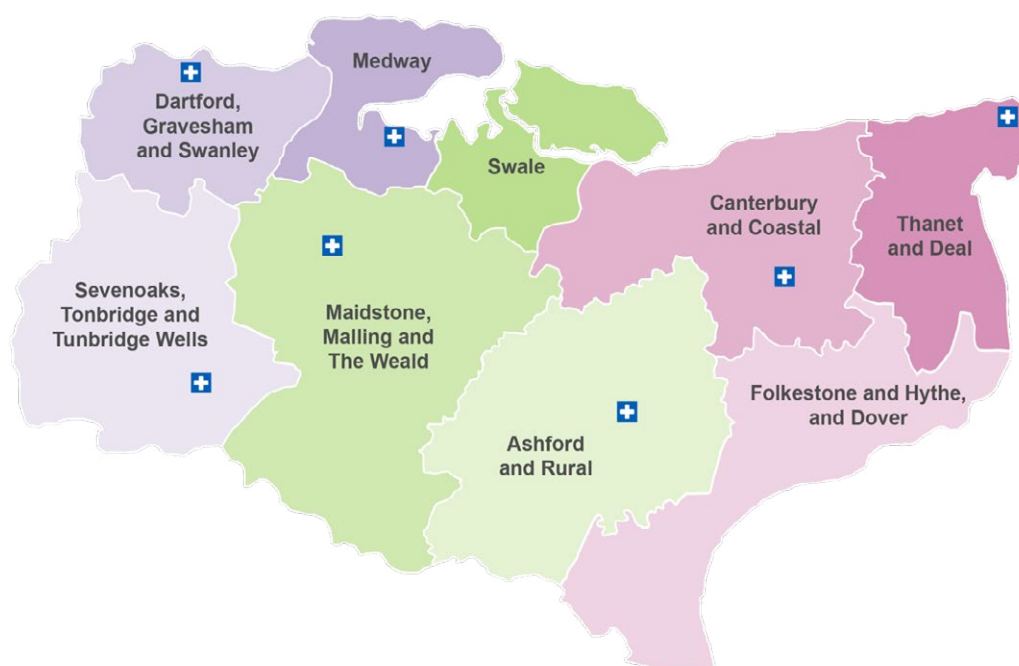
Multi-neighbourhood care will act as the bridge between neighbourhood services and hospital-based services. Nine multi-neighbourhood footprints have been established across Kent and Medway to provide the scale required to deliver integrated community and multi-neighbourhood care services whilst maintaining 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, Maidling 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.

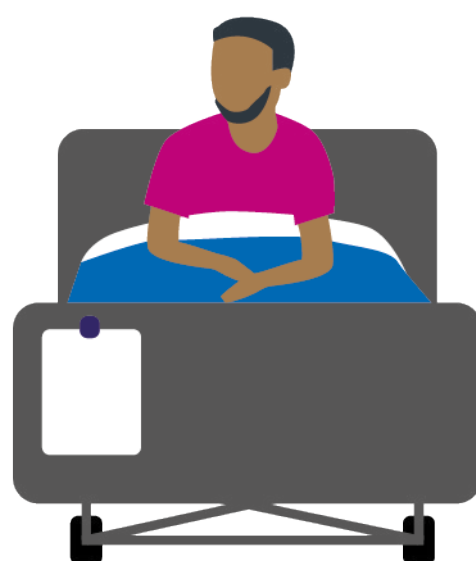
Traditional service models, organised around individual organisations or individual diseases, are no longer sufficient. The future health of the population depends upon commissioning integrated models of care that focus on people rather than organisations, prevention rather than reaction and proactive 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

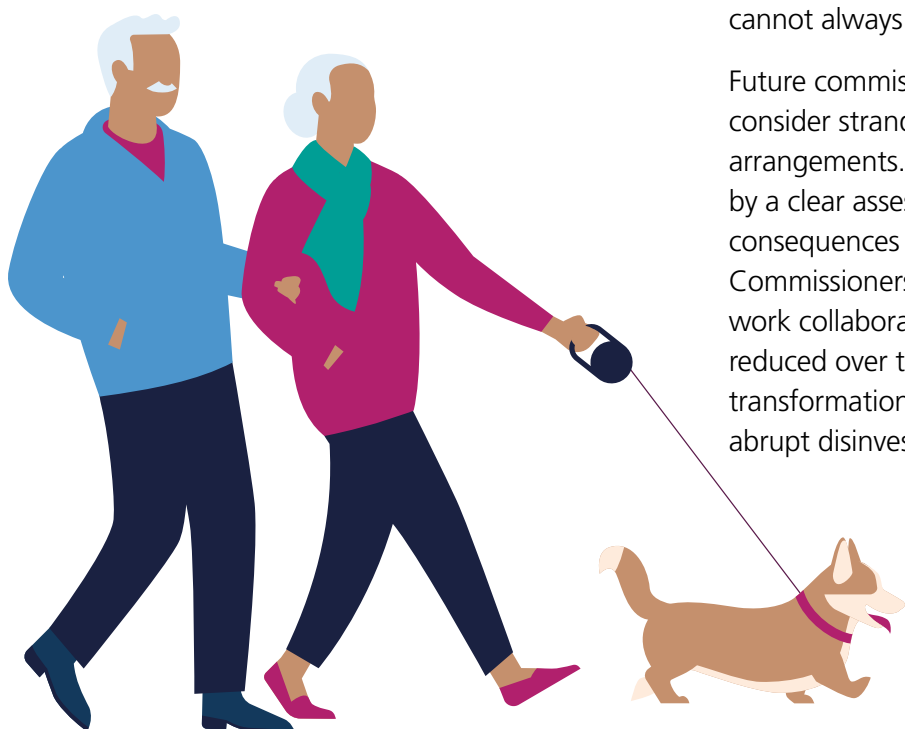
Successful transformation depends upon trust and transparency. Financial flows, activity assumptions, cost allocations and resource transfers must therefore be fully understood by all parties. Providers should expect future discussions regarding activity shifts and service redesign to be supported through 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

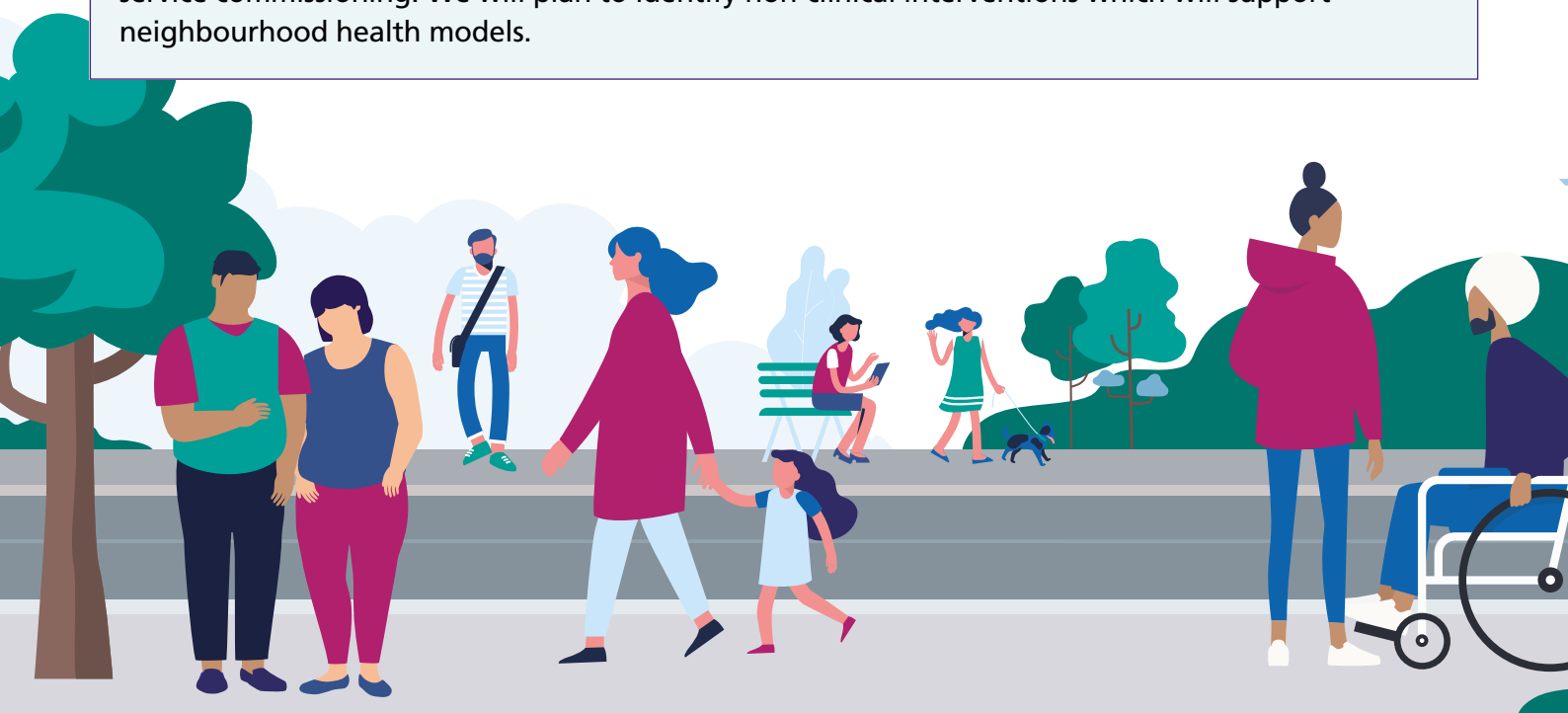
The final commissioning intentions place greater emphasis on prevention, early intervention, all-age mental health pathways, support before diagnosis and neighbourhood-based delivery. Our revised scope for the proposed review of Mental Health, Learning Disabilities and Autism and ADHD services across 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 multi-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

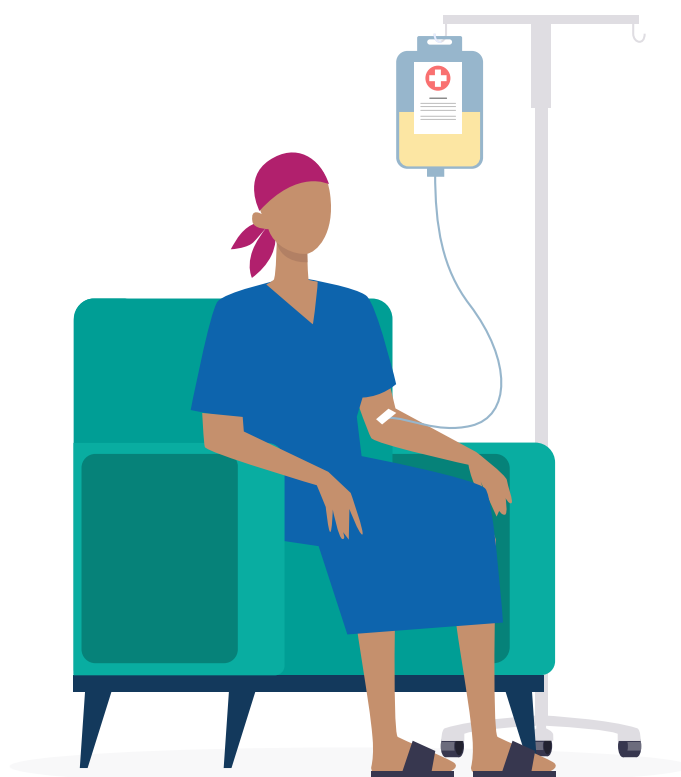
Providers will be required to:

- 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.

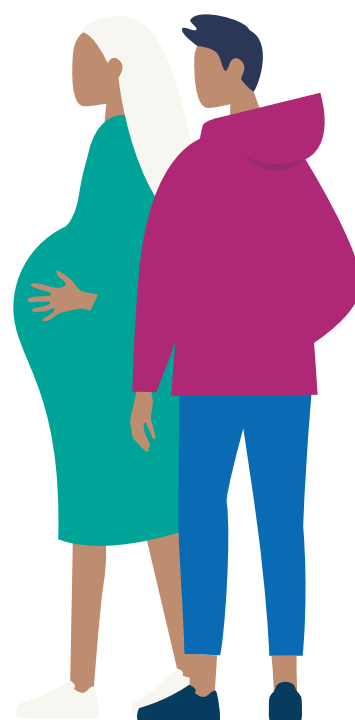
The findings of the National Maternity and Neonatal Investigation, combined with local quality intelligence, service user feedback, Care Quality Commission findings and operational performance information, demonstrate the need for a fundamentally different commissioning approach. The review highlighted 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 where 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.



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.

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The four layers of care

The clinical model for healthcare services and what people in Kent and Medway can expect from each layer



 **Caring for all**

 **Including everyone**

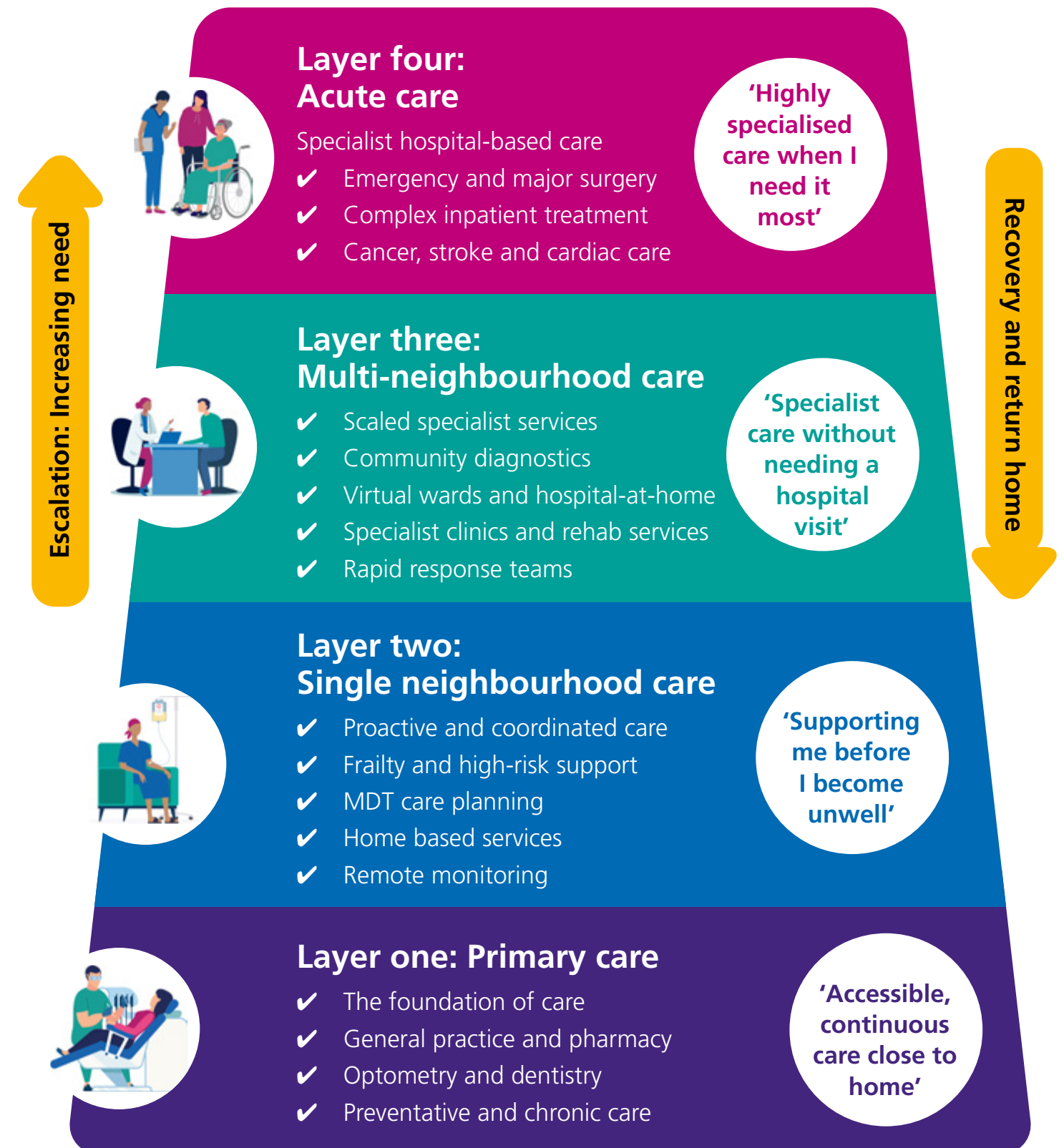
 **Building trust**

 **Doing what's right**

 **Being courageous**

Kent and Medway integrated model of care

Four layers of care: One seamless patient journey



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.

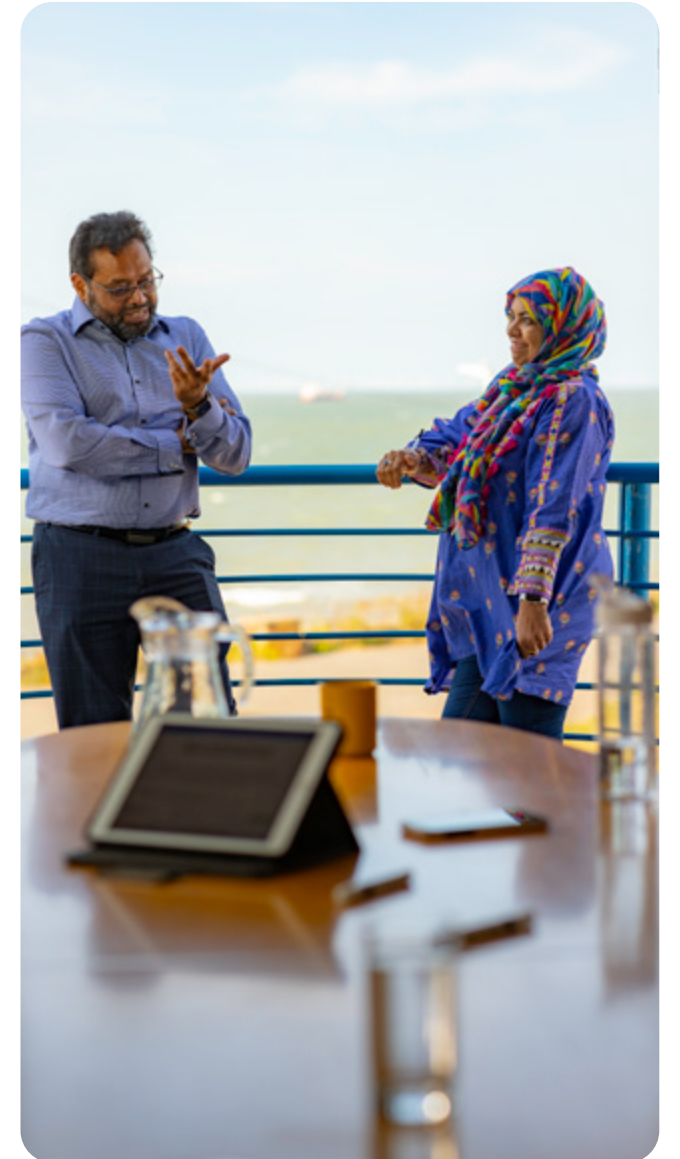
Future universal offer in layer one

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.

By 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

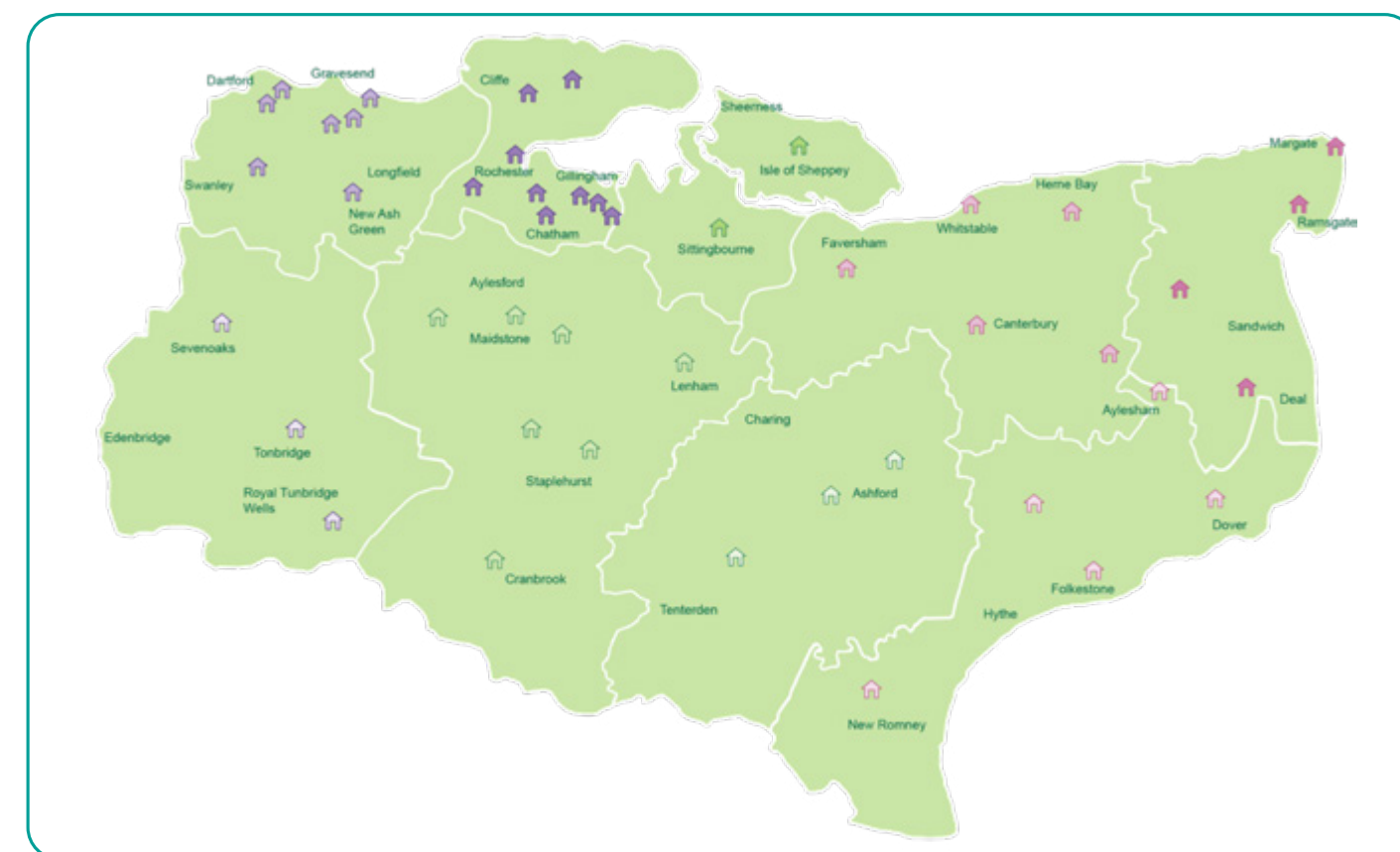
At layer two, residents will receive proactive, neighbourhood-based care focused initially on people living with frailty and long-term conditions, with additional population groups included over time. Care will be delivered closer to home through coordinated multidisciplinary teams, reducing the need 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.





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Item 8: Maternity Services Transformation Programme

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny
To: Health Overview and Scrutiny Committee, 7 October 2026
Subject: Overview of the Kent and Medway ICB Maternity Services Transformation Programme

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the NHS Kent and Medway Integrated Care Board (ICB).

1) Introduction

- a) The Kent and Medway Maternity Services Review is a system-wide programme established by NHS Kent and Medway Integrated Care Board (ICB) to develop a robust understanding of current maternity services and identify opportunities to improve outcomes, quality, safety and experience for women, babies and families across Kent and Medway.
- b) The Review forms part of the ICB's wider response to national and local maternity challenges, including the findings of the National Maternity and Neonatal Investigation (the 'Amos Review'), variation in service performance and outcomes and the need to ensure services remain sustainable and equitable for the future.

2) Recommendation

- a) RECOMMENDED that the Committee:
 - 1. Note the current position of the programme
 - 2. Advise what updates and assurances the Committee wish to receive at key stages of the Kent and Medway Maternity Services Review programme.

Background Documents

None.

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Report to	Kent HOSC Meeting
Meeting date	7 TH October 2026
Report title	Overview of the Kent and Medway ICB Maternity Services Transformation Programme
Key question	To Brief provide HOSC
Executive Lead	Jennie Hall: Chief Nursing, Quality and Experience Officer
Author	Jennie Hall Chief Nursing, Quality and Experience Officer Akeso: Programme Support and Delivery

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 note the programme of work being led by Kent and Medway ICB To ask the Committee what updates and assurance they would like to request	
Executive summary:	
The Kent and Medway Maternity Services Review is a system-wide programme established by NHS Kent and Medway Integrated Care Board (ICB) to develop a robust understanding of current maternity services and identify opportunities to improve outcomes, quality, safety and experience for women, babies and families across Kent and Medway. The Review forms part of the ICB's wider response to national and local maternity challenges, including the findings of the National Maternity and Neonatal Investigation, variation in service performance and outcomes, and the need to ensure services remain sustainable and equitable for the future. The programme is being delivered through a collaborative and coproduction approach involving provider organisations, clinical leaders, service users, Maternity and Neonatal Voices Partnerships (MNVPs), local authority partners and other stakeholders. A dedicated Programme Board has been established to provide independent oversight, assurance and challenge throughout the Review process.	

Since mobilisation, the programme has established its governance arrangements, agreed review objectives and scope, undertaken significant analytical activity and commenced stakeholder engagement activities. This work has created the foundations for the development of a comprehensive Case for Change that will articulate the challenges, opportunities and priorities for maternity services across Kent and Medway. Phase 1 has focused on evidence gathering, analysis and system engagement and has not sought to predetermine future recommendations or service configuration decisions.

The next phase of the programme will focus on completing the Case for Change, undertaking further engagement with women, families, staff and stakeholders, developing future model of care requirements and considering opportunities for service improvement. Any future proposals that may constitute substantial service change would be subject to appropriate governance, engagement and decision-making processes, including further engagement with Health Overview and Scrutiny Committee(s) where required.

Proposed next steps:

The next phase of the programme will focus on completing the Case for Change, undertaking further engagement with women, families, staff and stakeholders, developing future model of care requirements and considering opportunities for service improvement. Any future proposals that may constitute substantial service change would be subject to appropriate governance, engagement and decision-making processes, including further engagement with Health Overview and Scrutiny Committee(s) where required.

Governance pathway to date:

Meeting name:	Date:	Outcome:
Kent and Medway Trust Board	22 nd September 2026	Agreement of Scope and Terms Reference
Kent and Medway Trust Board,	21 st July 2026	Agreement of Draft Terms of Reference
Medway HASC	19 TH August 2026	None, Presentation of 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)

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

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

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 consultation where thresholds are met would apply and would be brought to the Kent and Medway ICB Board for decision.

Quality and safety implications

Are there quality or safety implications associated with this report?

☒ Yes ☐ No

The purpose of the Maternity Service Review Programme is to support an increased quality of service provision.

Patient and public engagement

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

☒ Yes ☐ No

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 ICB MATERNITY SERVICES REVIEW PROGRAMME

1. INTRODUCTION

This paper provides the HASC with an overview of the Kent and Medway Maternity Services Review and an update on progress to date. It outlines the purpose of the review, the work undertaken during Phase 1, and the proposed next steps as the programme moves into the next stage of development.

2. STRATEGIC ALIGNMENT

NHS Kent and Medway Integrated Care Board (ICB) commenced the Kent and Medway Maternity Services Review in 2026 as part of its ongoing commitment to improving outcomes for women, babies and families across the system.

The Kent and Medway (K&M) Maternity Services Review was approved in principle by the ICB's Executive Committee in June 2026, with its scope and Terms of Reference subsequently approved by the ICB Board in July 2026.

The Review was established as the ICB's primary commissioning response to a combination of national and local drivers, including the findings of the National Maternity and Neonatal Investigation (the Amos Review), wider quality and safety concerns within maternity services nationally, variation in outcomes and experience across Kent and Medway, and the need to ensure services remain safe, sustainable and equitable for future generations.

The Review is intended to provide an evidence-based assessment of current maternity services and to identify opportunities to improve quality, safety, outcomes and experience across the maternity pathway.

Importantly, the Review is not predicated on any pre-determined outcome: no service configuration decisions have been made. It is designed to develop a shared understanding of current services and future challenges before any options or recommendations are considered.

3. PROGRAMME APPROACH

The Review is a system-wide programme covering maternity, neonatal and women's health services across all four provider trusts (Dartford and Gravesham NHS Trust, East Kent Hospitals University NHS Foundation Trust, Maidstone and Tunbridge Wells NHS Trust and Medway NHS Foundation Trust), and all Four Layers of Care (Primary, neighbourhood, multi-neighbourhood and Acute). This will involve the ICB, provider trusts, service users, local authority partners, maternity and neonatal voices representatives, clinical leaders and wider stakeholders.

The programme is underpinned by three principles:

1. Co-production and collaboration across the system.
2. Use of robust evidence and analysis to inform conclusions.
3. Meaningful engagement with women, families, staff and communities.

A dedicated multi-organisation Programme Board has been established to provide independent oversight and assurance throughout the Review process, supported by governance, data and engagement arrangements.

The Review is being delivered in two phases.

Phase 1 built the evidence base and established governance, agreeing scope, objectives and the framing for a case for change through co-design, and testing key lines of enquiry through an evidence-led tabletop exercise across seven domains: population, equity, access, safety, activity, workforce, and experience and cost. A stakeholder workshop was held on 5 August to support this phase of the review.

The programme has now moved into Phase 2, which will take the validated evidence forward to co-produce the Case for Change, develop and recommend future care models and conduct an options appraisal.

4. PROGRESS TO DATE

Since mobilisation of the programme, significant work has been undertaken to establish the foundations for the Review.

Key achievements include:

- Agreement of the Review scope, objectives and governance arrangements through a multi-agency co-design process.
- Establishment of the Maternity Services Review Programme Board and supporting governance structures.
- Development of a Memorandum of Understanding across participating organisations.
- Production of a comprehensive baseline evidence base covering activity, quality, workforce, finance, inequalities, outcomes and service delivery.
- Development of a maternity dashboard and analytical framework.
- Initial stakeholder engagement with providers, clinical leaders and partner organisations.
- Commencement of engagement planning with women, families and wider stakeholders to inform the Case for Change.

The Maternity Services Review Programme Board held its inaugural meeting on 17th September 2026, approving its Terms of Reference and confirming arrangements for the supporting Data Subgroup. An Engagement Subgroup is also planned.

5. NEXT STEPS

Over the coming months, work will focus on:

- Completion of the Case for Change, with a first draft expected at the Programme Board in October for iteration and co-production
- Further analysis of quality, activity, workforce, finance and population need.
- Ongoing engagement with women, families, frontline staff, community representatives and stakeholders.
- Current-state pathway mapping across maternity services.
- Identification of Future Care Model requirements.
- Clinical workshops to define Future Model principles
- Development and testing of potential service improvement opportunities.

- Continued assurance through the Programme Board and wider governance structures.
- The April Board meeting will serve as a key gateway to consider the need to progress with an Options Appraisal.

The purpose of this phase is to establish a shared understanding of the challenges facing maternity services and the outcomes that any future service model should seek to achieve.

6. ENGAGEMENT AND INVOLVEMENT OTHER CONSIDERATIONS

The Review recognises that the experiences of women, families and staff are critical sources of evidence.

An engagement programme and subgroup are being developed to ensure that lived experience, clinical insight and stakeholder perspectives directly inform the emerging Case for Change and future recommendations. The engagement subgroup will provide a layer of assurance to the Programme Board. This will include engagement with service users, Maternity and Neonatal Voices Partnerships (MNVPs), provider organisations, local authorities, community groups, HOSC and HASC, and wider partners.

The Maternity Services Review Programme will consider the fundings from the Thirlwall Inquiry published in September 2026

7. REQUIRED OUTCOMES AND NEXT STEPS

The meeting is asked to note:

The current position of the programme

Further updates and progress can be provided at key stages of the Kent and Medway Maternity Services Review programme.

8. SUPPORTING DOCUMENTATION

There are no supporting Documents

Item 9: Work Programme

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 7 October 2026

Subject: Work Programme

Summary: This report gives details of the proposed work programme for the Health Overview and Scrutiny Committee.

1) Introduction

- a) The proposed work programme has been compiled from actions arising from previous meetings and from topics identified by Committee Members and the NHS.
- b) The Health Overview and Scrutiny Committee (HOSC) is responsible for setting its own work programme, giving due regard to the requests of commissioners and providers of health services, as well as the referral of issues by Healthwatch and other third parties.
- c) HOSC will not consider individual complaints relating to health services. All individual complaints about a service provided by the NHS should be directed to the NHS body concerned.
- d) HOSC is requested to consider and note the items within the proposed work programme and to suggest any additional topics to be considered for inclusion on the agenda of future meetings.

2) Recommendation

- a) RECOMMENDED that the Committee note the work programme.

Background Documents

None

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Health Overview and Scrutiny Committee

Work Programme

1. Proposed items for upcoming meetings

10 December 2026

Item	Item Background	Substantial Variation?
Phlebotomy service in Deal.	To receive an update on the current situation on, and the future of, the phlebotomy service provision in Deal.	-
William Harvey Hospital's urgent and emergency care service.	To receive an update on progress made to address the CQC inspection's concerns.	-
East Kent Hospitals University NHS Foundation Trust's Aquatic Therapy review.	To receive a paper on the Aquatic Therapy Review.	-

2. Items that have been declared a substantial variation of service and are under consideration by a joint committee

No proposals are currently under scrutiny by the Kent and Medway Joint HOSC.

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