Medway Council
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Health and Adult Social Care Overview and Scrutiny Committee

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Commissioning Intentions 2027/28

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Summary

This paper outlines and aligns our key commissioning documents, which set our direction and will drive our commissioning cycle/approach over the next 5 years.

The Key documents accompanying this report are:

- Five Year Plan 2026-2031 (final version post engagement)
- Three Year Commissioning Plan 2026-2029
- Commissioning Intentions for 2027/28 (to be engaged upon over summer, with the final version to be approved at the ICB's September Board)

1. Recommendations

1.1. The Committee is asked to note commissioning direction which will drive commissioning cycle/approach over the next five years. To discuss and respond to the specific questions outlined below.

2. Budget and policy framework

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

3. Background

3.1. This paper outlines and aligns the ICB's key commissioning documents, which set out its direction and will drive its commissioning cycle/approach over the next five years.

3.2. Five Year Plan 2026-2031 – This sets a clear ambition and commitment for the NHS to reimagine health and care across Kent and Medway from 2026 to 2031. It describes the outcomes the system will deliver over the next five years, the priorities that will guide collective effort, and the operating architecture that will enable delivery at scale. An extensive public engagement programme has been completed to understand what matters most to our population and to inform priorities. Details of the engagement and outcomes can be found on the ICB's website.

3.3. Three Year Commissioning Plan 2026-2029 - This strategy describes the ICB's plan for the next three years, using annual commissioning intentions to set expectations/ambition for radical change, which is clinically-led. The ICB's transition to a new operating model is underpinned by effective multidisciplinary working and development of its Commissioning Multi-Disciplinary Teams.

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3.4. The ICB's commissioning intentions have been published in draft for engagement. It wrote to HASC on 22 July 2026 to describe the opportunity to influence the intentions over the engagement period. The commissioning intentions will provide NHS providers with greater certainty on what it expects them to work on individually and when it would like them to collaborate through the Acute or Neighbourhood Alliance. This will enable investment in workforce, digital capability and service redesign. The ICB will commission services across the four layers of care it has defined for the system, primary care, single neighbourhoods, intermediate care/multi-neighbourhoods and acute.

3.5. The commissioning intentions are informed by extensive engagement with residents, staff, community organisations, voluntary sector partners, local authorities 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.

3.6. 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, the ICB will increasingly commission against

outcomes, quality, patient experience, productivity, value for money and reduction in health inequalities. It 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.

3.7. 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.

3.8. The most significant area of transformation will be the continued shift towards neighbourhood health and community-based care. The ICB 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 local authorities around shared populations, shared outcomes and shared responsibility for improving health. Intermediate 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.

3.9. Alongside this, the ICB 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.

3.10. 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. The ICB will use its 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.

3.11. Digital, data, intelligence and research will become core commissioning requirements rather than supporting functions. The ICB 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. It expects digital capability, intelligence and evaluation to be embedded within operational delivery rather than sitting alongside it.

3.12. These draft Commissioning Intentions represent the continuation of a conversation rather than the end of a planning process. Over the summer the ICB 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 the ICB will create a more sustainable health and care system and deliver better outcomes for the people of Kent and Medway.

3.13. The health and wellbeing of our population is shaped by housing, education, employment, social care, public health, community resilience and the wider determinants of health. The ICB would therefore like to use the engagement period to strengthen both the content of the commissioning intentions and its wider engagement with local government partners to ensure that the final document better reflects our collective ambitions for Kent and Medway.

3.14. The ICB would be particularly interested in the Committee's reflections on the following questions:

a) **Does the document adequately reflect the role of local government in improving the health and wellbeing of our population?**
Where could we better describe the role of local authorities and wider partners in delivering improved outcomes for local people?

b) **Have we given sufficient emphasis to prevention and the wider determinants of health?**
Are there opportunities to strengthen the focus on housing, education, employment, community resilience, public health and tackling the root causes of poor health?

c) **What opportunities exist for deeper collaboration between local authorities, the NHS, communities and the voluntary sector?**
Where should we be more ambitious in relation to neighbourhood health, integrated services, prevention and population health management?

d) **Are there specific population needs or local priorities that require greater emphasis in the final document?**
What should we add or amend to better reflect the experience and needs of local communities?

e) **How can we strengthen the role of neighbourhoods, communities and residents in improving outcomes?**
What more should we do to support community-led solutions, early intervention and prevention?

f) **What would success look like from a local government perspective?**
If these commissioning intentions are successfully delivered, what improvements would you expect to see for residents, communities and local public services over the next three to five years?

3.15. Finally, it would welcome the Committee's views on one broader question: What is missing from this document that would make it feel like a genuinely shared strategy for improving the health and wellbeing of the people of Kent and Medway, rather than a document focused predominantly on NHS delivery?

4. Risk management

4.1. Risks are identified in the individual appendices.

5. Financial implications

5.1. As we commission more strategically, we will strive to deliver better value and outcomes through:

- Outcome-based funding (Moving towards quality and outcomes)
- Shift from Acute to Community Care
- Risk sharing

6. Legal implications

6.1. Legal implications are identified in the individual appendices

Lead officer contact

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Appendices

Appendix 1: Commissioning Intentions 2027/28
Appendix 2: 5 Year Plan
Appendix 3: 3 Year Commissioning Plan

Background papers

None