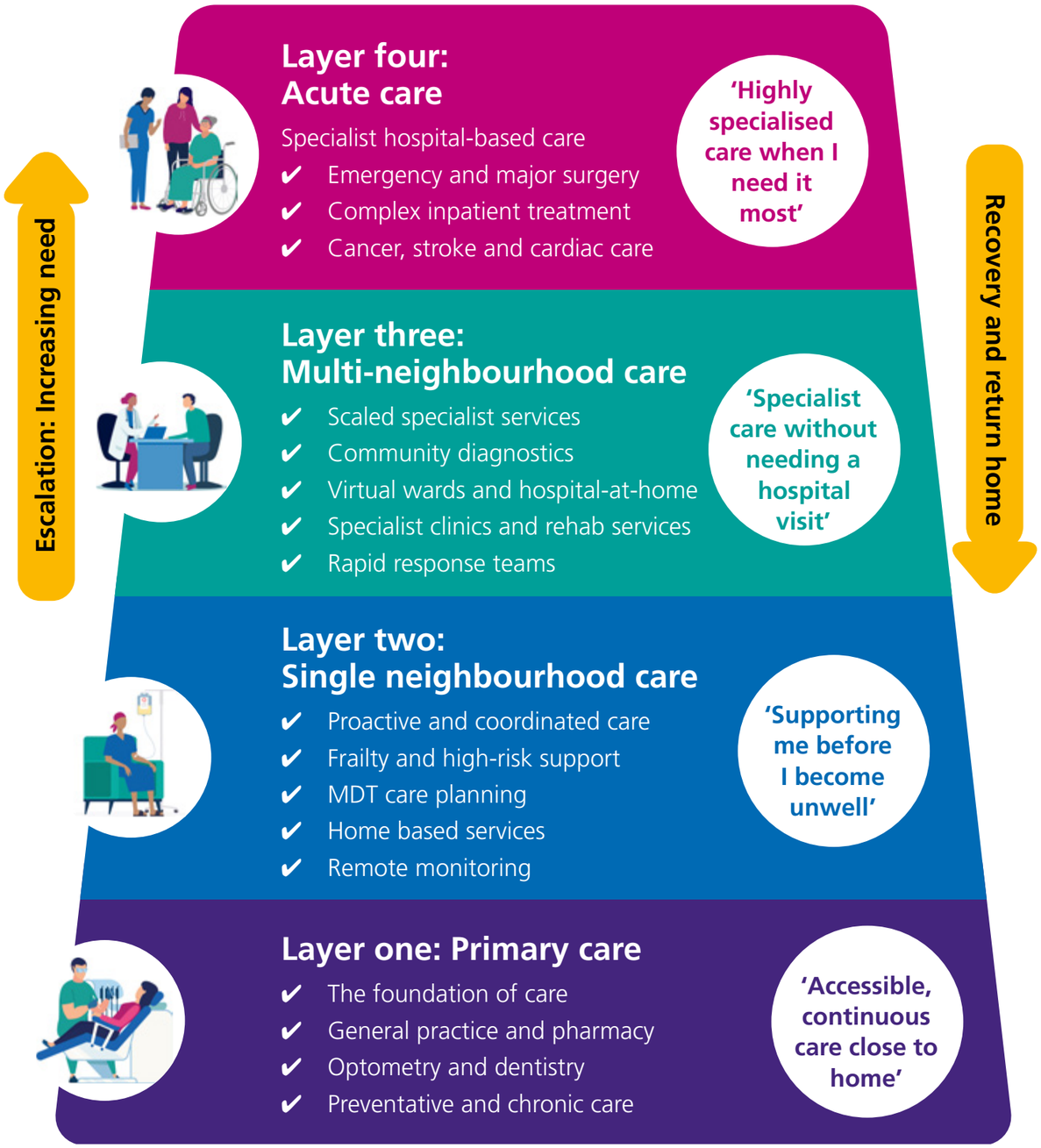
NHS
Kent and Medway

The four layers of care

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

Kent and Medway integrated model of care

Four layers of care: One seamless patient journey



Executive summary

Change is needed in the way healthcare is commissioned and delivered in Kent and Medway.

- Too many outcome and quality metrics are poor and inequitable with life expectancy 10 years lower in the most deprived locations versus the least.
- Access is limited in both elective and non-elective care with lengthening waiting times to be seen in the emergency department or for an outpatient's appointment. We hear repeatedly the effect difficulties accessing care has on people's experience of healthcare.
- Healthcare is reactive not proactive and too often delivered in an expensive inconvenient hospital setting.
- This has contributed to a £300m structural deficit across Kent and Medway, which is unsustainable.

The Kent and Medway 'four layers of care' model describes a single, coherent healthcare offer organised across four interdependent layers: Primary care, single neighbourhood care, multi-neighbourhood care, and acute hospital care. These layers operate not as separate services, but in a continuous model through which patients move as their needs change.

In the past, providers both large and small have operated as isolated units within the system rather than working collaboratively. This will change as providers work in two collaboratives and one alliance, with the ICB commissioning for better outcomes and experience.

Patients will experience a single joined-up system, rather than multiple disconnected services. Most care begins and continues within primary care, supported by continuity and accessibility.

As needs increase, care is strengthened through multidisciplinary support at neighbourhood level. Where greater intensity or specialist capability is required, services operate at multi-neighbourhood scale. Acute hospital care remains essential but is reserved for those with the highest level of clinical need, or where highly specialised staff, equipment or estates are required – with a consistent emphasis on returning people safely home at the earliest opportunity. A core principle of the model is the shift from reactive, episodic care toward proactive and anticipatory care, particularly for those at highest risk.

The four layers of care also supports a deliberate transfer of elective care out of hospital settings, ensuring services are delivered as close to home as possible while maintaining clinical safety and quality.

The case for change

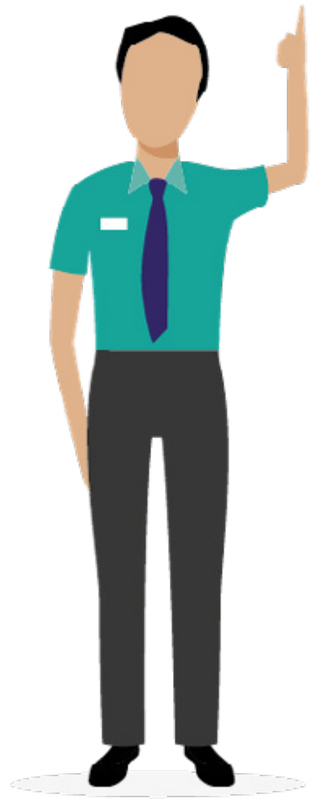
NHS Kent and Medway faces growing demand from an ageing population with increasing levels of frailty, long-term conditions and mental health need, alongside persistent health inequalities, workforce pressures and significant financial challenges. Variation in quality, safety, access and outcomes remains too great, while current models of care are often reactive, fragmented and focused on responding to illness rather than preventing it.

Residents, communities and staff have told us they want healthcare that is easier to access, better coordinated and delivered as close to home as possible. They want earlier support, greater continuity of care and services that help people remain independent and in their own homes for as long as possible, avoiding unnecessary hospital attendances and admissions wherever safe to do so.

This aligns directly with the NHS 10 Year Health Plan and Neighbourhood Health Framework, which call for a fundamental shift from hospital to community, analogue to digital and sickness to prevention.

The Kent and Medway four layers of care model provides the framework for delivering this change. By progressively moving activity and resource from higher-cost, reactive services into primary care, single neighbourhood care and multi-neighbourhood care, we can provide more proactive support, prevent deterioration, improve outcomes and reduce avoidable hospital use. Acute services remain essential but will increasingly focus on specialist, complex and emergency care that can only be delivered in hospital settings.

Through this approach, NHS Kent and Medway aims to improve safety, quality and patient outcomes, reduce health inequalities, strengthen workforce and provider sustainability, and create a clinically and financially sustainable health and care system for the future.



Layer 1: Primary care - the foundation of care

Primary care forms the foundation of the integrated model. It is the first point of contact for most patients, the setting in which the majority of clinical care is delivered, and the ongoing clinical home for registered populations. Delivered through general practice, community pharmacy, optometry and dentistry and supported by a wider multidisciplinary team, it provides accessible, continuous and coordinated care.

Patients experience this layer as the most familiar and consistently available part of the system. It is where new health concerns are assessed, long-term conditions are managed and preventative care is delivered. Access is designed to be flexible, combining telephone, online and face-to-face routes, with urgent needs addressed promptly and planned care arranged to support continuity.

In an environment of growing demand and workforce pressures, general practice is evolving through smarter triage systems, digital access and multidisciplinary teams to ensure patients receive the right care, from the right professional, at the right time. While the route into care may be changing, continuity remains a defining feature of effective primary care. Long-term relationships between patients and clinicians foster trust and a detailed understanding of medical, social and personal circumstances, supporting proactive intervention, personalised care and seamless coordination with wider services.

Future universal offer in layer one

At layer one, residents will benefit from a consistent, universal offer across general practice, community pharmacy, dentistry and optometry, providing accessible, proactive and coordinated care close to home. General practice will deliver core and locally enhanced services through multidisciplinary teams, including GPs, nurses, advanced clinical practitioners, pharmacists and allied health professionals, with a strong focus on prevention, improved access and systematic management of long-term conditions. Community pharmacy will play an expanded role in delivering accessible, preventive and clinically effective care, helping people stay well and independent while reducing pressure on general practice and hospitals. Dentistry and optometry services will be available and accessible to all communities regardless of residency or registration status, ensuring equitable access to essential primary care services.

The ICB will commission and deliver

- **Modern General Practice**, including digital triage, multidisciplinary team-based care and a more diverse workforce.
- **Improved access standards**, with 90 per cent of urgent cases seen on the same day within general practice.
- **An expanded community pharmacy offer**, supporting management of same-day need, long-term conditions, prevention and vaccination programmes.
- **Independent prescribing for cardiovascular disease**, enabling community pharmacists to manage hypertension and lipid reduction closer to home and at times convenient for patients.
- **Improved access to dental care under general anaesthesia**, ensuring no patient waits longer than 18 weeks through partnership with the Acute Provider Collaborative.

Together, these changes will strengthen primary care, improve access, support prevention and long-term condition management, and provide more care closer to home.

Layer two: Single Neighbourhood Care – proactive and coordinated care for defined populations

Layer two is made up of 45 distinct geographic regions covering populations of roughly 30,000 to 50,000 each. It represents a shift from reactive, episodic care to a more structured and proactive model.

The ICB will risk stratify our population to identify cohorts of patients who will benefit from proactive intervention. Over time, this will improve their health outcomes and the quality of the care they receive.

In 26/27, the primary focus is the frailest five per cent of the population (PNG 10/11 plus). Physical health is often the cause of this extreme frailty, but for some it is a mental health need that must be proactively addressed. This group were prioritised as the evidence shows poor patient outcomes and experience through unnecessary hospital admission and loss of independence.

The ICB will commission a bundle of proactive care elements designed to reduce the likelihood of physical or mental deterioration that would previously require a hospital attendance and admission.

1. Comprehensive geriatric assessment to understand a patient's health needs.
2. Structured medication review to make sure medications and doses are optimised.
3. Respect form to make sure a patient's wishes are understood and followed.

The second targeted cohort, planned for 27/28, are those identified through population health analyses as 'rising risk'. Patients with diabetes or cardiovascular disease who without proactive management are likely to deteriorate, having poorer health outcomes and escalating cost to the healthcare system. In future, patients will receive regular review, coordinated multidisciplinary input and structured care planning that anticipates need rather than responding only when problems occur.

In parallel, layer two supports the movement of selected elective care out of acute hospitals, enabling more services to be delivered within a community settings. Some of the diagnostics currently found in layer four can be moved to layer two, this can support diagnosis and management closer to home.

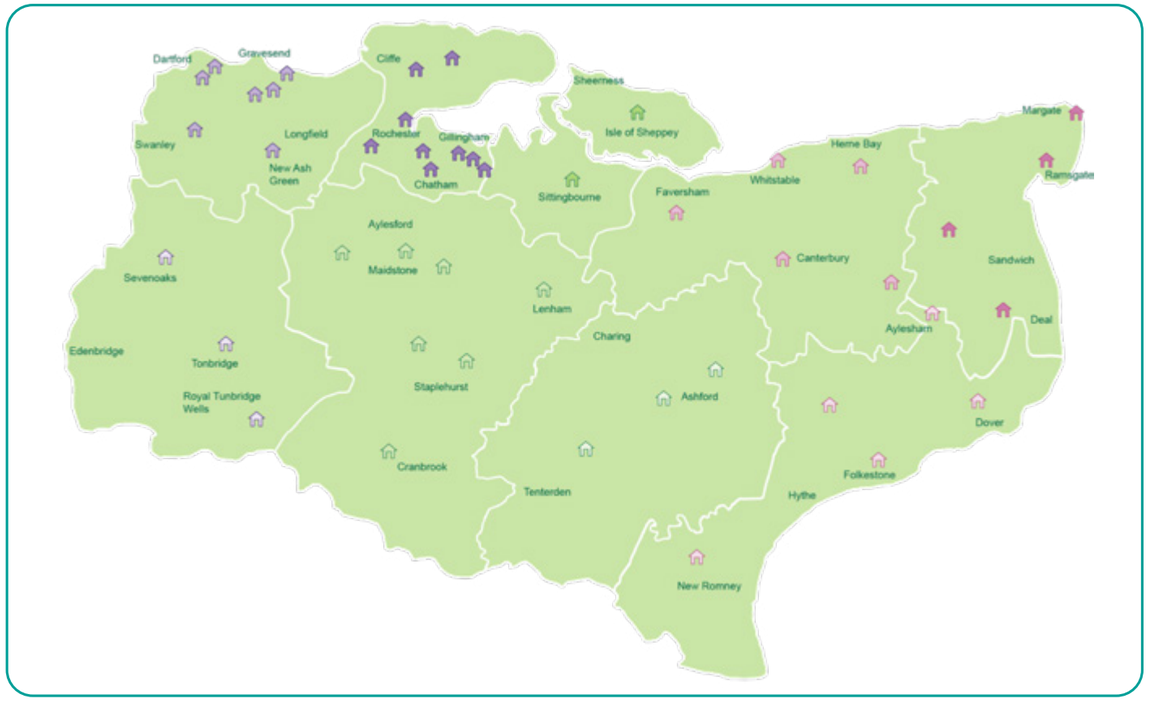
Future universal offer in layer two

At layer two, residents will receive proactive, neighbourhood-based care focused initially on people living with frailty and long-term conditions, with additional population groups included over time. Care will be delivered closer to home through coordinated multidisciplinary teams, reducing the need for hospital attendance and supporting earlier intervention. Residents will benefit from extended access to general practice appointments during evenings and weekends, alongside greater availability of diagnostics and outpatient services within neighbourhood settings. Services that have traditionally only been available in hospital, such as specialist diabetes support, will increasingly be delivered locally, improving convenience and access while supporting better health outcomes.

The ICB will commission and deliver

- **Specialist frailty multidisciplinary teams (MDTs)** to proactively manage the complex needs of the five per cent most frail residents identified through primary care records.
- **Proactive population health interventions** for additional cohorts, beginning with people living with diabetes and cardiovascular disease.
- **Extended access to general practice**, including evening and weekend appointments.
- **Neighbourhood-based diagnostics and outpatient services**, bringing appropriate services currently delivered in hospital settings closer to patients' homes.
- **Specialist community-based clinics**, including services such as diabetes nurse specialists and GPs with specialist interests, delivered at neighbourhood level where appropriate.

Together, these developments will provide more proactive, preventative and personalised care, helping residents manage their health conditions effectively while reducing the need for hospital-based care.



Layer three: Multi-neighbourhood care – scaled services serving larger localities

Multi-neighbourhood care operates across populations of approximately 250,000 people, bringing together several of the single neighbourhoods to provide layer three care. There are nine in Kent and Medway.

Care commissioned in this layer typically requires a greater level of healthcare resource, coordination or specialist capability than can be delivered within a single neighbourhood.

Layer three offers both an elective and a non-elective alternative to hospital care that is more convenient, closer to home and lower cost than layer four.

Non-elective care

This layer supports patients during periods of acute deterioration, recovery following illness and transition from hospital back into the community. Care will be delivered in the patient's home or community setting, avoiding hospital admission where clinically appropriate and supporting recovery in a more familiar environment.

Multi-disciplinary teams including geriatricians, GPs, advanced clinical practitioners (ACPs), nursing staff and the voluntary sector will work together to deliver hospital level care in a patient's own home. These multidisciplinary teams (MDTs) are supported in their work through wearable technologies, community virtual wards, shared care records and access to specialist input through advice and guidance or same day emergency care (SDEC) in layer four.

Layer three will also provide extended GP access through same-day hubs, supported by diagnostics and a MDT providing urgent treatment.

For some conditions such as stroke, where part of the recovery pathway is a period of specialist rehabilitation before continuing recovery at home, these beds will be part of the offer in layer three.

Elective care

Care which has traditionally been delivered in a hospital setting can often be done in layer three. Many outpatient clinics only require simple diagnostics or treatments so do not need to be in an acute hospital but can be delivered closer to home in layer three.

Examples of care that will move out of layer four into layer three are:

- Outpatient activity in cardiology, orthopaedics and gynaecology. The data shows this group have some of the longest waits to be seen and the poorest outcomes while waiting.
- Diagnostics can also be placed at layer three with MRI, CT, X-ray and ultrasound placed closer to home.
- Certain treatments, biologics for autoimmune conditions, rheumatology treatments and others, should no longer require a hospital trip.

Universal offer in layer three

At the multi-neighbourhood level, residents will receive a consistent, scaled offer that brings some urgent treatment and elective care closer to home. Services will include same-day access hubs, rapid community response services, community diagnostics and community virtual wards, enabling more people to receive specialist and acute-level care in community settings. Residents will also benefit from access to outpatient services that have traditionally been delivered in hospitals, alongside coordinated rehabilitation, reablement and recovery support to help them regain independence following illness or hospital care. This model will provide more integrated care pathways across neighbourhoods, ensuring patients receive the right care, in the right place, at the right time.

The ICB will commission and deliver

- **Community-based outpatient services** across each of the nine multi-neighbourhood areas, initially covering cardiology, orthopaedics and gynaecology, with further specialties added over time.
- **Redesigned community urgent treatment centres (UTCs)**, transforming the current 12 community UTCs into enhanced same day GP access hubs to increase access to urgent care.
- **Specialist frailty multidisciplinary teams** in each multi-neighbourhood area, providing responsive, hospital-level care for frail residents within their own homes.
- **A redesigned virtual ward model**, rationalising the current nine services into two consistent models: Community Virtual Wards supporting frailty and Acute Virtual Wards supporting early discharge from hospital.
- **Enhanced community diagnostic services**, including expansion of diagnostic capacity across all nine multi-neighbourhood areas.
- **Advanced community treatment services**, including delivery of some therapies traditionally provided in hospital settings.

Together, these changes will create a stronger community-based care model that delivers more specialist, urgent and recovery services closer to home, improves patient experience and outcomes, and reduces reliance on hospital-based care.

Layer four: Acute hospital care

Acute hospital care provides the most specialised and resource-intensive component of the system, including emergency care, inpatient treatment and complex procedures. It is designed for those with the highest level of clinical need where there are interdependencies between specialised services or where specialist equipment or estates are required.

Patients enter this layer when hospital-level care is required and cannot be safely delivered within community settings. Within the four layers of care model, this represents a targeted escalation rather than the default pathway.

Care within the acute setting is recovery focused and time limited. There is a strong emphasis on delivering the necessary intervention efficiently and initiating discharge planning at the earliest possible stage. Acute care operates as part of a continuous pathway, with clear links to the multi-neighbourhood and single neighbourhood layers that provide ongoing care following discharge and supports recovery.

In Kent and Medway, our four acute hospital trusts will be more efficient and improve patient outcomes if they work together through the Acute Provider Collaborative. Better sharing of staff, estates and patients will reduce inequalities, increase access and reduce costs to the system.

Universal offer in layer four

At layer four, residents will receive access to the most specialised hospital-based services for urgent, complex and life-threatening conditions. This includes emergency department care, major surgery, complex inpatient and outpatient treatment, and specialist pathways such as stroke, cardiac and critical care services. Care will be delivered through consultant-led multidisciplinary teams supported by advanced diagnostics and specialist facilities. While this layer will continue to provide high-quality acute care when needed, there will be a stronger focus on making sure patients move seamlessly through the system, with diagnostics, assessment, discharge planning and follow-up care organised more efficiently and with greater consistency across Kent and Medway.

The ICB will commission and deliver

- **A single patient tracker list across Kent and Medway,** enabling patients to be offered the next available appointment or operation regardless of provider, rather than waiting solely for treatment at their local hospital.
- **A Single Point of Triage (SPOT)** for the 10 highest-volume specialties, making sure patients are assessed to consistent standards across all trusts and, wherever appropriate, managed within layers one to three rather than referred into acute hospital services.
- **Implementation of Getting It Right First Time (GIRFT) 'Straight to Test' pathways** across all trusts, allowing patients to undergo relevant diagnostic tests before their first outpatient appointment to reduce delays and improve productivity.
- **A redesigned discharge support model**, including a review of rehabilitation capacity, care packages and care home provision to ensure patients are discharged as soon as they are clinically ready.
- **A 'home first' approach to therapy and assessment activities**, with physiotherapy, occupational therapy and council assessments delivered in community settings, wherever appropriate.
- **A single Kent and Medway urgent care hub**, combining the single point of access, clinical advisory service and 999 validation functions into a coordinated 24/7 service supporting timely access to the right level of care.

Together, these changes will improve access to specialist hospital services, reduce waiting times and unnecessary variation, support faster discharge from hospital, and make sure acute care is focused on those residents who need it most while enabling more care to be delivered in community settings.

Conclusion

The Kent and Medway four layers of care represents a fundamental transformation of how health and care is delivered, experienced and sustained across our system. Over the next three years, we will move decisively from a model built around organisations and episodes of illness to one built around people, neighbourhoods and outcomes.

By 2029, residents should experience a genuinely integrated health and care system in which access is simpler, care is delivered closer to home, and support is increasingly proactive rather than reactive. The majority of care will be provided within layers one to three, supported by strong neighbourhood teams, expanded community diagnostics, digital technology, and a multidisciplinary workforce. Layer four acute hospital services will remain a vital component of the system but will be focused on those patients whose needs genuinely require acute, specialist or highly complex care.

This transformation will be underpinned by a new provider architecture. The Neighbourhood Collaborative, bringing together primary care, community and mental health providers, will be responsible for delivering integrated services across layers one to three. The Acute Provider Collaborative will lead the delivery of specialist and hospital-based care within layer four. Together, through the Kent and Medway Provider Alliance, providers will share accountability for population outcomes, patient experience, workforce sustainability and financial performance, moving beyond organisational boundaries to operate as a single coordinated system.

Our ambition is that within three years:

- unplanned hospital admissions will reduce through earlier intervention and proactive management of frailty, mental health needs and long-term conditions
- significantly more outpatient, diagnostic and treatment activity will be delivered in community settings
- waiting times for urgent, elective and diagnostic care will improve through greater collaboration and more efficient use of capacity
- patients will report better experiences of care coordination, continuity and access
- health inequalities will begin to narrow through targeted population health interventions and equitable access to services
- the system will be placed on a more sustainable financial footing through the transfer of care to lower-cost, higher-value settings and improved productivity across providers.

Success will not be measured solely by activity or performance targets, but by the outcomes that matter most to residents: Living longer in good health, maintaining independence, receiving care closer to home, and having confidence that services will be available when needed. Progress will be monitored through a clear outcomes framework, informed by population health intelligence, patient experience and regular engagement with residents, communities and frontline staff.

The four layers of care provides the blueprint for achieving the ambitions of the NHS 10-Year Health Plan in Kent and Medway. By working together as one layered health and care system, we have the opportunity to improve outcomes, reduce inequalities, strengthen our workforce and secure long-term sustainability. Our vision is clear: A system that delivers the best possible care, in the best possible place, for every resident of Kent and Medway, every time they need it.

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