NHS
Kent and Medway

Appendix 2

Five year plan

2026 to 2031


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

Contents

1. Executive summary

Kent and Medway faces a defining moment. Life expectancy differs by more than a decade between neighbourhoods. Our population of more than two million people is growing and ageing, with increased multimorbidity and complexity. Persistent health inequalities, linked to deprivation, ethnicity and geography compound these challenges. Elective waiting lists are at historic highs. Urgent and emergency care is under unrelenting strain. Mental health needs are rising sharply, and the system carries a £300m recurrent deficit. Without radical change, these gaps will widen, outcomes will worsen, and the sustainability of health and care will be at risk.

This document sets out the five year strategy for the NHS in Kent and Medway. 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 and pace.

Over the next five years we will:

- Improve health outcomes and reduce inequality: Prevention and equity will be at the heart of commissioning and service redesign. We will target resources to areas and groups with the greatest need to narrow the healthy life expectancy gap, reduce premature mortality from preventable causes and improve outcomes for groups experiencing the poorest health.

- Shift care towards prevention, neighbourhood and community-based provision: Neighbourhood health will be our cornerstone. Through primary care, Integrated Neighbourhood Teams, expanded community services, virtual wards, Hospital at Home and stronger intermediate care we will shift from reactive to proactive care, reducing reliance on hospitals.

- Stabilise and then improve performance across access, flow, quality and productivity: We will commission and provide improved access to services and reduce waiting times, redesigning clinical pathways to enabler faster diagnosis and treatment without digital exclusion.

- Achieve financial balance and system productivity through transformation rather than short term mitigations: We will commission and provide high-value, digital-first, proactive care to address the £300m system deficit and meet the mandatory two per cent annual productivity improvement.

Clear roles, while not the strategy themselves, are essential to deliver our Five-Year Plan. NHS commissioners and providers have distinct but complementary responsibilities: Commissioners set the strategic direction and allocate resources, while providers deliver care and transformation on the ground. Understanding these roles will drive alignment, accountability, and a shared focus on outcomes.

This strategy supports reset, recovery and long-term transformation and provides a single framework against which plans, contracts, investment decisions and performance will be judged. Year one will focus on reset and stabilisation, year two and three on embedding new care models and alliances, and year four and five on consolidation and sustainability. It will be refreshed annually.

Involving people and communities is integral to implementation. We have heard from individuals and our communities, ensuring our plan reflects the needs and experiences of residents, our workforce, and partners. The challenges are stark and the status quo is not an option, but our commitment is firm: By 2031, Kent and Medway will be a system that leads nationally in integrated, neighbourhood and community-first care with improved health outcomes for all.

2. Why we need to change: Population, performance and finance

2.1 Overview

Kent and Medway faces a combination of pressures that require a fundamental change in how care is planned and delivered over the next five years. These pressures are well evidenced in what our residents tell us, population data, performance trends and the system financial position.

2.2 What our residents want

People's voices are at the heart of our transformation. We spoke to more than a thousand people across Kent and Medway by attending public events, sharing online surveys and asking trusted community leaders to hold local conversations. We also heard from our colleagues in NHS organisations across the county and from our extensive stakeholder groups including VCSE organisations, councils, councillors and MPs.

People in Kent and Medway have told us what matters most: **Services that are easier to access, easier to navigate and more joined up**. We have heard that:

- the cumulative effect of trying to get help is the most difficult. Concerns didn't highlight just one service but the impact of getting a primary care appointment, waiting for a referral or results, repeating the story, chasing responses, etc.
- communication needs to be better between services and to explain pathways or delays
- people want to feel their voices are heard and to be treated as an individual with dignity and respect
- shared records could make communication better
- waiting times cause poor experience and can make health conditions worse
- digital access is welcome but there should always be alternatives, otherwise it can be frightening or encourage misrepresentation of symptoms
- service availability and quality varies between areas, especially in coastal communities
- local access and travel times for non-specialist care are important
- more support is required for mental health
- people want to be proactive and supported in identifying ways to prevent ill health
- healthcare staff seem to be under pressure.

We heard that different groups experience the NHS differently. Older people are especially likely to raise GP access, phone and online barriers, continuity and the difficulty of travelling. Younger adults are more likely to talk about mental health. Disabled respondents more frequently describe accessibility problems, multiple-condition care and the poor fit between service design and everyday life. Some places, particularly coastal, rural and fast-growing areas, describe themselves as disadvantaged by poor transport, uneven provision and services not keeping pace with population growth. Marginalised groups emphasised how important it was to have someone they trust help them navigate the system, particularly if they have no family or social support networks.

"Digital will never be inclusive unless you have a back-up plan for those not using it."	*"Unable to get a GP appointment."*	*"Getting information about my care in a timely way and not having to chase it."*
"Too many electronic data systems which are not interconnected and coordinated. I am the only one who has all the information."	*"Mental health is so low down and treated as not important."*	*"Problems worsen while waiting making them more complex and expensive to fix."*
"I have no children, and no family in the area to help me… the NHS doesn't recognise the fact that there are people without children or families to look after them."	*"I waited 13 weeks for a CT scan test result… it was a really worrying time for me and my family."*	*"Long waits for all services, mental health support for my child."*
"A fragmented mental health service. Total lack of preventative support to help reduce the risk of people reaching a mental health crisis."	*"Postcode lottery of provision … you can travel long distances for services with no public transport options."*	*"The numerous specialisms that treat us do not work holistically and joined up."*

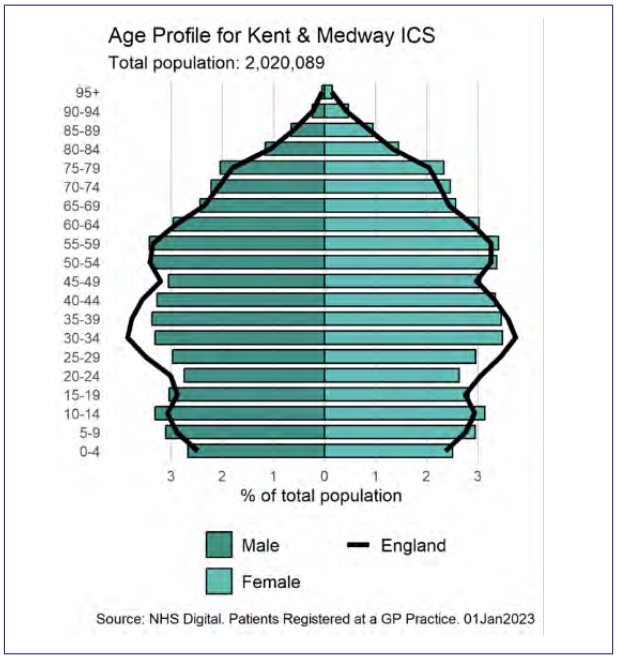
Based on our discussions we have developed this five year plan, making sure our strategic ambitions remain rooted in what matters most to the people and communities we serve. We need to improve the day-to-day experience and address the issues most visible to our residents: Can I get help when I need it? Do services talk to each other? Can I get care closer to home? Can I still access the NHS if I am older, disabled, working, isolated or not confident online? And when I do get through, will I be treated like a person rather than processed like a task?

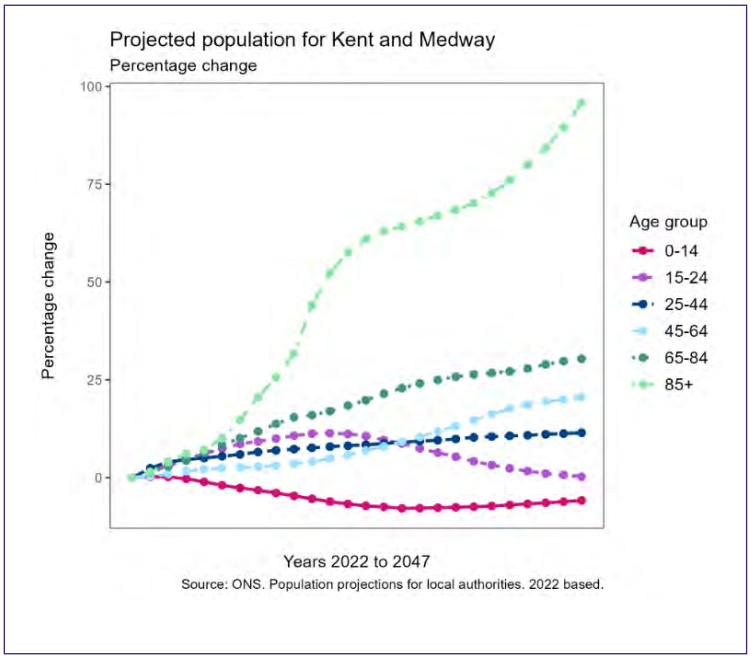
This is only the beginning of an ongoing conversation. We will engage our communities at each stage, reporting back on what we hear and the actions we take, ensuring transparency and building trust.

2.3 Demographic profile

The NHS in Kent and Medway serves a population of more than 2 million people, encompassing urban, rural, and coastal communities, each with distinct health needs and demographic profiles. Kent remains the most populous county council area in the south east, with Medway as a significant urban centre. Population growth and demographic change across Kent and Medway are shaping current and future health and care needs, as outlined below.

- **Population growth and ageing:** Kent and Medway's population is growing and ageing faster than the national average. Older age groups will see the greatest increase over the next 20 years, driving demand for long-term condition management, frailty support and dementia care.
- **Diversity:** Kent remains predominantly White British (83 per cent) but Medway is increasingly diverse, with a 3.1 per cent rise in Black, Asian and minority ethnic communities between 2011 and 2021.
- **Deprivation:** Health outcomes are strongly linked to deprivation. Thanet, Swale, Ashford, Dover and Medway have the highest concentrations of areas in the most deprived decile, while Sevenoaks, Tonbridge and Malling and Tunbridge Wells have none.





2.4 Health outcomes and Inequalities – why change is urgent

Kent and Medway faces significant and persistent health challenges that threaten population wellbeing and system sustainability. These issues are driven by deprivation, geography, and demographic change, creating stark gaps in outcomes and access. The employment gap for those with long-term health conditions is concerning. Without decisive action, these trends will worsen, placing further strain on urgent care, elective recovery, and financial stability.

Life expectancy gap

Life expectancy differs by more than a decade between the most and least deprived neighbourhoods, reflecting deep-rooted inequalities across our communities.

Cardiometabolic disease

- Cardiovascular diseases (CVD), diabetes, and kidney disease are major contributors to mortality and morbidity.
- In 2023/24, 105,000 people aged 17+ diagnosed with diabetes (7.7 per cent of population, +1.5 per cent in 10 years).
- Chronic kidney disease: Rising incidence and prevalence. 67,500 people aged 18+ (5.1 per cent of registered population).

Cancer

- Leading cause of death, especially under 70 years.
- 26 per cent of all deaths in Kent (2024); 36 per cent of premature deaths (<70 years).
- Biggest contributor to inequality in male life expectancy, and the second biggest for females.

Dementia, multimorbidity, and frailty

- Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life and can be caused by various diseases.
- Dementia prevalence rising with ageing population.
- 40 per cent of cases linked to modifiable risk factors including physical inactivity, high blood pressure (hypertension), type 2 diabetes, obesity, smoking, midlife hearing loss, depression, and social isolation
- Multimorbidity and frailty increases treatment burden and unplanned care.

Mental health

- Mental health conditions can have a significant impact on all areas of someone's life, and their prevalence is increasing worldwide.
- Depression prevalence and self-harm admissions for children and young people (10 to 24 years) in Kent are higher than the England average.
- Suicide is the main cause of death in ages 10 to 35 years.
- Only 47 per cent of people with a severe mental illness (SMI) received a physical health check (England average: 58 per cent), a leading cause of life expectancy inequality.

Neurodivergence

- National autism prevalence is estimated at 1-2 per cent and Attention Deficit Hyperactivity Disorder (ADHD) prevalence at 3-4 per cent. Both nationally and locally there are significant waiting lists for diagnostic assessment, so the true prevalence is likely higher.
- National Learning Disabilities prevalence is estimated at 2.2 per cent.
- Neurodivergent people have far higher service usage and lower life expectancy.

Respiratory disease

- Chronic Obstructive Pulmonary Disease (COPD) is a common chronic condition which is responsible for early mortality and places significant demand on NHS services.
- COPD prevalence increasing; 2 per cent of population in England, 4.5 per cent of those aged 40+.
- Smoking and poor air quality are key risk factors.

Maternal and child health

- Children living in deprivation experience different outcomes in health and education, particularly notable in their emotional and mental health.
- Emergency admissions are highest in districts with greater ethnic diversity.
- Child obesity and dental decay are prevalent in deprived areas.
- Approximately 22,500 pregnant women across Kent and Medway are supported annually. While this represents 1.2 per cent of the population, this group accounts for 2.6 per cent of A&E attendances and 2.1 per cent of emergency admissions, indicating opportunities to strengthen community-based and preventative maternity care.
- Health inequalities in maternal and neonatal outcomes persist, with ethnic minority women (23 per cent of low-complexity pregnancies) and women with complex needs facing disproportionate risks. Nearly 30 per cent of women with high-complexity pregnancies experience depression, and 13 per cent have musculoskeletal conditions, highlighting the need for integrated, multidisciplinary approaches.

Health inequalities

The Kent and Medway Annual Health Inequalities Report (2024/25) highlights disparities by deprivation, ethnicity, gender, and geography. It highlighted significant variation in:

- hypertension control
- uptake of covid and flu vaccines
- early cancer diagnosis
- physical health checks for people with serious mental illness
- children's oral health
- smoking at delivery and preterm birth rates
- longer waiting times in areas of deprivation and for some ethnic minority groups
- more frequent use of emergency care in more deprived populations.

Targeted outreach and multidisciplinary clinics based in communities have shown promising outcomes, but sustained effort is needed to close gaps and improve outcomes for all.

2.5 Demand and performance pressures

Demand for services continues to rise across almost all sectors. Data shows sustained year on year growth in:

- emergency department attendances and non-elective admissions
- referrals into elective pathways
- demand for mental health and community services
- length of stay and delayed discharge remain above benchmark, indicating insufficient intermediate and community capacity and suboptimal flow through hospitals
- variation in access and outcomes between places and providers remains unwarranted and impacts both quality and equity
- workforce availability is a further constraint. vacancy rates, reliance on temporary staffing and challenges in recruiting to key clinical and professional roles are affecting productivity and resilience across the system.

2.6 Financial context

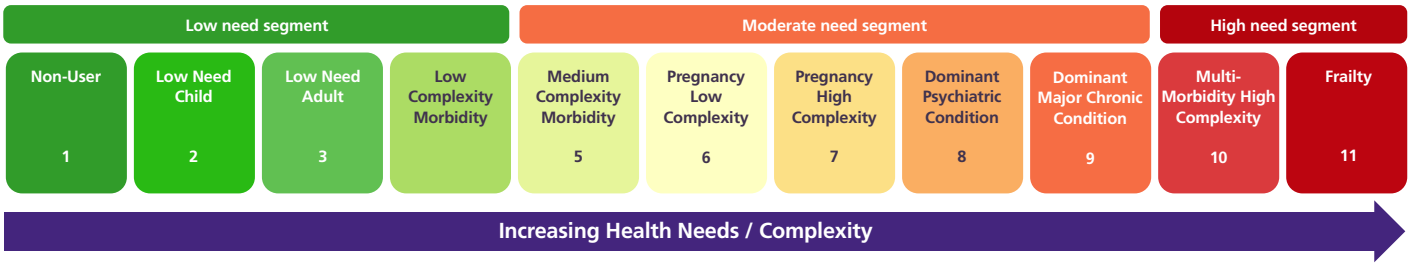
The system financial position reflects a long-standing imbalance between investment, activity and outcomes, particularly within the acute sector. Comparative analysis shows that spending on acute services in Kent and Medway is approximately three per cent higher than that of comparator systems, while outcomes are not three per cent better.

This indicates cost and value are not aligned. The level of investment has not translated into proportionate improvements in population outcomes, access or productivity. Instead, it reflects high levels of avoidable demand, inefficiencies in pathways, extended length of stay and insufficient alternative provision outside hospital settings. The current pattern of spend therefore reinforces pressure in the acute sector rather than relieving it.

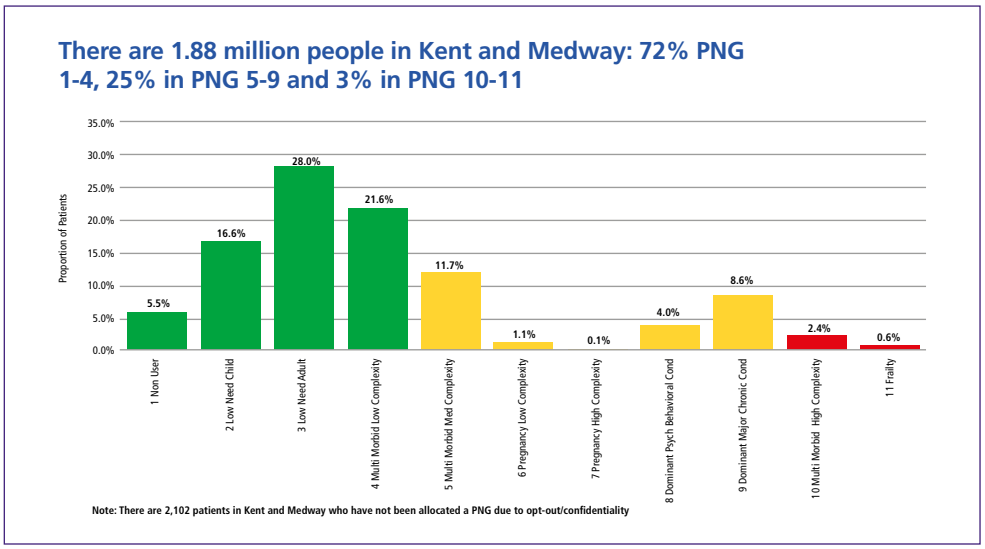
Short term mitigations will not resolve the challenges, a deliberate shift in how resources are used is required to support prevention and reduce reliance on hospital care. The plan therefore prioritises a rebalancing of investment away from avoidable acute activity and towards prevention, neighbourhood, intermediate and community based care. Improving productivity and outcomes within the acute sector, while reducing inappropriate reliance on hospital care, is central to achieving a recurrently balanced financial position.

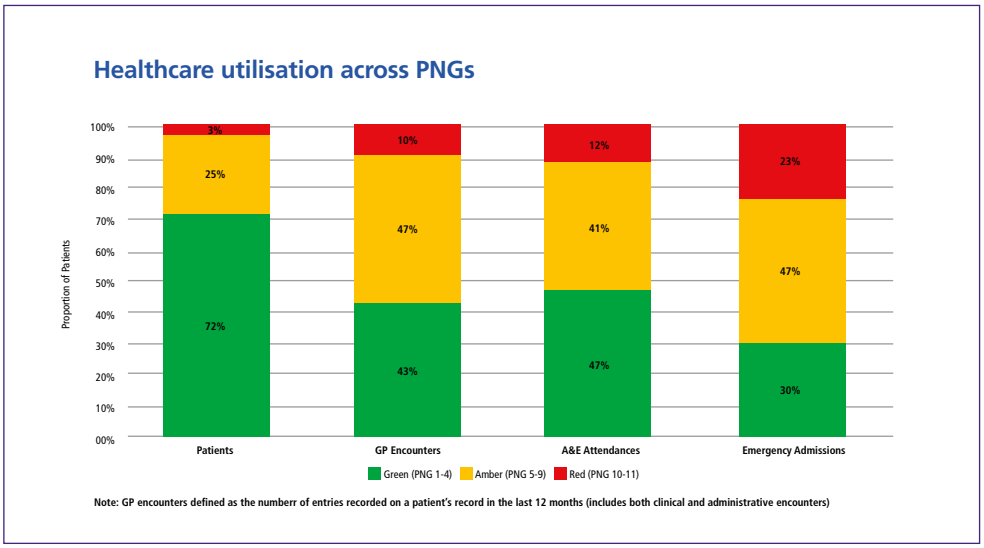
2.7 Population Health Management

Population Health Management (PHM) will be a core way of working for the NHS in Kent and Medway, underpinning commissioning, service redesign, and frontline delivery. The Patient Need Groups (PNG) allows standardised segmentation and risk stratification of the population. This data is used to drive insight, risk stratification, and proactive intervention to improve outcomes and reduce inequalities.



Most of the Kent and Medway population is healthy or in the low need / low complexity segmentation. Those with high needs have high healthcare use.





Why we need to change – a patient story

An 80-year-old man with advanced dementia, severe frailty and multiple health conditions lived in a care home, supported by carers and his wife. After developing a chest infection, he was treated remotely by his GP but deteriorated despite two courses of antibiotics. Two emergency calls followed, and although his ReSPECT plan stated a preference for community-based care, he was admitted to hospital. He died there without his wife at his side.

Under our future Neighbourhood Model, such individuals in care homes or their own homes, would contact a single point of access, receive an in-person assessment by a multidisciplinary team, point-of-care tests, and dual planning for treatment and what matters most to them and their family. Options like Hospital at Home for IV antibiotics, updated care plans accessible to all, and Just in Case medications would have enabled him to remain in familiar surroundings with his loved ones present, supported by 24/7 holistic and end-of-life care. This approach ensures dignity, choice, and better outcomes for patients and families.

3. Where we want to get to: Our four care models

Primary, Neighbourhood, Intermediate Care and Acute Care

Our residents told us they want better and quicker access to local care with a focus on prevention and proactive support to improve health. Our vision is for our neighbourhood health approach to deliver more care closer to home, reduce avoidable hospital use, enable long term financial sustainability and improve population health outcomes.

Population health data and a system-wide roll-out of our risk stratification tool will support us in identifying those in our population at greatest risk, targeting our interventions, monitoring our impact in real time and thereby providing proactive, personalised care.

Primary Care will be the anchor of our system for continuity, prevention, proactive management of complex patients, and urgent access. This is the route through which most people will experience physical and mental health care. Continuity will support people to build trust and enable advocacy for those without close family or social support.

Neighbourhoods will be commissioned with a clear accountability to anticipate and manage demand for services. We will invest in strong clinical leadership with a responsibility for quality, safety and outcomes. Single neighbourhoods will align to Primary Care Networks and serve a population of 30-50k. Each neighbourhood will be supported by an integrated neighbourhood team, bringing together GPs, community pharmacy, dentistry, optometry, community health, mental health, social care (local authority), and voluntary sector partners.

Intermediate care will be redefined as a seamless bridge between hospital and home, providing support at scale, step-up and step-down support, rehabilitation and reablement. This will be delivered through Multi Neighbourhood footprints with a population of 250k+ and expanded community services including virtual wards, hospital at home, remote monitoring and community diagnostics.

In shifting from a hospital-first to community-first approach, hospitals will be redesigned to ensure stronger integrated with neighbourhood teams, single points of access and greater use of virtual care and digital tools. Acute Centres of Excellence will deliver high quality specialist care with reduced variation and drive innovation and research.

Our communities will shape these changes and challenge us to commission and provide the services they need.

The next section describes key areas of focus, with clear outcomes and metrics for each, which will drive this vision. The outcomes respond directly to what our residents told us, population and performance data and financial challenges. In summary, key transformation and new models of care initiatives include:

- reducing avoidable demand through prevention and early intervention
- managing complexity and frailty proactively in neighbourhoods, bringing together primary, community, mental health, voluntary sector and social care (council) professionals
- improving flow and recovery through strengthened intermediate care
- operating acute services as a coordinated system to improve quality and productivity
- improving access and reducing waiting times by optimising urgent treatment centres, developing community diagnostic centres, virtual wards and remote monitoring, virtual consultations, straight-to-test access for elective pathways, and enhancing patient initiated follow up

- digitally transforming pathways including digital-first urgent care, digital triage, using AI and genomics to shorten pathways and lead to faster and better diagnoses and shared care records to support seamless transitions between services
- managing the transfer of services, for example some specialised services, from NHS England
- engaging and co-producing with residents and colleagues, continuous learning, and a focus on reducing inequalities
- directing investment to high-value interventions, digital transformation, and workforce development
- adopting a strengths-based approach to identify, scale and showcase nationally the innovations Kent and Medway has developed at pace.
- new models of care supported by a disciplined system architecture, clear accountability and consistent use of data to drive improvement. Developing organisational models and capabilities that enhance delegation, accountability and leadership.

Successful neighbourhood care – a patient story

A 55-year-old music industry manager with metastatic bowel cancer and recurrent chest infections wished to avoid hospital, prioritising time at home with family and familiar surroundings. Through our Neighbourhood Model of Care, he received intravenous antibiotics and complex symptom management at home, supported by district nurses, hospice teams, and urgent community response seven days a week. His final months were spent doing what mattered most – at home with his wife and dog, overlooking the seafront – rather than repeated hospital admissions. He died peacefully at home, with family present, supported by a coordinated, compassionate team.

4. How we will get there

4.1 Priority 1 – Improve health outcomes and reduce inequality

1. Population health management

People told us they want more prevention focused care, with support for healthy living and ageing well. Population health management (PHM) will be a core way of working, using data to support our understanding of local need. This will support earlier identification and intervention, improved management of long-term conditions, and reduction of risk factors, and is therefore a key feature of our neighbourhood health model.

Our ambition is to improve healthy life expectancy and reduce preventable deaths by focusing earlier on people at highest risk, strengthening prevention across the life course, and improving access to diagnostics, screening and health checks. We know people experience unfair variation between places so we will narrow inequalities for underserved groups, improve management of long-term conditions, and support more people with health conditions to stay in or return to work through integrated wellbeing and employment support.

Metrics:

- **Healthy life expectancy gap** between most and least deprived areas (narrowing trajectory).
- **Percentage of patients supported by obesity programmes** (proportion of people taking up lifestyle/behavioural programmes).
- Metrics to be developed for **WorkWell** programme and included in future reports.

2. Cardiometabolic

The neighbourhood-based model will strengthen the focus on earlier identification of risk, personalised support for multimorbidity and long-term health of communities.

Our ambition is to prevent more cardiometabolic illness by improving early detection and management of risks such as hypertension and diabetes, reducing avoidable strokes, heart attacks and complications. We will focus on narrowing inequalities, particularly for deprived and underserved groups and for people with learning disabilities and autism, to improve outcomes and reduce premature deaths.

Metrics:

- **Hypertension treatment-to-target rates**, with improvement over time, segmented by deprivation and ethnicity.

4.2 Priority 2 – Shift care from hospital to neighbourhoods

Our new neighbourhood approach focuses on prevention and better health management that our residents have told us they want. It will deliver the national shift from hospital to community care, becoming the cornerstone of delivery and prevention. Primary care is the foundation of the system and will provide continuity, prevention, proactive management of complex patients, and urgent access. It will enable the continued development of person centred care, building trusting and supporting advocacy.

Each neighbourhood footprint will have an agreed leadership structure and delivery plan, enabling local teams to provide joined up, proactive support based on what matters to residents. Single neighbourhoods will align to Primary Care Networks (serving 30-50k population) while Multi Neighbourhood footprints (covering 250k+ population), will deliver scale, flexibility, and hospital at home capability. Neighbourhoods will implement non-elective demand management plans reducing avoidable admissions for frailty and high-risk cohorts, thereby supporting people to remain independent and releasing resources for reinvestment into community services and infrastructure.

At neighbourhood level, shared care records, population risk stratification and multidisciplinary team working will enable proactive identification and support of people at highest risk. This will address the current high use by a relatively small cohort of people with complex needs, significant variation between neighbourhoods, and insufficient coordination between services, as evidenced by our data. Digital tools such as remote monitoring, virtual wards and virtual consultations will support care closer to home, reduce avoidable admissions and improve coordination across primary, community and secondary care. We will always make sure alternatives are available to prevent digital exclusion. Progress will be monitored through maturity assessments and transformation plans to achieve our ambitions and the scale of change required.

3. Primary care including general practice

When we spoke to our communities, general practice was consistently described as a key pressure point in the system, feeling like a barrier rather than a gateway to services. Our neighbourhood approach will support general practice through strengthening all primary care services including community pharmacy, dentistry and optometry, and general practice. Primary care services will work as equal partners within neighbourhood health and care models to improve access, prevention and continuity of care.

We recognise that digital systems are welcomed by many but can be a barrier or encourage symptom misrepresentation for some. So, while we will make greater use of digital tools such as consultations, triage and the NHS App, we will always make sure alternatives are available to support fair access.

Together, these changes will support our ambition to reduce variation in access and improve outcomes for people with long-term physical and mental health conditions by providing more effective, proactive care.

Metrics:

- Growth in **number of urgent dental appointments** provided versus target.
- **Uptake of community pharmacy** clinical services.
- **GP leaver** rate.
- **Percentage** of patients to describe **booking a general practice appointment as easy**.

4. Integrated Neighbourhood Teams

We will deliver Integrated Neighbourhood Teams (INTs) across all neighbourhoods, addressing existing geographical boundaries to bring together general practice and primary care networks, community health services, mental health, pharmacy, dentistry, optometry and local authority and VCSE partners.

Integrated Neighbourhood Teams will provide more proactive support for people with frailty, long-term conditions and complex needs, while improving access to general practice. Since local access and travel times for routine care matter, they will also reduce avoidable hospital use and bring more planned and specialist care closer to home, including diagnostics and expert advice.

Metrics

- **Reduction in non elective admissions** for frailty, care homes and high risk neighbourhood cohorts, segmented by deprivation and ethnicity.

5. Intermediate care

Intermediate care is critical to flow, patient recovery and independence and is a key determinant of acute performance. We will transform community services through integrating them around neighbourhood footprints, community diagnostics, wearable technologies and virtual wards. We will focus on prevention, seamless support for long-term conditions, eliminating long waits for community health services, frailty, end-of-life care, and integration of children's and adult services. This will include supporting safe discharge and flow, working with acute, mental health, and social care partners to reduce readmissions and ensure home first approaches which support independence.

Our key outcomes include increased capacity, strengthened rehabilitation and reablement outcomes, and improved experience and continuity of care.

Metrics:

- **percentage of urgent community response** episodes meeting national standards.

4.3 Priority 3 – Stabilise and then improve performance

Access to care was the top priority in all our discussions with individuals and communities, with long waits impacting experience and outcomes. Over the next five years, we will make services more accessible, efficient, safe, and environmentally responsible, ensuring every professional has the right information at the right time and every person can access care in the way that suits them. Digital innovation, as a key enabler, will support this priority.

6. Urgent and emergency care

Urgent and Emergency Care (UEC) in Kent and Medway will be transformed to deliver the national shift towards timely, digitally enabled, community-first urgent care. Over the next five years, our focus is on reducing unnecessary emergency department (ED) attendances, improving patient flow, enabling same-day access to appropriate urgent care, and supporting safe, effective discharge through integrated coordination with community teams.

This will support our aim to reduce inequalities in urgent care access and outcomes while improving safety and patient experience across the whole urgent and emergency care pathway.

Metrics:

- **Four-hour standard A&E performance.**
- **Average number of days from discharge ready date and actual discharge date.**

7. Acute care and diagnostics

We heard how care feels fragmented and how people must repeat their story. Acute care will operate as a coordinated system rather than a set of independent organisations. We will redesign elective pathways for straight-to-test pathways, shift care to community settings, expand community diagnostic centres (CDCs), and enhance patient-initiated follow-up and digital triage. Cancer care will be driven by a strong focus on early diagnosis, improved cancer survival rates and personalised stratified follow-up (PSFU) models to tailor post-treatment care to individual need. We will embed digital technologies such as AI and genomics into clinical pathways to improve quality, productivity and to shorten pathway lengths, leading to faster and better diagnoses.

In doing so we will meet national waiting time standards, improve diagnostic accuracy and productivity, and concentrate specialist services where this improves quality and sustainability. This approach will also increase patient choice and self-management while reducing unfair variation in access and outcomes between different places.

Metrics:

- Annual change in the **size of the waiting list.**
- System quartile for **18-week performance.**
- Percentage of all **cancers diagnosed at stage one or two.**

8. Maternity, neonatal, and women's health

We will commission a single, system-wide specification for maternity and women's health that brings greater consistency, quality and equity across services. This includes expanding women's health hubs, implementing digital maternity records, and centralising access to services. A comprehensive rollout of the Maternity Information System (MIS) across all four trusts will provide real-time system oversight, reduce administrative burden for clinicians, and strengthen evidence-based decision-making.

Care pathways will be further strengthened through the expansion of integrated models of care. The Maternal Medicine Network will play a key role in supporting women with medical complexity and co-morbidities, enabling access to specialist multidisciplinary care closer to home and reducing fragmentation across services. System-wide implementation of the Perinatal Pelvic Health Service (PPHS) will address musculoskeletal conditions during pregnancy and support recovery, rehabilitation and long-term wellbeing following birth.

Key outcomes will be improvements in safety and quality, more personalised care and better access to services such as contraception, pelvic health and menopause support. We will also reduce inequalities in maternal and neonatal outcomes and improve access to perinatal mental health support

Metrics:

- Deprivation and ethnicity gap in **pre-term births** score.
- Number of neonatal deaths and stillbirths per 1,000 total births.
- Percentage of pregnant women who **quit smoking.**

9. Mental Health, Learning Disability, Autism, and ADHD

Our communities see mental health services as underprovided and difficult to access, particularly at times of crisis. We will deliver an integrated, preventative and neighbourhood-aligned all-age service prioritising shifting care closer to home, strengthening early intervention, reducing inequalities and improving outcomes, while ensuring sustainable and high-quality services.

Services will be developed through engagement, co-produced where possible, community-based and delivered in partnerships with primary care, councils, education, VCSE partners, and neighbourhood teams. All with shared governance, digital interoperability and joint commissioning.

For children, young people and young adults, we will prioritise earlier help, integrated pathways and improved transitions, including a clear 16 to 25 model across education, primary care, VCSE and specialist services. Mental Health Support Teams, strengthened early intervention and transformed neurodevelopmental pathways, will reduce long waits, crisis presentations and out-of-area placements.

For adults, delivery will build on the Community Mental Health Transformation Framework to strengthen integrated primary–community mental health pathways, assertive outreach for people with psychosis and improved support for people with complex emotional needs, reducing reliance on urgent and inpatient care.

Our ambition is that mental health is no longer seen as underprovided but offers timely access to services, with reduced crisis presentations and improved physical health for people with severe mental illness. Timely access to mental health, autism and ADHD support will improve inequalities, outcomes and experience.

Metrics:

- **Percentage of people with SMI or a learning disability receiving annual physical health checks**, segmented by deprivation and ethnicity.
- **Number of out-of-area placements**, with year on year reduction.

4.4 Priority 4 – Achieve financial balance and system productivity

Our financial approach is focused on achieving long-term sustainability, addressing the system's recurrent deficit, and maximising value for money. Core components include a multi-year Financial Recovery Programme, robust financial controls, and transparent governance. We will prioritise investment in high-value interventions, digital transformation, and workforce development, while decommissioning low-value services and optimising estate use. Value-based commissioning and outcome-based contracting are central, supported by collaborative financial planning across partners.

Delivery of financial balance and sustained productivity improvement is a national requirement set out in the NHS Medium Term Planning Framework and is essential to maintaining local autonomy and unlocking future investment. Digital transformation, including automation and AI enabled pathways will play a critical role in releasing staff time, reducing duplication and supporting sustainable productivity improvements, contributing directly to financial recovery and long term system sustainability.

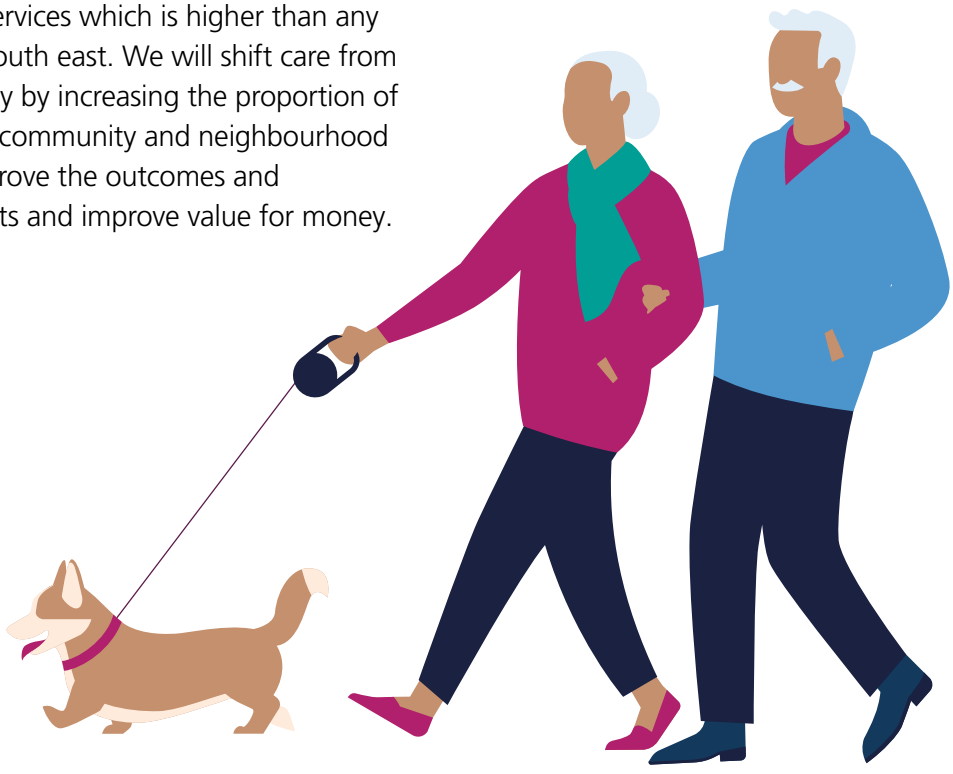
NHS Kent and Medway spends 53 per cent of its allocation on acute services which is higher than any other system in the south east. We will shift care from hospital to community by increasing the proportion of resources invested in community and neighbourhood services. This will improve the outcomes and experiences of patients and improve value for money.

Key Outcomes:

- **Achieve recurrent financial balance by 2027/28** and maintain it thereafter through a multi-year financial recovery programme.
- **Delivery of year on year productivity improvements**, including the mandatory two per cent requirement.
- **Shift of resources toward prevention, early intervention and neighbourhood level care**, with reduced proportion of spend in acute settings.
- **Strengthened financial stewardship, transparency and shared accountability** across the system.

Metrics:

- **Delivery of minimum two per cent annual productivity gain.**
- **Reduction in system cost per weighted activity unit**, indicating efficiency improvement.

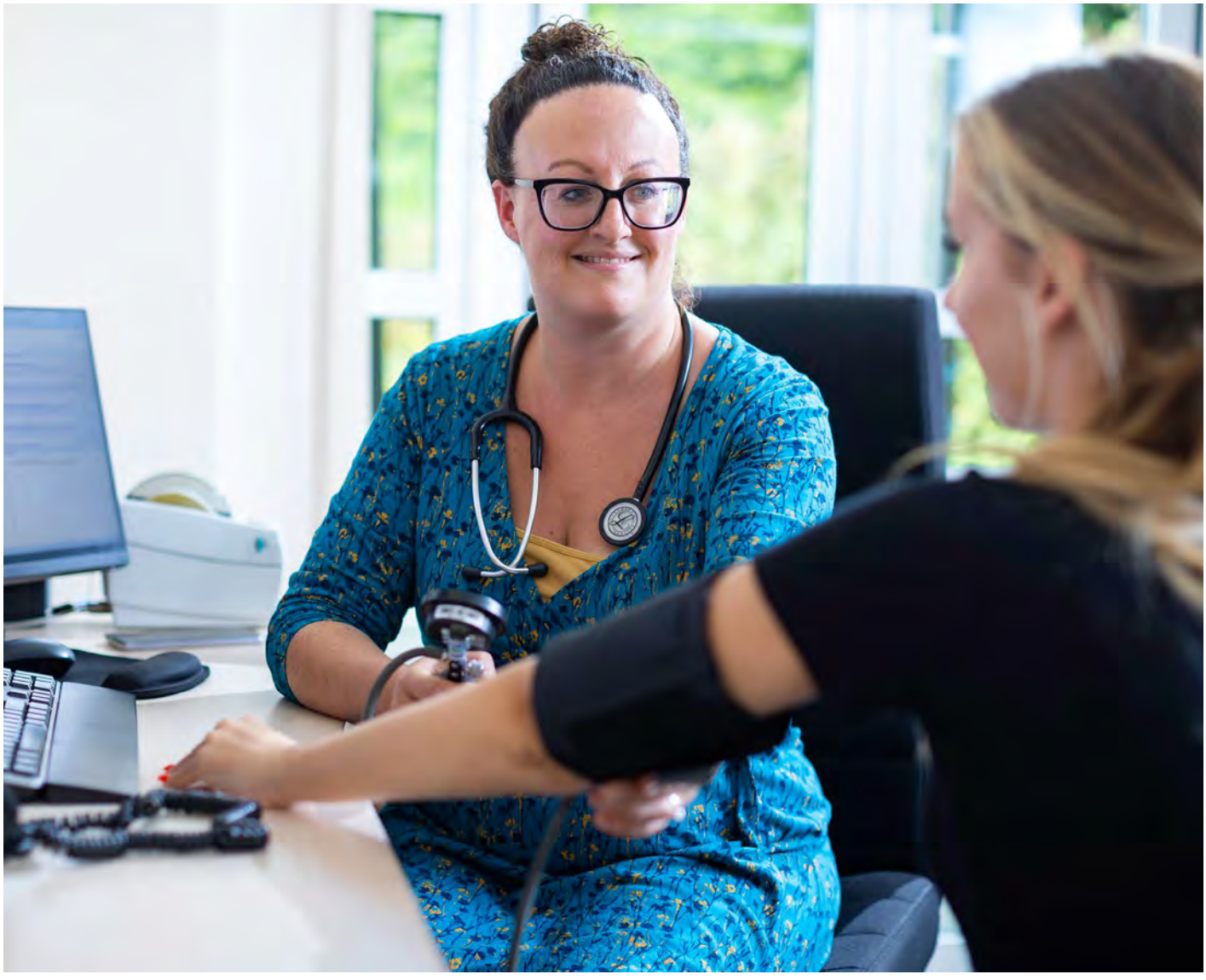


5. System architecture and enablers

During our discussions we heard how people believe shared records, consistent digital tools, simpler communication and standardised pathways are all essential for a better NHS. So, having set out our ambition for primary, neighbourhood, intermediate and acute care, the next step is to describe how these priorities will be delivered in practice. This section begins to translate intent into action, outlining delivery roles and the enablers to our vision. These enablers are not standalone workstreams, they are integrated across all priorities, shaping how services are commissioned, delivered, and improved.

5.1 Clear roles and responsibilities

Understanding our roles as a strategic commissioner and as providers is essential to deliver our plan in an aligned and accountable way with a shared focus on outcomes. NHS Kent and Medway will lead strategic commissioning, ensuring resources are targeted to deliver maximum impact. We will focus on improving outcomes for our population rather than directly delivering services.



Area	Commissioner responsibilities
Strategic commissioning and resource allocation	**Set system strategy and priorities** aligned to population need, using a data driven approach. This includes this five-year plan and three-year numerical plans (finance, workforce, activity) that triangulate across domains. Operate a **rolling multi-year commissioning framework** with commissioning intentions engaged on and issued to provide early clarity on delivery of this plan. This will offer providers greater certainty and enable investment in workforce, digital capability and service redesign. Allocate resources transparently, ensuring value for money, a longer-term approach to investment in innovation, technology and infrastructure, and maintaining financial balance. Shift resources from hospital to prevention and neighbourhood, tackling inequalities and commissioning for optimal cost and quality. **Manage contracts**, holding providers to account. Commission Integrated Health Organisation (IHO) contracts and multi-neighbourhood provider contracts to enable end-to-end pathway redesign with clear accountability and demand management. **Listen to our population** about what matters to them. Use data and intelligence to understand need, target investment and evaluate whether we're achieving our intentions.
Driving the three national shifts	Act as the **system intelligence hub**, triangulating provider data, population health insights and regulatory information to identify risk and variation, target commissioning and drive improvement. Neighbourhood Health: Identify high-need cohorts (frailty, care homes, end of life) and commission integrated neighbourhood teams with a minimum two-hour urgent community care offer. Digital by default: Ensure providers adopt NHS App, Federated Data Platform (FDP), and NHS Notify; commission digital-first pathways and modern service frameworks. Prevention: Commission secondary prevention services in areas such as obesity, tobacco dependence and cardiovascular disease.
Oversight and accountability	Provide commissioning grip and assurance, while NHSE carried out formal provider management. Use the NHS Oversight Framework to operate a single performance framework across all sectors. Monitoring access, quality, finance, productivity, and delivery of the three shifts. Performance data will be reviewed through a consistent cadence: • monthly contract review focused on delivery and recovery • quarterly strategic review focused on trajectories and transformation • annual assessment aligned to the planning and contracting cycle Embed outcome-based commissioning with shadow outcome measures from 2026/27. Ensure compliance with quality measures, productivity targets (minimum two per cent annual improvement) and financial discipline (break even without deficit support funding).
Partnership and governance	Work with councils and voluntary sectors to co-produce neighbourhood health plans Strengthen assurance processes and risk management, including reprioritisation actions for unforeseen pressures. Lead cultural renewal by embedding behavioural frameworks in commissioning processes.

Provider roles go beyond meeting activity targets, they will lead service transformation, embed digital-first care and uphold high standards of quality and patient experience.

While all providers will remain sovereign, **two formal provider alliances** will act as the primary delivery vehicles:

- **The Community Alliance** will deliver primary, neighbourhood and intermediate care at scale, enabling consistent pathways, shared workforce models and population based delivery. The alliance founding members will be comprised of the Primary Care Provider Collaborative, Kent Community Health NHS Foundation Trust (KCHFT), Kent and Medway Mental Health Trust, the Voluntary and Community Sector Alliance and the hospice sector.
- **The Acute Alliance** will deliver the acute model of care, including clinical networks, centres of excellence and shared transformation programmes. The alliance founding members will be Dartford and Gravesham NHS Trust, East Kent Hospitals University NHS Foundation Trust, Maidstone and Tunbridge Wells NHS Trust and Medway NHS Foundation Trust.

Area	Commissioner responsibilities
Delivering care and transformation	Accountable for delivery of contracted services to the required specification, meeting quality and operational trajectories including (but not limited to): • Elective: 92 per cent RTT by 2028/29. • Cancer: 96 per cent (31-day), 85 per cent (62-day). • Diagnostics: ≤1 per cent breaches. • A&E: 85 per cent four-hour standard. • Ambulance Cat 2: 18 minutes average. Deliver the national shifts from treatment to prevention, hospital to neighbourhood and analogue to digital. Implement digital-first outpatient and urgent care models, reducing unnecessary follow-ups and expanding advice and guidance. Expand mental health support teams, reduce out-of-area placements, and deliver dental and community service targets.
Workforce and productivity	Implement consultant job planning reforms, reduce agency spend (zero by 2029), and improve sickness absence rates. Right size the workforce to meet service specifications and healthcare transformation needs. Adopt digital tools (FDP, NHS Notify) and modern service frameworks for conditions like CVD and serious mental illness.
Quality and patient experience	Embed the Patient Safety Strategy, implement Martha's Rule, and improve maternity services using MOSS and inequalities dashboards. Capture real-time patient experience and act on feedback to improve care quality.

Shared commitment

As a commissioner and providers, we share accountability for delivering the four system priorities and enabling plans. We will all drive the three national strategic shifts while improving productivity, quality, and patient experience. This clarity of roles underpins our ability to meet constitutional standards and transform care for our communities.

5.2 Workforce

It is well evidenced that a supported, valued workforce delivers care with respect and dignity, which is a key priority for residents who describe how it feels to seek care is as important as the outcome. Our vision is to sustain a skilled, compassionate, and resilient right-sized workforce that is empowered to deliver high-quality, person-centred care across Kent and Medway. We will invest in strong clinical leadership as well as the development, wellbeing, and adaptability of all our people, to ensure confidence in delivering strategic commissioning and service redesign.

Metrics:

- **Staff survey engagement theme sub-score** (annually).
- Staff survey **education and training theme score** - "we are always learning" section score (annually).
- **Sickness absence rates.**

5.3 Digital, data and technology (DDaT)

We recognise digital, data and technology is at the heart of modern, efficient, and equitable health and care. It underpins integrated care, supports population health management, and enables new models of service delivery. Digital delivery will be sequenced to prioritise the foundations required for neighbourhood health, productivity and financial sustainability. In the early years of this strategic plan, the focus will be on shared records, interoperability and core digital infrastructure, responding to resident concerns about fragmentation and enabling risk stratification, multidisciplinary working and proactive care at neighbourhood level.

We will continue to engage with and develop more advanced automation and AI enabled pathways to scale these as the foundations mature.

We will deliver the following key components:

- **comprehensive electronic patient record (EPR)** coverage across all NHS provider organisations
- **interoperable clinical systems** that enable timely and safe sharing of core patient information across organisational boundaries
- **shared care records** accessible to all relevant professionals and, where appropriate, patients, to address concerns about repeated story telling
- **advanced population health analytics**, planning and performance oversight, supported by federated data capabilities as functionality becomes available
- a single, shared digital order communications system to support diagnostics, including imaging and pathology, across the system
- **digital front door** (NHS app and web portals) for access to appointments, results, and self-care, with alternative access available to prevent exclusion
- **AI and automation** for diagnostics, triage, and administrative efficiency
- **digital inclusion** initiatives to ensure equitable access for all communities
- **cyber security and resilience**, safeguarding patient data and maintaining system integrity.

5.4 Quality and safety

The 10-Year Health Plan places quality, transparency, patient feedback, and patient choice at the heart of healthcare transformation. We recognise an embedded quality improvement and safety culture is essential for delivering high standards of care and learning from experience. NHS Kent and Medway will achieve this by enshrining quality standard in commissioning approaches and contracts, with a single set of quality standards aligned with National Quality Board (NQB) guidance, and the expected National Quality Strategy.

Providers will demonstrate how quality, innovation, prevention, and productivity are considered at every stage of service design and delivery, including reference to certification and accreditation against national standards where appropriate. In addition, there is a requirement for system-wide learning collaboratives and peer review, real-time incident reporting and thematic analysis and mandatory use of the Patient Safety Incident Response Framework (PSIRF). Patient and carer involvement in service design and quality assurance is essential, with annual quality reporting and public transparency.

5.5 Sustainability and Net Zero

Environmental sustainability is a statutory and moral imperative. The system is committed to achieving Net Zero carbon emissions and embedding sustainability in all decisions through our Kent and Medway Green Plan. This promotes sustainable procurement and clinical practice, including staff and patient engagement in sustainability initiatives. Our neighbourhood approach will support sustainability.

5.6 Partnership and engagement

Involving people and partnering are central to delivering this strategic plan. Involving residents, patients, carers, communities, staff and system partners has reinforced the importance of collaboration, clear communication and visible responses. The NHS is often experienced not as a standalone organisation, but as part of a wide councils. We will continue to work closely with local authorities, NHS providers, and the VCSE sector to improve services, particularly for communities experiencing the poorest outcomes.

Involving people and communities will be an ongoing cycle, not a one-off activity. We will maintain transparent communication, including regular public updates on progress, impact and decisions. We will ensure our engagement practice is inclusive, accessible and tailored to communities experiencing the poorest outcomes, including people with protected characteristics, seldom-heard groups and those facing digital, language or social barriers.

6. Risk and mitigation

Delivering the ambitions of the Kent and Medway Five Year Plan requires a robust approach to risk management. The complexity of the health and care system, combined with significant demographic, financial, and operational pressures, means that risks are inevitable. However, with proactive identification, clear accountability, and effective mitigation strategies, we can manage these risks to tolerable levels to safeguard delivery and maintain public trust.

All Kent and Medway NHS organisations operate comprehensive risk management frameworks. The Board Assurance Framework provides oversight, ensuring that risks to strategic objectives are systematically monitored and mitigated to acceptable levels, while operational risks are captured through the Corporate Risk Register. Regular reviews ensure that emerging risks are captured, assessed, and escalated as appropriate. By embedding risk management into every aspect of planning and delivery, we can anticipate challenges, respond effectively, and ensure that the system remains resilient, adaptive, and focused on delivering better health outcomes for all.

Key system risks and mitigations

Risk	Description	Mitigation
Finance	The system faces a recurrent deficit (c. £300m), with ongoing pressures from inflation, rising demand, and the need for investment in transformation.	Multi-year Financial Recovery Programme with clear savings targets. Value-based commissioning and outcome-based contracting. Gain-share mechanisms and transparent allocation models.
Workforce	Our workforce are key for every successful transformation within our health system but wellbeing and adaptability risks impacting delivery.	Integrated workforce planning. Shared people services. Expansion of the Kent and Medway Health and Care Academy. Regular monitoring of staff survey results and turnover rates, with follow up actions to address engagement and wellbeing.
Quality and safety	Variability in quality and safety standards, risk of avoidable harm, and challenges in maintaining consistent improvement.	System-wide quality standards and assurance processes, linked to certification and accreditation against national standards where appropriate. Real-time incident reporting and thematic analysis. Learning collaboratives and peer review. Patient and carer involvement in service design and assurance.
Digital and cyber security	Increasing reliance on digital systems heightens the risk of cyber-attacks, data breaches, and system failures.	Compliance with NHS Data Security and Protection Toolkit and Cyber Essentials Plus. Regular cyber security audits and staff training. Investment in robust digital infrastructure and incident response plan. Robust post deployment monitoring of new digital technologies to confirm ongoing quality and safety.
Health inequalities	Persistent gaps in access, experience, and outcomes for deprived and minority communities.	Targeted interventions using population health management data. Embedding CORE20PLUS5 and Equality Impact Assessments in all programmes. Monitoring and reporting of progress against inequalities metrics.
Partnership and delivery	Complexity of system-wide collaboration may lead to misalignment, duplication, lack of trust or delivery delays.	Formal partnership agreements and shared governance structures. Clear escalation routes to the System Improvement Board and Joint Committee. Continuous engagement, to include building trust, with our partners, workforce, and communities.

7. Conclusion – turning vision into impact

This is not just a plan; it's a call to action. A fundamental reset of how we commission and provide care to meet the rapidly growing needs of our population.

Our commitment is clear.

- **Improve health outcomes and reduce inequality:** Move from transactional contracting to outcome-based commissioning and align resources to population need.
- **Shift care towards prevention, neighbourhood and community-based provision:** Primary care as the anchor. Neighbourhoods commissioned as loadbearing units with clear accountability for demand management, supported by integrated teams and a multidisciplinary clinical leadership model. Intermediate care supporting flow, recovery and independence.
- **Stabilise and then improve performance:** Acute care, with centres of excellence for specialist care, integrated with neighbourhood teams. Interoperable shared care records to enable proactive, personalised care and system-wide productivity. Reduced waiting times and improved access.
- **Achieve financial balance and system productivity.** Deliver the mandatory two per cent annual improvement, shift resources to prevention and community care, and reinvest savings into neighbourhood services.

These priorities, each with defined outcomes and metrics, are delivered through our **four care models: Primary, neighbourhood, intermediate, and acute care**. They are supported by a clear **system architecture** and strong **enablers** – workforce, digital transformation, quality improvement, sustainability and effective partnerships.

Our **risk management framework** underpins the plan, ensuring financial, workforce, quality, digital, and partnership risks are proactively identified and addressed as fully as possible.

Our **delivery approach** is phased. Year one will focus on reset and stabilisation, year two and three on embedding new care models and alliances, and year four and five on consolidation and sustainability. We will refresh our approach annually based on updated data and trajectories, while maintaining the same overall direction.

People are at the heart of this strategy. Ongoing **engagement and co-production** with our residents, workforce, and partners will make sure services remain responsive to local needs and that health inequalities are systematically reduced. Annual delivery plans, transparent reporting, and regular review cycles will turn strategic intent into real-world impact.

The challenges facing Kent and Medway are significant, but by harnessing collective strengths, embracing innovation, and focusing relentlessly on prevention and equity, the system can deliver its vision: For people in Kent and Medway to live longer, healthier lives in thriving neighbourhoods, supported by integrated, compassionate, and sustainable health services.