

Kent and Medway Community Services Transformation and Neighbourhood Health



1. Introduction

This paper sets out the transformation priorities for community services across Kent and Medway, with a particular focus on the evolving Neighbourhood Health Model. It outlines the strategic direction of the Kent and Medway Integrated Care Board (KMICB) following the reprocurement of community health services and the award of a new long-term contract.

In response to changing national priorities and local needs, the paper examines how the ICB is driving improvements in service integration, accessibility, and quality through a targeted community services transformation plan, ensuring care is increasingly delivered within neighbourhoods including alignment with Primary Care Networks. The following sections detail the ambitions, investment plans, and specific schemes aimed at enhancing community-based care for local populations.

2. ICB Community Services Ambitions

KMICB has established clear ambitions for the future of community health services, building on the foundation of a new long-term contract. Following a comprehensive reprocurement process, a decision was made in April 2025 to award a 5+3-year contract to Kent Community Health NHS Foundation Trust (KCHFT) as Lead Provider, with HCRG and Medway Community Healthcare (MCH) acting as subcontractors. After a successful six-month mobilisation period, the new contract commenced on 27 October 2025.

At the heart of the ICB's vision is a fully funded 3–4 year transformation plan, informed by the ICB's 'Ambitions' document developed in 2024 and published as part of the reprocurement process. This ensured that providers understood the scope of work required to achieve best practice in community services during the life cycle of the contract.

A significant development since publication has been the strengthened focus on neighbourhood health, which was elevated to a national priority within the NHS 10-Year Health Plan. The shift represents a move away from fragmented, acute-centric care towards an integrated, community-based approach, where services are embedded within local neighbourhoods and aligned with Primary Care Networks.

In collaboration with the new provider, the ICB is redirecting the planned £4.6 million p.a. community services transformation investment towards neighbourhood health delivery, with a particular focus on the development and expansion of multi-neighbourhood (MNH) services.

Multi-neighbourhood (MNH) services

This investment supports schemes designed to deliver timely, flexible care and reduce unnecessary hospital admissions, including:

- 24/7 Urgent Community Response teams (covering both in-hours and out-of-hours home visiting)

- Virtual Wards
- Frailty Services
- Dementia Care.

The intermediate tier also plays a vital role in bridging the gap between hospital and home, supporting patients with complex needs who do not require acute hospital care but benefit from enhanced community support. Key services in this tier include:

- Community nursing
- Reablement
- Short-term crisis response
- Therapy-led interventions
- Transfer of Care Hubs

Community services underpin this entire model by providing personalised care through multidisciplinary teams. These teams offer a broad spectrum of support, including management of chronic diseases, rehabilitation, palliative care, and health promotion.

By working alongside GPs, social care and VCSEF organisations, community services ensure that residents receive holistic, tailored support. This integrated approach is key to improving health outcomes and quality of life across the population.

Healthcare Inequalities

In line with local and national strategic ambitions, the transformation plan will also focus on addressing healthcare inequalities throughout Kent and Medway. The ICB and KCHFT are working together to offer a harmonised service, actively closing gaps that resulted from historic variations in commissioning by former Clinical Commissioning Groups (CCGs).

Key areas of focus include:

- Children's audiology
- Children's therapies
- Community paediatrics
- Diabetes (covering nutrition and dietetics, podiatry, and education)
- Looked After Children
- Lymphoedema
- Respiratory services, including COPD and pulmonary rehabilitation
- Self-care and shared care – inc tracheostomy consumables, catheters
- Speech and Language Therapy
- Transition from children's to adults' services
- Wound management, including podiatry and tissue viability nursing

This comprehensive approach aims to deliver equitable, high-quality care for all residents, ensuring that people receive consistent support regardless of where they live.

3. Kent and Medway's neighbourhood health model

Kent and Medway's neighbourhood health (NH) model is an integrated approach to healthcare, designed to bring services closer to people's homes and communities. It reflects national NHS priorities and the Government's 10-Year Health Plan, focusing on three strategic shifts:

- **From hospital to community** – reducing reliance on acute settings by strengthening primary and community-based care.
- **From sickness to prevention** – investing in proactive health measures such as early cancer diagnosis, cardiovascular disease prevention, and respiratory care improvements.
- **From analogue to digital** – using tools like the NHS App and Kent and Medway Care Record (KMCR) to provide joined-up, accessible care.

The model anchors services in local neighbourhoods, aligning with Primary Care Network (PCN) footprints (typically 30,000–50,000 people) to ensure care is person-centred and community-driven.

Local neighbourhoods will also scale into 'multi-neighbourhoods' (MNH), representing footprints of an average of 250,000 people, for services that work better at scale.

Key components include:

- Integrated intermediate care ('Home First')
- Modern general practice
- Neighbourhood multidisciplinary teams
- Population health management
- Standardised community health services
- Urgent neighbourhood services

This approach is not just about clinical care—it involves partnership working across NHS providers, local authorities, voluntary and community organisations, and social care. It aims to reduce health inequalities, improve outcomes, and make services more equitable. It builds on areas of good practice developed by local teams of primary and community healthcare professionals.

There will be a 'core offer' for the whole of Kent and Medway, then population health data will be used to inform neighbourhood-specific priorities to address local health issues and inequalities

The Kent and Medway NH model has been developed by clinicians from across the system. It was clinically approved in December 2025 by a steering group with representation from the ICB, all Kent and Medway community providers, the Kent and Medway mental health trust, primary care representatives, all Kent and Medway acute hospitals, and hospice providers, alongside local authority partners and VCSEF representatives.

Neighbourhood health provides the strategic framework for the transformation of community services across the system, enabling a shift from fragmented, reactive provision to proactive, integrated, neighbourhood-based care through the MNH footprint, providing scale, flexibility and higher-acuity community-based care. This will be delivered in close partnership with Single Neighbourhoods (SNH) to ensure seamless pathways, effective step-up and step-down arrangements, and a consistent neighbourhood offer across Kent and Medway.

The model is underpinned by the Johns Hopkins population risk stratification approach, ensuring that neighbourhood services are systematically aligned to population need and system impact. In its first year of implementation, the NH Model will focus on the highest-need 5% of the population—individuals with the most complex proactive, ongoing and reactive care requirements, who account for around 25% of urgent and unplanned activity.

For this cohort, neighbourhood services will play a central role in delivering coordinated, 24/7 neighbourhood-based support, with clear interfaces to primary care, mental health, social care and acute services.

The strategic emphasis is on strengthening proactive, accessible and coordinated community-based care, enabling earlier intervention, improved continuity and better outcomes, while reducing reliance on hospital-based services.

Delivery of this ambition requires integrated working across all four sectors—primary care, community services, mental health and social care—supported by shared governance, population health analytics and aligned incentives. This approach directly supports the NHS 10 Year Health Plan and Medium-Term Planning priorities and is grounded in the system ethos of Our Population, Our Resources and Our Responsibility.

4. Neighbourhood model priorities - year one

Key priorities for the first year of development include:

- Defined neighbourhood responsibility for **Frailty, Dementia and Palliative & End of Life Care (P&EOLC)**, delivered through integrated teams spanning primary care, community services, mental health, acute providers and the VCSEF, operating on a 24/7 basis where required.
- A **Neighbourhood Community Front Door**, providing a single, consistent access point for patients, families, carers and professionals, supporting step-up and step-down across neighbourhood pathways.
- A **'No Wrong Door'** approach, underpinned by robust MDT working, ensuring needs are triaged, prioritised and coordinated until safe discharge back to general practice or PCN-led care.

- Clear **interdependencies and mutual aid arrangements** between neighbourhoods, ensuring continuity of agreed inputs where local capacity is constrained.
- A consistent **Care Homes** offer, with defined neighbourhood support and MNH escalation where required.
- A **system-wide** data and outcomes framework, aligned to the NH Model of Care, with agreed proactive, ongoing and reactive measures.
- **Workforce planning, education and development** aligned to current and projected population need.
- A commitment that **resources follow the patient**, with SNH and MNH contracts designed around defined neighbourhood populations rather than organisational boundaries.

5. Collective Out-of-Hospital priorities

The collective out-of-hospital priorities are framed around coordination, rapid response and continuity, rather than individual service lines. Key priorities include:

1. Neighbourhood community front door (24/7)

A single point of access for neighbourhood populations and professionals, supporting triage, coordination and step-up/step-down across SNH and MNH pathways.

2. Integrated Neighbourhood MDTs

MDTs operating as one team, combining proactive, ongoing and reactive functions. Referrals are managed through a No Wrong Door approach, avoiding fragmentation or re-referral between community teams, and ensuring seamless interfaces with PCN hubs, acute providers, ambulance services, hospices and the VCSE.

3. Urgent community response (UCR) and virtual ward / hospital at home (H@H)

UCR services provide a consistent 24/7 response, including rapid assessment, point-of-care testing and oral/IV therapies. These services operate as part of the wider Frailty Virtual Ward and H@H model, supporting both reversibility and, where appropriate, palliative trajectories in line with ReSPECT plans.

4. Care homes, hospices and ambulance services

Care homes, hospices and ambulance services are enabled to use neighbourhood pathways as the default route, including out-of-hours, weekends and bank holidays, where community-based care is clinically appropriate.

5. Shared care records and digital enablement

While native systems will continue initially, KMCR will be used as the shared record for key NH interventions.

6. Remote monitoring and surveillance

Agreed remote monitoring solutions will support early identification of deterioration, with inclusive access for acute partners as the model matures.

7. Acute interfaces and flow

Structured interfaces with ED, SDEC, AFU and inpatient units, including daily multi-agency flow discussions, support admission avoidance and timely discharge.

8. Intermediate capacity and step-down options

Community beds, hospice partnerships and selected nursing home capacity will support short-term step-down and admission avoidance for high-need cohorts.

9. Data-led improvement

A shared NH dashboard will enable monthly review of activity, outcomes and variation, supporting continuous improvement across neighbourhoods.

6. Specific programme priority needs

In Year one, the KCHFT Community Services Transformation Plan will prioritise delivery of the NH Model for the highest-need 5% of the population, working in close collaboration with system partners.

1. Frailty

Community teams will lead delivery of proactive identification, CGA, anticipatory care planning and 24/7 response, expanding UCR, Virtual Ward and H@H capacity, and strengthening workforce capability through targeted training (e.g. DiaDEM).

2. Dementia

Dementia pathways will be embedded within neighbourhood frailty models, with structured post-diagnostic support and crisis response, and expansion of dementia crisis services in partnership with mental health and VCSE providers.

3. Palliative & End of Life Care

Community nursing capacity, verification of expected death, syringe driver support and anticipatory prescribing will be strengthened. For the highest-need cohort, ACP, ReSPECT and medication reviews will be systematically completed and maintained.

4. Care homes

Neighbourhood-led care home support will be strengthened, with UCR as the first response for urgent needs, proactive follow-up and expanded training to support quality and reduce avoidable admissions.

5. Falls

Falls prevention and response will be optimised using pooled resources and data-led targeting, with responsive rehabilitation and rapid community support.

6. Specialist community services

Specialist nursing and therapy services (e.g. heart failure, respiratory, diabetes, Parkinson's, LD, CYP) will be aligned to neighbourhood population need, supporting both frailty and rising-risk cohorts.

7. Children and young people

Community services will focus on high-risk CYP cohorts, working with acute partners to deliver integrated neighbourhood care and reduce avoidable admissions, with an expanding role over time for rising-risk children.

8. Mental health, learning disabilities and autism

Community teams will work in partnership with mental health providers to deliver 24/7 wraparound support, improve physical health monitoring, support carers and reduce admissions, with standardised health checks and improved flagging and reasonable adjustments.

9. Professionalism, Digital and Feedback

Reflective MDT practice, shared learning, KMCR-enabled care coordination, point-of-care testing and structured patient and staff feedback will underpin safe, high-quality delivery.

7. Engagement

KMICB has unified its engagement work to drive the transformation of community services and advance Neighbourhood Health priorities. By collaborating with KCHFT and a wide range of partners, neighbourhood health objectives are being woven directly into the community services transformation plan, ensuring both strategy and practical delivery are shaped by collective input.

To promote inclusive participation, four workshops are taking place, commencing from the end of January, inviting community representatives and stakeholders to discuss the proposed model, highlight challenges, and share suggestions. This collaborative forum gathers a diversity of views early in the process.

We are working collaboratively with public health teams to align the work to local health and wellbeing strategy through HWB boards.

Next Steps

After the engagement workshops, the draft community services transformation plan will be further developed by KCHFT, who have played an active role in the workshops. The final draft plan will reflect all feedback—including that relating to neighbourhood health priorities to give a strengthened focus on enhanced neighbourhood health planning. The final draft

will be submitted to the ICB by 31.03.26 for approval. This is subject to alignment with other ICB planned investments to support the neighbourhood health programme.

Once approved, preparations for implementation will commence, including the development of detailed action plans for neighbourhood health, the establishment of monitoring and evaluation frameworks tailored to neighbourhood objectives, and ensuring ongoing involvement and collaboration with stakeholders to facilitate smooth delivery and continuous improvement.

Regular updates and opportunities for continued involvement and input will be provided, guaranteeing transparency and accountability in neighbourhood health planning within the wider context of community services transformation.

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