NHS
Kent and Medway

Commissioning intentions for 2027/28

Planning improvements for the people of Kent and Medway


Caring for all
Including everyone
Building trust
Doing what's right
Being courageous

Contents

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 draft 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 draft priorities, standards and expectations that will shape commissioning decisions, provider contracts and service transformation from 1 April 2027 onwards. These proposals will be tested and refined throughout summer 2026 through a comprehensive programme of engagement with residents, communities, staff, providers, councils, voluntary sector partners and wider stakeholders. The final commissioning intentions will be 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 apply to both physical and mental health. This model recognises that sustainable improvement will only be achieved if we 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 stronger provider collaboration through new arrangements, 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 care they receive. Staff have reinforced these priorities and highlighted the importance of integrated working, digital capability, workforce sustainability and reducing unnecessary bureaucracy. The draft 2027/28 commissioning intentions are designed to respond directly to those priorities.

A central principle of the draft 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 commission against outcomes, quality, patient experience, productivity, value for money and reduction in health inequalities. We will strengthen service specifications, develop clearer outcomes frameworks, improve the quality of data and introduce more explicit performance expectations across all commissioned services. 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 and 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 model across Kent and Medway. This will bring together primary care, community services, mental health services, voluntary sector partners and councils around shared populations, shared outcomes and shared responsibility for improving health. Multi-neighbourhood care services will be redesigned as the bridge between hospital and home, providing a stronger focus on admission avoidance, discharge support, 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, 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 accelerating 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. Providers will increasingly be expected to work through the Acute and Neighbourhood Collaboratives, with greater emphasis placed on pathway performance, shared outcomes and collective accountability for delivery.

Improving 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 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 requirement of every contract, every service specification and every 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 draft commissioning intentions represent the continuation of a conversation rather than the end of a planning process. Over the summer we will test the proposed priorities, commissioning approaches, outcome measures and contractual expectations with residents, communities, providers, staff and partners. Feedback will be used to strengthen and refine the final document ahead of formal board approval in September 2026. While elements of delivery will continue to evolve through that engagement, the direction of travel is clear. 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 draft 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 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 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 draft 2027/28 commissioning intentions is to move beyond describing that future and begin commissioning it. They establish 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 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.

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

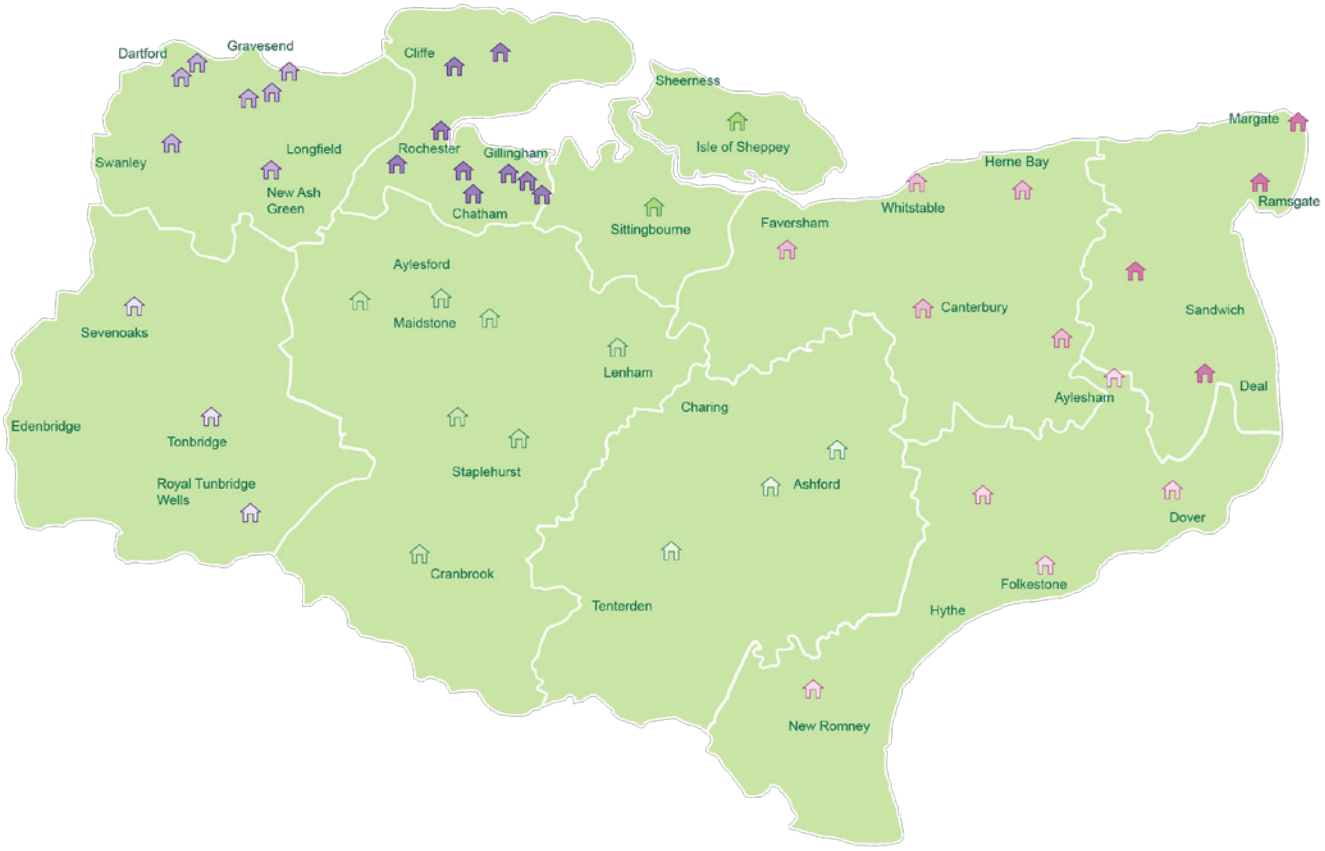
Neighbourhood health will become the principal model for proactive, integrated and preventative care delivery. 45 neighbourhoods have been identified across Kent and Medway, each broadly aligned to primary care network footprints and serving populations of approximately 30,000 to 50,000 residents.

These neighbourhoods will increasingly bring together general practice, community services, mental health services, social care and voluntary sector organisations into integrated multidisciplinary teams with shared objectives for improving health outcomes and reducing inequalities.

The intention is to move from fragmented service delivery towards a model where 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.

Kent and Medway's 45 single neighbourhoods



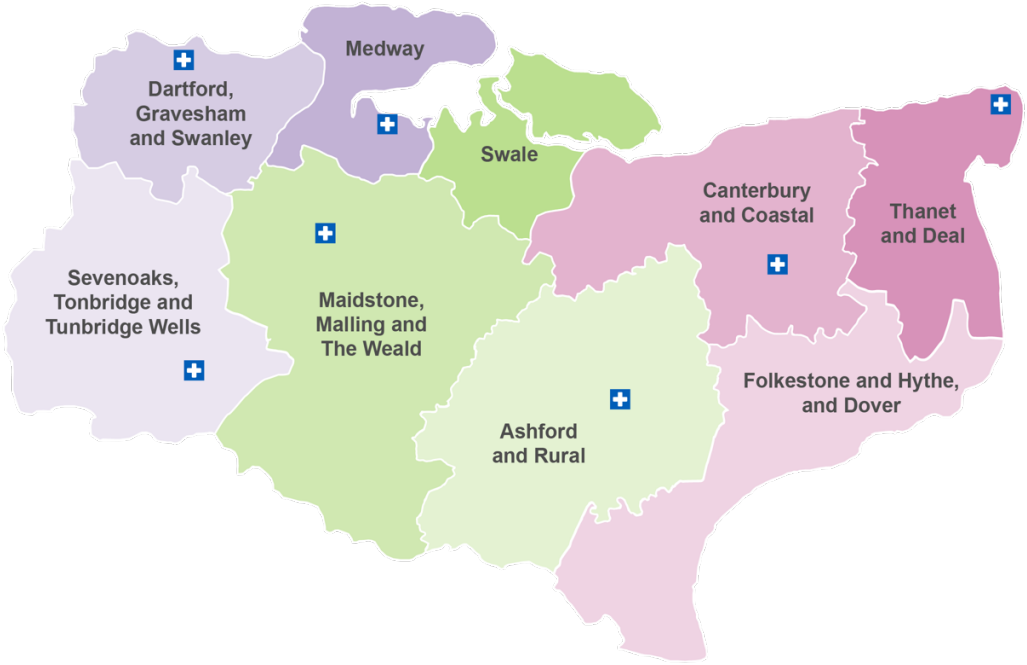
Multi-neighbourhood care

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.

Kent and Medway's nine multi-neighbourhoods



	Multi-Neighbourhood Footprints	Population Count
1	Dartford, Gravesham and Swanley	c.297,955
2	Medway	c.338,780
3	Swale	c.109,030
4	Canterbury and Coastal	c.221,200
5	Thanet and Deal	c.205,020
6	Dover, Folkestone & Hythe	c.180,890
7	Ashford and Rural	c.216,000
8	Maidstone, Malling and The Weald	c.297,990
9	Sevenoaks, Tonbridge and Tunbridge Wells	c.241,660

Acute care

Acute services remain essential to the future sustainability of the NHS and will continue to provide specialist, complex and emergency care for the population of Kent and Medway. However, acute services must increasingly focus on the care that can only be delivered within hospital settings.

As neighbourhood and multi-neighbourhood care services mature, acute providers will be expected to support a significant shift in activity towards prevention, community-based care and integrated pathways. This will allow hospitals to focus their resources on specialist treatment, complex interventions, emergency care, research, innovation and centres of excellence.

The Acute Collaborative will become an increasingly important mechanism for reducing unwarranted variation, improving productivity, standardising clinical pathways and delivering consistent outcomes across Kent and Medway.

Provider collaboratives and alliance working

The Four Layers of Care model will be supported through the continued development of two formal provider collaboratives: the Neighbourhood Collaborative and the Acute Collaborative.

These collaboratives are intended to move the system beyond organisationally focused delivery and towards shared responsibility for outcomes, productivity and transformation. Increasingly, providers will be expected to work together to redesign pathways, manage demand, improve outcomes and deliver system priorities.

Future commissioning arrangements will increasingly focus on pathways and populations rather than individual organisational performance alone. Providers will therefore be expected to demonstrate both organisational delivery and collective contribution to system improvement.

Modern service frameworks

Alongside local strategy and clinical leadership, commissioning intentions will continue to 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 service specifications, contract variations, outcomes measures and quality standards. This will ensure that 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 draft 2027/28 commissioning intentions therefore 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. Providers should expect 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.

3. Population health, outcomes and inequalities: Why change is important

Improving the health of the population is the fundamental purpose of the draft 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 draft 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 draft 2027/28 commissioning intentions. 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.

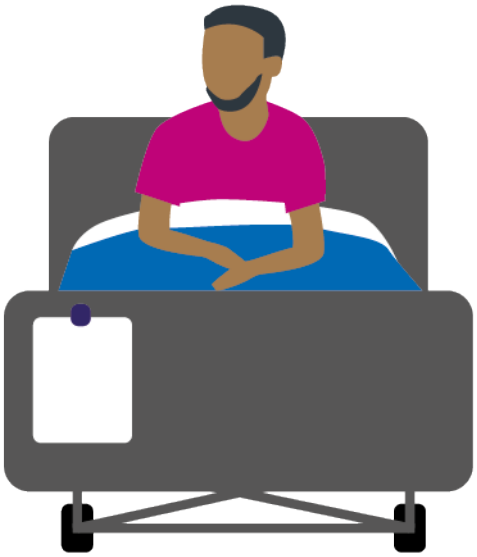
Traditional service models, organised around individual organisations or individual diseases, are no longer sufficient. The future health of the population depends upon commissioning integrated models of care that focus on people rather than organisations, prevention rather than reaction and proactive 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 draft 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
- 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 draft 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 want your ongoing feedback about the priorities that you 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 draft 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 draft 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 commissioning intentions and 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 draft 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 draft 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 draft 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. Providers should expect increasing emphasis on collective responsibility, collaborative planning and system-wide decision making. No organisation should improve its position at the expense of another system partner unless there is a clear, agreed and demonstrable system benefit.

Resources must follow clinical strategy

Financial flows must actively support the strategic direction set out within the draft 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 draft 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.

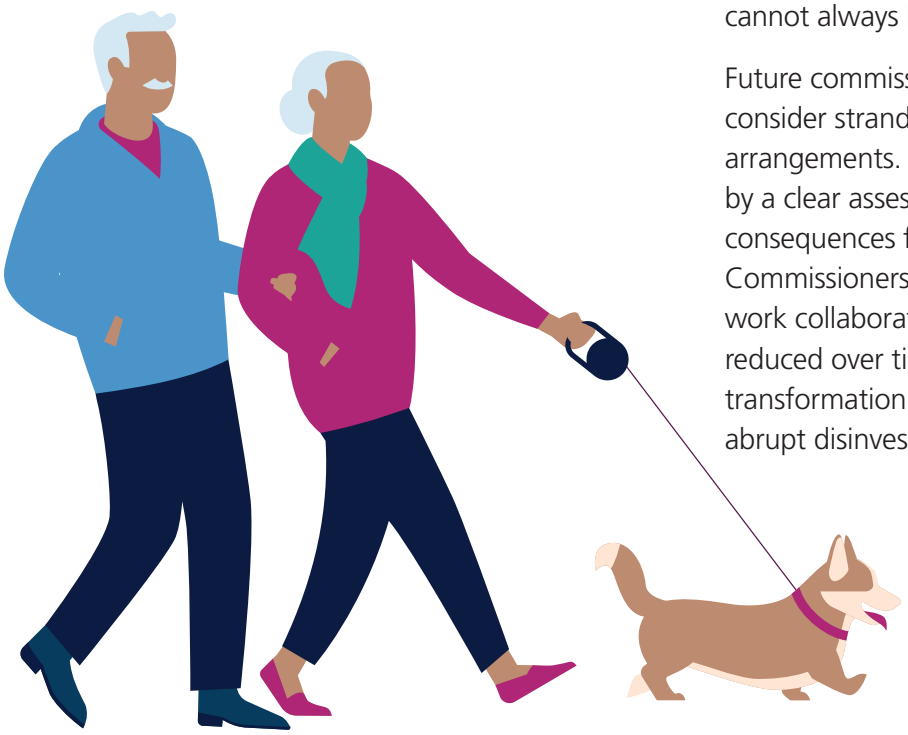
Future investment decisions will increasingly favour organisations, pathways and programmes able to demonstrate measurable improvement in quality, outcomes, productivity, reduction in inequalities and delivery of the objectives set out within the draft 2027/28 commissioning intentions.

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 proposals 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:

- 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 rather than transferred. Providers should expect future commissioning arrangements to increasingly incorporate shared accountability, pathway-level oversight, 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 should be 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 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 through provider alliances and pathway-based models of care.

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 draft 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

The development of the draft 2027/28 commissioning intentions has been informed by one of the largest engagement exercises carried out across Kent and Medway in recent years. More than 1,600 residents, staff and stakeholders directly contributed through surveys, community engagement activity and workforce engagement. A further 295 people participated through targeted engagement with underserved communities, while digital campaigns achieved reach to almost 650,000 people. More than 900 organisations were engaged through partner networks including NHS providers, councils, voluntary sector organisations, Healthwatch, patient groups, elected members and community leaders.

The consistency of the feedback is striking. While people described different experiences of services, communities across Kent and Medway consistently described similar aspirations for the future. Residents want an NHS that is easier to access, easier to navigate and better connected. They want services that are organised around people and communities rather than organisational boundaries. They want a stronger focus on prevention, earlier intervention and care delivered closer to home. Most importantly, they want to see measurable improvements in their experience of care and the outcomes achieved.

Residents want an NHS that feels simpler and more joined up

The strongest message from residents was not about any single service. It was about the overall experience of 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 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:

- difficulty obtaining GP appointments
- 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 neighbourhood-based care strongly reinforces the strategic direction described within the draft 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 communities 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 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 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, councils and wider system partners broadly support the strategic direction set out in the draft 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:

- future commissioning expectations
- 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 draft 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

These draft 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. Throughout summer 2026, we will continue a comprehensive programme of engagement and testing using a combination of locally led engagement activity and independent research and insight organisations. This 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 will be presented to the NHS Kent and Medway Board in September 2026. By that stage they will have been strengthened through extensive public discussion, clinical challenge, partner engagement, independent analysis and community insight. Our ambition is that the final document 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: 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 draft 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 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 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 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 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 regarding 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 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 draft 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 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 draft 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 draft 2027/28 commissioning intentions requires significantly better use of information. The future commissioning model will increasingly be underpinned by:

- population health intelligence
- activity data
- 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 the 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 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 delegation of public health (screening and immunisation) and health and justice services also create 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 draft 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 accountability
- 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 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 draft 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.

Community pharmacy

Community pharmacy will increasingly operate as an integral clinical component of primary care. Providers will be expected to:

- accept referrals from general practice, urgent care and neighbourhood teams
- provide structured feedback to referring clinicians
- increase identification and management of cardiovascular disease
- expand delivery through independent prescribers
- support prevention and population health priorities
- improve hypertension detection and management
- demonstrate measurable improvements in cardiovascular outcomes.

Dentistry

NHS Kent and Medway will carry out a review of all NHS dental contracts. Future commissioning decisions will increasingly be informed by:

- population health intelligence
- levels of deprivation
- oral health outcomes
- access challenges
- unmet need.

Providers will be expected to deliver commissioned activity in full and demonstrate value for money. Organisations consistently failing to deliver agreed levels of activity or quality will be required to improve performance through contract management arrangements or risk activity being redistributed to alternative providers.

From 2027/28, activity redistribution will be actively used as a commissioning tool to increase capacity within underserved communities and improve equitable access to NHS dentistry. Providers will also be expected to support reductions in waiting times for procedures requiring general anaesthetic. Acute providers will be required to collaborate in ensuring sufficient anaesthetic capacity exists across Kent and Medway, and this expectation will form an explicit contractual requirement.

Neighbourhood health

Every provider contributing to neighbourhood delivery will be expected to operate within the Kent and Medway Neighbourhood Model. By April 2027 every neighbourhood will have:

- defined geographic populations
- agreed leadership arrangements
- operational mutli-disciplinary teams (MDTs)
- shared care planning
- risk stratification models
- common outcome measures.

Providers will be expected to demonstrate through a single:

- consistent MDT operation
- management of high-risk cohorts
- reduction in emergency admissions
- reduction in ambulance conveyance
- proactive care planning
- improved experience of coordinated care
- reduction in inequalities.

By October 2026 each neighbourhood will be expected to have a delivery plan for the rest of 2026/27 and by April 2027 a masterplan will be in place for each of our single neighbourhood areas describing how they will develop services and enablers to deliver the required impact.

Multi-neighbourhood care

By April 2027 a single multi-neighbourhood care model will be commissioned across nine multi-neighbourhood footprints. Providers will be expected to deliver a series of improvements, many focussed on supporting the complex care cohort to be supported at home and to return home as soon as possible if a hospital stay is required:

- urgent community response
- hospital at home
- virtual wards
- Home First
- rehabilitation services
- community frailty services
- community nursing
- therapy services
- end-of-life crisis response
- an expanded model of neurorehabilitation to support stroke recovery and wider pathways.

An expansion of home-based services will allow us to review the requirements for community beds in the future, starting with the principle that all care should be delivered at home wherever possible.

Performance expectations will include:

- two-hour urgent community response (UCR) response standards
- same-day urgent assessment
- agreed virtual ward utilisation rates
- consistent discharge to assess pathways
- improved admission avoidance
- improved discharge performance
- improved rehabilitation outcomes.

How this will be commissioned

Contracts will increasingly move beyond service descriptions and activity schedules. From April 2027 contracts will increasingly specify:

- core service requirements
- access standards
- quality trajectories
- outcome measures
- health inequality targets
- neighbourhood delivery expectations
- population health requirements
- activity trajectories
- workforce expectations
- patient experience requirements.

Funding will increasingly be linked to delivery of agreed service standards, quality requirements and outcomes. Neighbourhood health funding will increasingly be aligned to delivery against agreed outcomes rather than solely activity. VCSE organisations will increasingly move from grant-funded arrangements towards formally commissioned neighbourhood services with defined specifications, outcome measures and accountability requirements.

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 and gynaecology 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

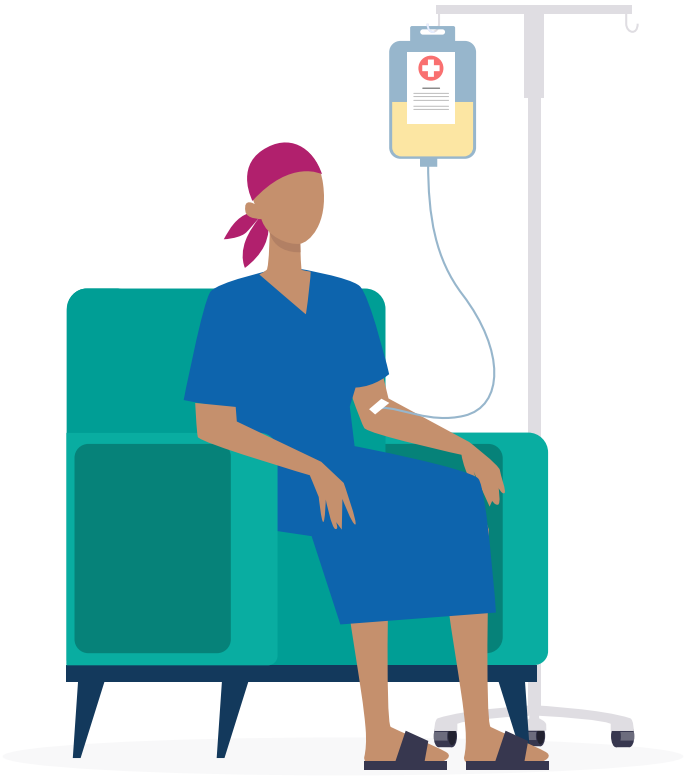
Providers will be required to:

- 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:

- operate specialty clinical networks
- agree common referral criteria
- implement common pathway standards
- share best practice
- reduce unwarranted variation
- improve outcomes across Kent and Medway
- deliver agreed pathway redesign programmes
- 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 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 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 systems.

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 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 a single system 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 techlogoy (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.

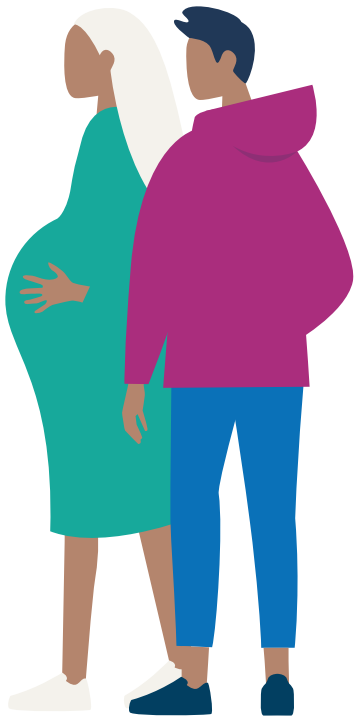
The findings of the National Maternity and Neonatal Investigation, combined with local quality intelligence, service user feedback, Care Quality Commission findings and operational performance information, demonstrate the need for a fundamentally different commissioning approach. The review highlighted 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 2026/27 Maternity Services Review will determine 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

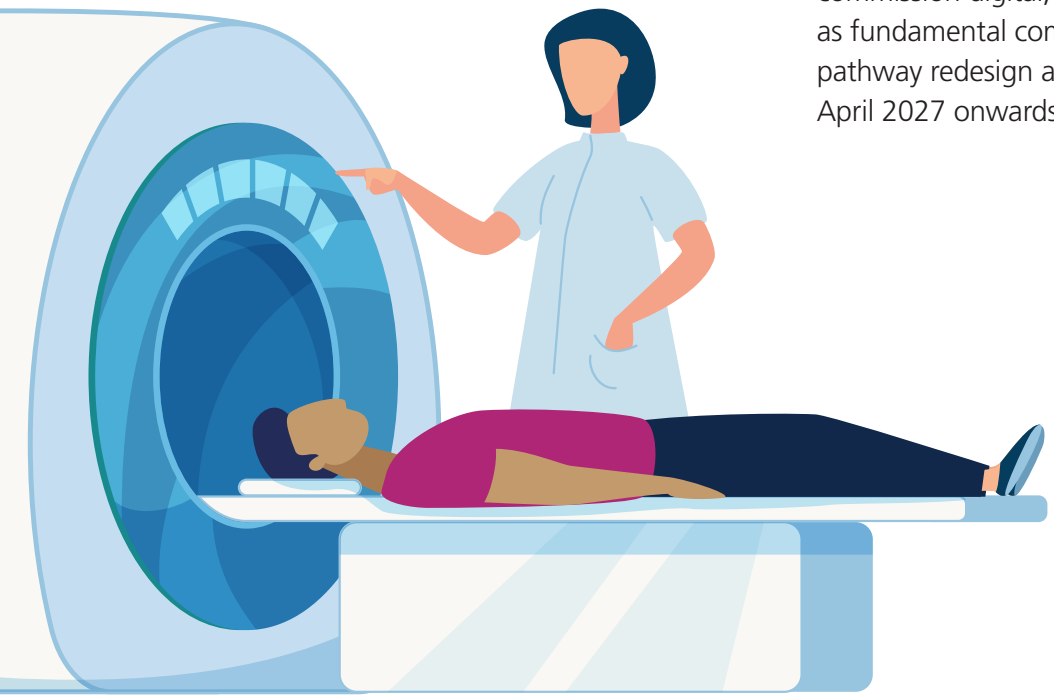
Digital, data, intelligence and research will become core commissioning requirements from 1 April 2027, rather than supporting functions. Every major ambition within the draft 2027/28 commissioning intentions depends on our ability to use information, technology, analytics and evidence more effectively. Improving access, reducing inequalities, improving outcomes, managing demand, reducing waiting lists and delivering financial sustainability will require significantly better use of digital capability and intelligence than is currently the case.

Despite significant progress, Kent and Medway continues to experience variation in digital maturity, interoperability, data quality, analytical capability and adoption of technology across providers. Information remains fragmented between organisations, creating duplication, inefficiency and poor experiences for residents and staff. Too often patients are required to repeat information, professionals cannot easily access the information they need and pathway performance cannot be monitored consistently because data is held in multiple systems.

Variation also exists in the use of population health management, risk stratification, predictive analytics and evaluation. Too often services measure activity rather than outcomes and transformation programmes are implemented without robust evaluation frameworks or benefits realisation arrangements. As a result, digital investment has not always translated into measurable improvements in quality, productivity, outcomes or health inequalities. Future commissioning must therefore focus not simply on technology adoption but on demonstrable benefits for patients, communities and the wider health and care system.

The financial challenge facing Kent and Medway reinforces the need for change. Future improvements in productivity, workforce capacity and value for money will increasingly depend upon automation, artificial intelligence, better use of information, shared care records and intelligence-led decision making. Digital capability is therefore no longer a supporting function but a core component of service delivery.

For these reasons, NHS Kent and Medway will commission digital, data, intelligence and research as fundamental components of care delivery, pathway redesign and system transformation from April 2027 onwards.



What will change from April 2027

NHS Kent and Medway will move from commissioning individual digital projects towards commissioning a single Kent and Medway digital, data and intelligence architecture supporting delivery of the Four Layers of Care model. Providers will be expected to demonstrate how digital capability improves access, quality, outcomes, productivity and reduction of health inequalities rather than simply implementing new technology.

Providers will increasingly be expected to operate within common standards for:

- Shared Care Records (sharing data as required to support expanding use of the Kent and Medway Shared Care record, the use of which will become more and more important)
- information sharing
- population health management
- interoperability
- data quality
- digital inclusion
- cyber security
- evaluation and benefits realisation
- research and innovation.

The NHS App will increasingly become the principal digital front door for residents, whilst maintaining effective alternatives for people who cannot or do not wish to use digital services. Artificial intelligence, automation, ambient technologies and predictive analytics will increasingly become routine components of service delivery were supported by evidence, governance and clinical safety arrangements.

What providers will be required to do

Digital front door

From April 2027, all providers will be expected to contribute to a consistent Kent and Medway Digital Front Door to:

- enable access through the NHS App wherever appropriate
- support online appointment booking and management
- enable digital access to clinical correspondence and results
- support two-way communication with patient
- enable access to care plans and self-management tools
- improve digital navigation of services
- integrate digital access routes into commissioned pathways.

Residents should increasingly experience a coherent digital experience across Kent and Medway rather than multiple disconnected systems.

Neighbourhood health intelligence

From April 2027, providers delivering neighbourhood health services will be required to use population health management, segmentation and risk stratification as a routine part of service delivery. This includes:

- consistent identification of rising-risk populations
- proactive call and recall arrangements
- shared care planning across organisations
- integrated VCSE referral pathways
- use of neighbourhood-level dashboards and outcome measures
- remote monitoring to support earlier intervention and prevention.

Digital and intelligence capabilities will be commissioned to support earlier intervention, improved care coordination and reductions in avoidable deterioration, admissions and duplication.

Elective care intelligence

Providers will be required to:

- support Single Points of Access
- implement Advice and Guidance workflows
- deliver Straight-to-Test pathways
- support referral optimisation
- provide system-wide visibility of waiting lists
- share diagnostic capacity information
- support digital patient communication and self-management
- enable system-wide elective capacity management.

Digital capabilities must support consultant-led triage, improved productivity and reduction in unwarranted variation.

Urgent and emergency care intelligence

Providers will be expected to support:

- Single Point of Access and Clinical Assessment Services
- Urgent Community Response
- virtual ward
- Home First
- transfer of care hubs
- remote monitoring
- real-time flow and capacity management.

Providers will be expected to use shared information to identify risk earlier, support safer discharge, reduce avoidable admissions and improve system flow.

Digital maturity and interoperability requirements

From 1 April 2027, NHS Kent and Medway will establish a common Digital Maturity and Interoperability Framework applying to all commissioned providers. Digital maturity will be assessed in the same way as quality, access, activity and financial performance, with providers required to demonstrate year-on-year improvement against agreed standards.

Providers will be expected to demonstrate:

- full participation in Kent and Medway Shared Care Record arrangements
- compliance with agreed interoperability standards
- real-time availability of agreed patient information to authorised clinician
- digital transfer of referrals, discharge summaries, care plans and correspondence
- elimination of avoidable duplicate data entry and duplicate information requests
- consistent use of national coding standards
- compliance with cyber security and data protection requirements
- participation in system-wide intelligence platforms
- routine submission of agreed datasets
- digital capabilities supporting neighbourhood MDTs and integrated care delivery.

Digital infrastructure

Providers will be expected to demonstrate:

- modern and supported digital infrastructure
- secure network connectivity
- business continuity and disaster recovery arrangements
- cyber resilience and recovery plans
- workforce access to appropriate digital tools.

Clinical Systems and Integration

Providers will be expected to demonstrate:

- interoperable clinical systems
- shared access to care plans
- electronic referral management
- digital prescribing capability where appropriate
- integrated digital pathways supporting coordinated care.

Data quality

Providers will be expected to demonstrate:

- accurate clinical coding
- complete clinical records
- timely data submissions
- reduction in missing or duplicate records
- ongoing data quality improvement programmes.

Population health intelligence

Providers will be expected to demonstrate:

- routine use of risk stratification
- neighbourhood population dashboards
- identification of high-risk cohorts
- data-driven service planning
- outcome and inequality measurement.

Digital workforce capability

Providers will be expected to demonstrate:

- digital literacy programme
- training in data-driven decision making.
- adoption of AI and automation technologies where appropriate
- development of analytical capability within operational and clinical teams.

Performance against Digital Maturity Standards will be reviewed through routine contract management and annual assurance processes. Providers unable to demonstrate progress will be required to implement formal improvement plans with defined delivery milestones.

Data, interoperability and information sharing

From April 2027, all providers will be required to comply with agreed Kent and Medway standards for:

- interoperability
- data quality
- information governance
- information sharing
- cyber security.

Providers will be expected to:

- participate in system-wide dashboards and intelligence platforms
- share agreed datasets securely and consistently
- resolve data quality issues promptly
- support system performance management and commissioning intelligence
- use data to identify variation, inequalities and improvement opportunities.

Information will increasingly be used not only to support care delivery but also commissioning decisions, pathway redesign, resource allocation, prevention, evaluation and benefits realisation.

Artificial intelligence and automation

NHS Kent and Medway will actively support adoption of artificial intelligence, automation and ambient technologies where there is evidence of benefit to patients, staff or services.

Providers will be expected to identify and implement opportunities in:

- ambient clinical documentation
- clinical coding
- workflow automation
- administrative automation
- population risk stratification
- waiting list validation
- demand forecasting
- clinical decision support
- pathway optimisation
- call and recall systems.

All adoption must be clinically led and supported by robust governance, evaluation, clinical safety and accountability arrangements.

By the end of 2027/28, providers will be expected to demonstrate measurable productivity, workforce or quality benefits arising from AI implementation.

Research, evaluation and innovation

From April 2027, all major pathway redesign programmes, neighbourhood developments and digital investments will require formal evaluation frameworks.

Providers will be expected to demonstrate:

- baseline measures
- defined outcomes
- benefits realisation plans
- evaluation methodologies
- learning and dissemination arrangements
- evidence of continuous improvement.

No major transformation programme should proceed without clear evaluation criteria demonstrating how improvements in quality, outcomes, access, productivity, value for money or health inequalities will be measured. Research, innovation and evaluation will become routine commissioning requirements rather than standalone activities.

Contractual accountability

From April 2027, digital, data, intelligence and research requirements will be explicitly incorporated into provider contracts. Providers will be expected to demonstrate:

- adoption of agreed digital capabilities
- participation in system data and intelligence arrangements
- compliance with interoperability standards
- delivery of digital inclusion requirements
- achievement of digital maturity trajectories
- delivery of agreed benefits and outcomes
- compliance with cyber security and data quality standards
- participation in evaluation and benefits realisation frameworks.

Digital maturity, interoperability, cyber security, data quality, evaluation and benefits realisation will form part of routine contract management arrangements. NHS Kent and Medway will increasingly use contractual incentives, improvement plans, recovery arrangements and contractual consequences to accelerate delivery where required.

How success will be judged

Outcomes

Providers will demonstrate:

- improved population health intelligence
- earlier identification of high-risk populations
- improved pathway outcomes
- better targeting of prevention interventions
- improved commissioning intelligence.

Quality

Providers will demonstrate:

- improved data quality
- improved interoperability
- improved cyber security maturity
- improved outcome reporting
- reduced duplication
- improved information sharing.

Access

Providers will demonstrate:

- increased NHS App utilisation
- improved digital access
- faster communication with patients
- reduced administrative burden
- improved navigation through services.

Productivity

Providers will demonstrate:

- measurable benefits from automation
- reduced administrative workload
- improved clinical productivity
- better use of workforce capacity
- improved value for money.

Digital maturity

Providers will demonstrate:

- achievement of agreed Kent and Medway Digital Maturity Standards
- year-on-year improvement in digital maturity assessments
- reduction in reliance on paper-based processes
- increased utilisation of integrated digital pathways.

Interoperability

Providers will demonstrate:

- real-time sharing of agreed clinical information
- consistent use of shared records
- digital transfer of referrals and discharge information
- reduced duplication between organisations
- improved care coordination.

Health inequalities

Providers will demonstrate:

- reduced digital exclusion
- improved digital uptake within underserved groups
- better identification of high-risk population
- reduction in inequalities of access.

Research and innovation

Providers will demonstrate:

- evaluation of all major transformation programmes
- increased research participation
- routine benefits realisation reporting
- adoption of evidence-based innovation.

Patient experience

Providers will demonstrate:

- improved digital experience
- better communication
- greater access to information
- improved self-management support
- higher patient satisfaction.

By the end of 2027/28, NHS Kent and Medway expects digital, data, intelligence and research to be fully embedded within commissioning, operational delivery and clinical practice. Providers will be expected to demonstrate that technology and intelligence are delivering measurable improvements in outcomes, quality, productivity, patient experience and health inequalities, with digital capability regarded as a core component of service delivery rather than a supporting function.

14. Contract management, governance, assurance and provider board accountability

The draft 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 draft 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 draft 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 draft 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 draft 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 draft 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.

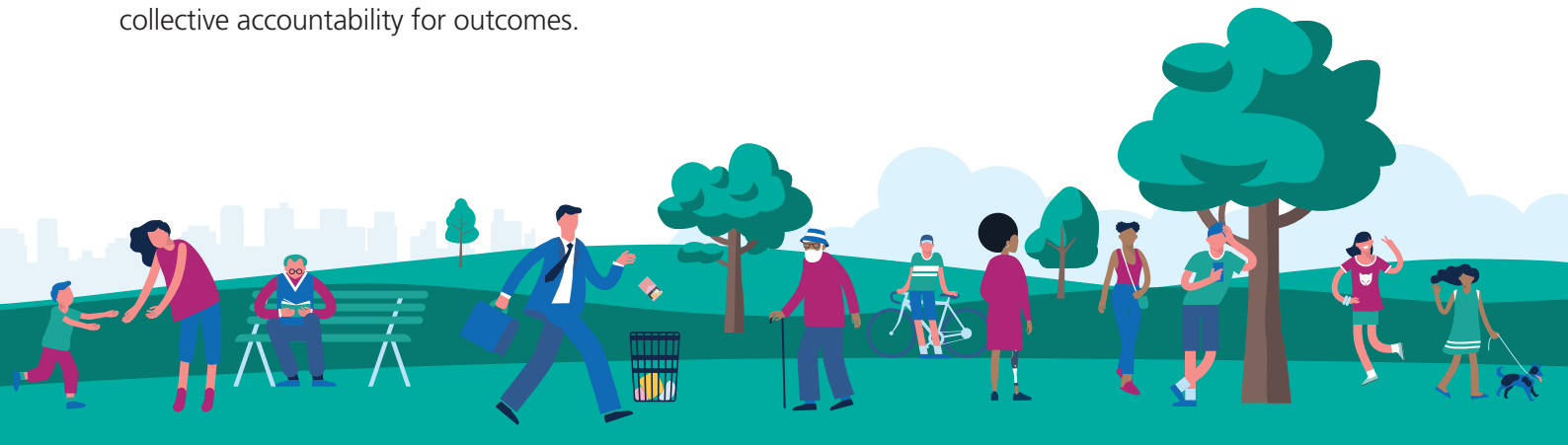
The implications are clear:

- 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 draft 2027/28 commissioning intentions.
- The draft 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 draft 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.