NHS
Kent and Medway

Appendix 3

Commissioning plan

2026 to 2029

Contents

Executive summary

Kent and Medway faces a combination of structural and wider system challenges that require a fundamental shift in how care is planned and delivered over the next three years. These pressures are well evidenced in population data, performance trends and the system financial position, and they define both the urgency and the scale of change required. We see inefficiencies across the system with both financial and outcome consequences:

- avoidable demand (acute attendances and admissions that could be managed in the community)
- inappropriate substitution of activity (for example type three UEC attendances for demand of a type which could be met in general practice)
- extended length of stay and discharge issues
- performance challenges.

Given current national benchmarking, there is significant potential for us to improve.

GP access (describe booking a GP appointment as easy)	41/42
Days from discharge ready and actual discharge dates	34/42
Percentage of patients who receive all eight diabetes care processes	38/42
Percentage of patients with CVD who have cholesterol levels managed	40/42
Percentage of hypertension atients treated to target	41/42
Percentage of inappropriate out of area placement adult acute mental health bed days	23/42

The system financial position reflects a long-standing structural imbalance. Comparative analysis shows that spending on acute hospital care is approximately three per cent higher than that of comparator systems, with lower comparative spend on mental health. Levels of acute spending drive deficit and are not translated into proportionate improvements in population outcomes, access or productivity.

Without the deliberate shift this strategy proposes in how resources are deployed to make the three shifts set out in the 10 Year Plan, we will not be able to meet the demographic and other pressures facing Kent and Medway; financial pressures will continue to escalate and we will not see the outcomes improvement we need.

We will deliver neighbourhood health in collaboration with our local council partners, in a way that will contribute to addressing the wider determinants of health.

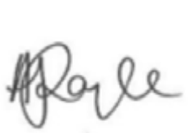
We must become a more capable organisation to deliver on this strategy, accelerating the implementation of strategic commissioning. This strategy describes the plan for the next three years, using annual commissioning intentions to set expectations and ambition for radical change which is clinically-led.

We will hold ourselves and our providers to account through newly robust contracts and performance frameworks to see through delivery. Our purchasing will become more outcomes-focused, and we will make maximum use of the contract and financial levers available to us. A new commissioning policy will be agreed this summer, followed by a joint policy with local government partners. This will describe how we will drive commissioning through our four new commissioning multi-disciplinary teams who will deliver on the strategic commissioning vision. They will work with local authorities, providers, VCSE groups, and the public to commission evidence and insight-based, data-driven, outcomes-based services that focus on access, health improvement, innovation and reducing inequalities.

We will commission services across the four layers of care we have defined for the system, primary care, single neighbourhoods, multi-neighbourhoods and acute. Kent and Medway providers will deliver through a provider alliance comprising two formal collaboratives for neighbourhood health and acute. We will support primary care to play a fuller role in these collaboratives by working across the ICB at scale.

The plan will deliver improvement starting with a stabilisation phase in year one (2026/27), locking in irreversible change that underpins a shift in the balance of care and risk into year two (2027/28) and a system which has made a fundamental shift by year three (2028/29).

This commissioning strategy reflects the ongoing system work being developed in Kent and Medway and is supported by chief executives of the system's NHS providers and our transition director as a basis for ongoing collaboration and improvement.



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Kent and Medway ICB

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1. Case for change

1.1. Population need and demographic change

Kent and Medway serves a population of around 1.9 million people and is experiencing faster and more complex demographic change than many comparable systems. Over the next 20 years, the population aged 85+ is projected to increase by approximately 84 per cent and those aged 65 to 84 by around 29 per cent. This growth is alongside an increasingly diverse population, with over 17 per cent from non white ethnic backgrounds and persistent health inequalities, including a life expectancy gap of up to eight years between the most and least deprived communities. Together, these factors are driving sustained growth in demand across health and care services and contributing to system fragility.[1]

At the same time, the system has higher than average prevalence of multiple long-term conditions, including cardiovascular disease, diabetes, respiratory illness and mental health needs. These needs are closely linked to deprivation, unemployment, housing insecurity and social isolation, which are present at scale in parts of the system.

This creates a strategic commissioning imperative. NHS Kent and Medway Integrated Care Board will move from a reactive model, responding to demand once it reaches services, to a more proactive, data-led approach that uses population health insight to predict need, target resources, reduce unwarranted variation and intervene earlier. This shift will be embedded through a multi-year commissioning cycle, with commissioning intentions being shaped by population need, translated into clear service requirements, and used to shift investment towards prevention, early intervention, neighbourhood-based care and more sustainable out-of-hospital models. Without this shift, demographic growth, complexity and inequality will continue to drive avoidable pressure into acute, crisis and high-cost services.

Population needs and insights will drive our new strategic commissioning approach. Needs and insights have been embedded within our new structures which includes our dedicated director of population insights and strategic improvement, who is a Public Health consultant. This will ensure our integrated needs assessment will drive our planning and prioritisation across our commissioning multi-disciplinary teams.

1.2. Service demand and performance pressures

The impact of Kent and Medway's changing population need is already visible in-service demand, operational performance and system flow. Demand continues to rise across urgent and emergency care, elective pathways, mental health, community services and social care, with increasing complexity in the cohorts requiring support.

Key system pressures include:

Urgent care demand and flow

- System performance against the 12-hour standard remains challenged. 10.7 per cent of major Emergency Department (ED) attendances wait more than 12 hours, compared with a peer median of 9.2 per cent. This places the ICB in the bottom third performing quartile nationally and raises the system mortality indicator to above the England average.
- The persistence of prolonged ED waits reflects ongoing system flow constraints, including delayed admission, limited downstream community capacity and insufficient alternatives to admission rather than peaks in demand.

Elective care waiting times

- In April 2026, the system elective waiting list stood at over 194k patients, with 61.5 per cent of patients treated within 18 weeks, significantly below the NHS constitutional standard of 92 per cent but marginally greater than peer average of 61.3 per cent.
- Our backlog has reduced by 12 per cent since its peak in 2023 but progress has stalled and admitted pathway capacity constraints mean waiting lists continue to exceed the elective throughput.

Primary care access and capacity

- In 2025/26, approximately 50 per cent of all urgent treatment centre activity in Kent and Medway was considered suitable for primary care delivery, with patient engagement findings highlighting that attendance was primarily driven by the inability to secure a GP appointment within 48 hours.
- An independent review of Kent and Medway GPs has identified a structural shortfall in medical staffing, with workforce and workload pressures limiting primary care access, particularly in higher-need and deprived communities .

Mental health demand and quality

- Around one in five adults in our population experience a common mental health disorder each year, with sustained increases in self-harm presentations and rising complexity.
- Relative under-investment in mental health compared to peer systems and system acute spend constraining primary and community capacity, has contributed to prolonged waits, avoidable emergency attendances, discharge delays and continued reliance on costly out-of-area inpatient care, also impacting on Police.

Maternity demand and inequalities

- Approximately 22,500 women are supported through our maternity services each year, representing 1.2 per cent of the population but accounting for 2.6 per cent of ED attendances and 2.1 per cent of emergency admissions.
- Persistent inequalities in maternal and neonatal outcomes across Kent and Medway, particularly for women from ethnic minority groups and those with complex needs, remain evident at system level.

For the ICB, the strategic commissioning response is to move beyond managing demand within individual services and instead commission whole pathways around population need.

This requires integrating and drawing insight from population health, activity, finance and outcomes data, to identify which cohorts are driving pressure, where current provision is not delivering value, and where resources need to be redirected or restructured over time.

1.3. Financial performance

Kent and Medway's independently verified underlying system deficit of around £300m will be addressed with urgency and through sustainable rebalancing of the system, led by clear commissioning.

The financial position reflects a structural mismatch between where the system spends money and where value is delivered. Kent and Medway spend around three percent more on acute hospital care than comparable systems, without proportionally better outcomes.

The imbalance is evidenced at a system level through:

Imbalanced allocation of sector spend

- In 2025/26, approximately 47 per cent of total system spend was on acute hospital services.
- Funding allocations for other sectors including primary care have not increased, despite the strategic shift to community and prevention.

Increased costs and weaker productivity

- Model Health System data shows a higher cost per weighted activity unit of £3,565, compared with a peer average of £3,372 for the equivalent activity.
- Acute productivity remains materially below pre-pandemic levels at -12.2 per cent compared to 2019/20 compared to a peer average of -5.4 per cent, demonstrating slower recovery and persistent inefficiency at system level.

1. National Association of Primary Care: Independent Review of Under Doctoring in Kent and Medway – March 2026

Inefficient use of acute capacity

- Average length of stay for non-elective admissions is 9.3 days compared with a peer average of 8.8 days, driving avoidable bed days, flow pressure and system cost.
- These inefficiencies reinforce reliance on high-cost acute activity rather than enabling reinvestment into preventative and neighbourhood alternatives.
- There is an over reliance on beds for recovery and a need to invest more in rehabilitation in people's homes and rehab facilities.

Under investment and inefficiency in mental health

- In 2025/26, mental health spend accounted for just 6.8 per cent of total ICB spend, reflecting a sustained imbalance in investment relative to need.
- This under-investment is associated with poorer flow and higher cost, with average length of stay for adult mental health inpatients at 96.5 days, compared with a peer average of 77.9 days, increasing quality risk and financial pressure across the system.
- Long waits for community services result in patients going into crisis. We also know that a large proportion of patients going to ED for self-harm are not known to us (40 per cent), which implies a lack of both primary and secondary care provision.

2026/27 acute provider contracts set a foundation for cost reduction, productivity and pathway redesign, including a shift to neighbourhood and out-of-hospital care.

However, as the only ICB nationally in a financial deficit, Kent and Medway must transition to a strategic commissioning model to deliver a sustainable cost base through evidence-led prioritisation, stronger financial control, and value-focused contracting.

2. How the ICB will achieve this

To address the challenges outlined in the case for change, this response is structured around two linked areas of action.

Part A sets out how the ICB will **organise itself to deliver the strategic objectives** set out in its five-year plan.

It describes the key internal challenges that need to be addressed to operate as an effective strategic commissioner by 2027/28, and how the Commissioning Development Programme, already underway, will strengthen organisational capability, embed a new operating model, improve governance and implement a clearer commissioning cycle supported by agreed policy and documentation.

Part B describes the future **system architecture required to deliver the ICB's priorities in practice across** primary, neighbourhood, multi-neighbourhood and acute care and the critical enablers needed to support implementation.

This includes the data, digital, workforce, governance, contracting and provider accountability arrangements required to translate strategic intent into delivery. It also sets out where targeted support from NHS England will be needed to help Kent and Medway move at pace, including:

- maternity improvement support
- national backing to accelerate Federated Data Platform (FDP) adoption
- funding to enable the ICB's transition to a strategic commissioning organisation
- technical support to establish the business intelligence capability needed to underpin evidence-based commissioning decisions.

Part C sets out the **high-impact priority areas where the ICB will focus its strategic commissioning effort and intent**. These are the areas with the greatest opportunity to improve quality, safety, access, outcomes, productivity, value for money and financial sustainability at pace.

Together, these elements describe both how the ICB will change, where that change will be applied, and what support will be needed to deliver rapid improvement for the population while building the foundations for sustainable service delivery over the longer term.

2.1. Part A: Redesigning the ICB internally to become a strategic commissioning organisation

The Commissioning Development Programme is already underway and is focused on enabling the ICB to operate as an effective strategic commissioning organisation by 2027/28. It provides the route through which the ICB will strengthen its internal capability, embed the new operating model, improve governance and implement a clearer commissioning cycle, supporting delivery of 2026/27 set out below.

2.2. NHS Kent and Medway ICB corporate objectives 2026/27

- Commission the right services every year.
- Ensure financial sustainability over three years.
- Lead strategy and ensure commissioning levers deliver impact.
- Develop into a high-performing commissioning organisation.
- Renew our culture for long-term sustainability.

The programme will build on the ICB's existing strengths while focusing on addressing four key challenges that will accelerate its development as an effective strategic commissioning organisation and support delivery of the above objectives.

2.3. Key challenges

Challenge 1:
Building capability, knowledge and skills

Diagnosis

The ICB has recognised the opportunity to strengthen its strategic commissioning capability, knowledge and skills following a period of structural change, cost pressure and limited investment into commissioning development. This has created a variation in confidence, technical expertise and delivery discipline across commissioning related functions.

Risk

Without a more consistent capability baseline, the ICB risks continuing to operate with variable commissioning practice, inconsistent use of evidence and data, and limited delivery grip. As demonstrated through the 2026/27 commissioning process, this can result in commissioning intentions that are too high-level, insufficiently connected to resource decisions, and not translated into clear actions, accountabilities or measurable benefits.

Solution

The programme will address this by developing a clearer and more consistent capability offer for staff, including strategic commissioning, population health management, business intelligence interpretation, pathway design, financial and activity modelling, contracting, policy, benefit realisation and evidence-based decision making. This will ensure staff have the skills required for their roles, and that the organisation has the collective capability to translate population need into commissioning intentions, resource decisions and delivery action.

Challenge 2:
Embedding multi-disciplinary working

Diagnosis

The transition to a new operating model depends on effective multidisciplinary working. At present, the skills, behaviours and ways of working required to make cross-functional commissioning decisions are not yet consistently embedded across commissioning, clinical, finance, business intelligence, quality, contracting and wider enabling teams.

Risk

Without consistently embedded multidisciplinary ways of working, the ICB risks continuing to make commissioning decisions through siloed functions, with unclear ownership, variable clinical input and limited alignment between commissioning, finance, contracting, analytics, quality and patient experience. As demonstrated through the 2025/26 contractual arrangements, this can result in sub-optimal decision-making, limited contractual and commissioning levers to drive quality, performance and value for money, and care being commissioned in a way that is not clearly aligned to the ICB's strategic priorities.

Solution

The programme will address this through the establishment of commissioning multi-disciplinary teams as the initial core mechanism for strategic commissioning. Bringing the right expertise together around commissioning multi-disciplinary teams will align the right skills around population need, priority pathways and areas of spend. As the Target Operating Model develops, additional multi-disciplinary arrangements may also be established where there is a clear need to support specific objectives, enabling functions or cross cutting priorities. All commissioning multi-disciplinary teams will operate to a common set of principles: clear purpose, defined accountability, evidence-led decision-making, strong clinical input and alignment to the ICBs strategic objectives. This will support clearer ownership, better use of insight and a more joined-up route for strategy through to commissioning action.

Challenge 3:
Strengthening governance and decision making

Diagnosis

The ICB's historic governance framework required further clarity to support timely and assured commissioning decision-making. This had led to variation in how decision rights, escalation routes, joint commissioning arrangements and formal approval routes were understood, which created duplication, delays, risk aversion and unclear accountability.

Risk

Without clearer governance and decision rights, the ICB risks continuing to experience duplicated discussions, delayed decisions, risk aversion and unclear accountability for delivery. As demonstrated in the 2025/26 Financial Recovery Programme, this can result in opportunities, risks and trade-offs being surfaced too late, decisions being escalated unnecessarily or inconsistently, and actions not being translated into clear ownership, implementation and measurable impact.

Solution

The programme is in the process of addressing this by strengthening governance around strategic commissioning. This includes the development of a new governance framework that clarifies which decisions sit within commissioning multi-disciplinary teams, which require escalation to senior ICB forums, and which require wider system-level agreement. It will also create clearer routes for surfacing risks, opportunities and trade-offs earlier, ensuring decisions are made at the right level, with the right evidence and clear accountability for delivery.

Challenge 4:
Implementing the commissioning cycle

Diagnosis

The ICB has recognised that, while its strategic direction is now clearer and supported by a Strategic Commissioning Policy, its commissioning cycle has historically operated as a largely transactional annual contracting process. This has limited the organisation's ability to consistently use evidence, population need, outcomes, quality, finance and value for money to shape commissioning decisions in a systematic way.

Risk

Without embedding a consistent commissioning cycle into the operating model, the ICB risks continuing to treat commissioning as a transactional annual process rather than a strategic, evidence-let discipline. As demonstrated through last year's commissioning cycle, this could result in compressed timelines, limited opportunity for meaningful engagement, and commissioning intentions that are disconnected from strategy, population need, delivery oversight and benefits tracking. This could limit the ICB's ability to drive outcomes, improve value for money and hold providers to account for delivery. There is a risk that we commission an overly medicalised model of neighbourhood health unless partnership arrangements deliver a model that addresses wider determinants.

Solution

The programme will build on this by embedding the cycle into the ICB's operating model, linking the Five-Year Plan, commissioning intentions, commissioning multi-disciplinary teams, business planning, contracting, delivery oversight and benefits tracking into one consistent way of working. This will help ensure commissioning decisions are shaped by population need, quality, performance, finance, inequalities and value for money, and are translated into clear delivery plans and provider expectations.

These challenges have driven our Commissioning Development Programme for 2026/27.

From quarter two, the programme shifts from introducing our commissioning multi-disciplinary teams and foundational capability to embedding, refining, and building a self-sustaining operating model. Each quarter has a clear ambition: quarter two is to operationalise and reinforce, quarter three to optimise and integrate, and quarter four to sustain and ensure continuity.

The work being delivered through 2026/27 is a springboard for 2027/28. By April 2027, the ICB will have an established operating model, a capable workforce, and the data and digital infrastructure to support evidence-based commissioning at pace.

During 2027/28, we will build on these foundations, moving from embedding to accelerating. We will use the commissioning cycle to drive measurable improvement in population outcomes, deploying business intelligence and digital tooling to enable real-time decision-making, deepening provider relationships through outcome-aligned contracting, and extending multi-disciplinary ways of working across the wider ICB. Kent and Medway ICB will enter 2027/28 with the structures, skills, and intelligence to commission with confidence and the momentum to improve at pace.

2.3. The Commissioning Development Programme

The Commissioning Development Programme is the vehicle for change that directly responds to the internal challenges identified above and supports delivery of the ICB's strategic objectives.

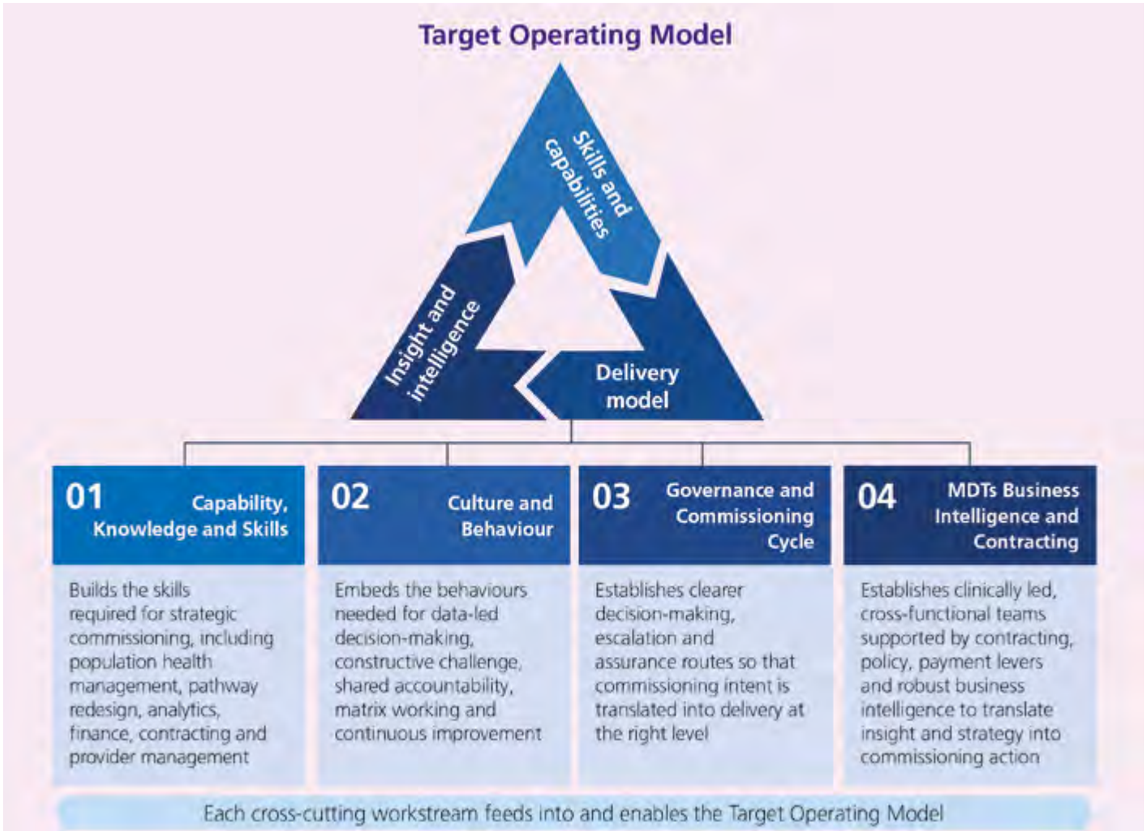
The ICB has commissioned a transformation and development partner to support our programme. This programme sets out a three-year journey from stabilisation to transformation to innovation, resetting the ICB in year one, embedding the new model in year two, and maturing into a high-performing strategic commissioner by year three.

Central to the programme is the design and implementation of the Target Operating Model (TOM), which defines how the organisation will operate once the programme concludes.

The Target Operating Model sets out how the ICB will make decisions, use intelligence, and translate commissioning intent into delivery. It is being developed through four cross-cutting workstreams:

- capability, knowledge and skills
- culture and behaviour
- governance and commissioning cycle
- commissioning multi-disciplinary teams (including business intelligence and contracting).

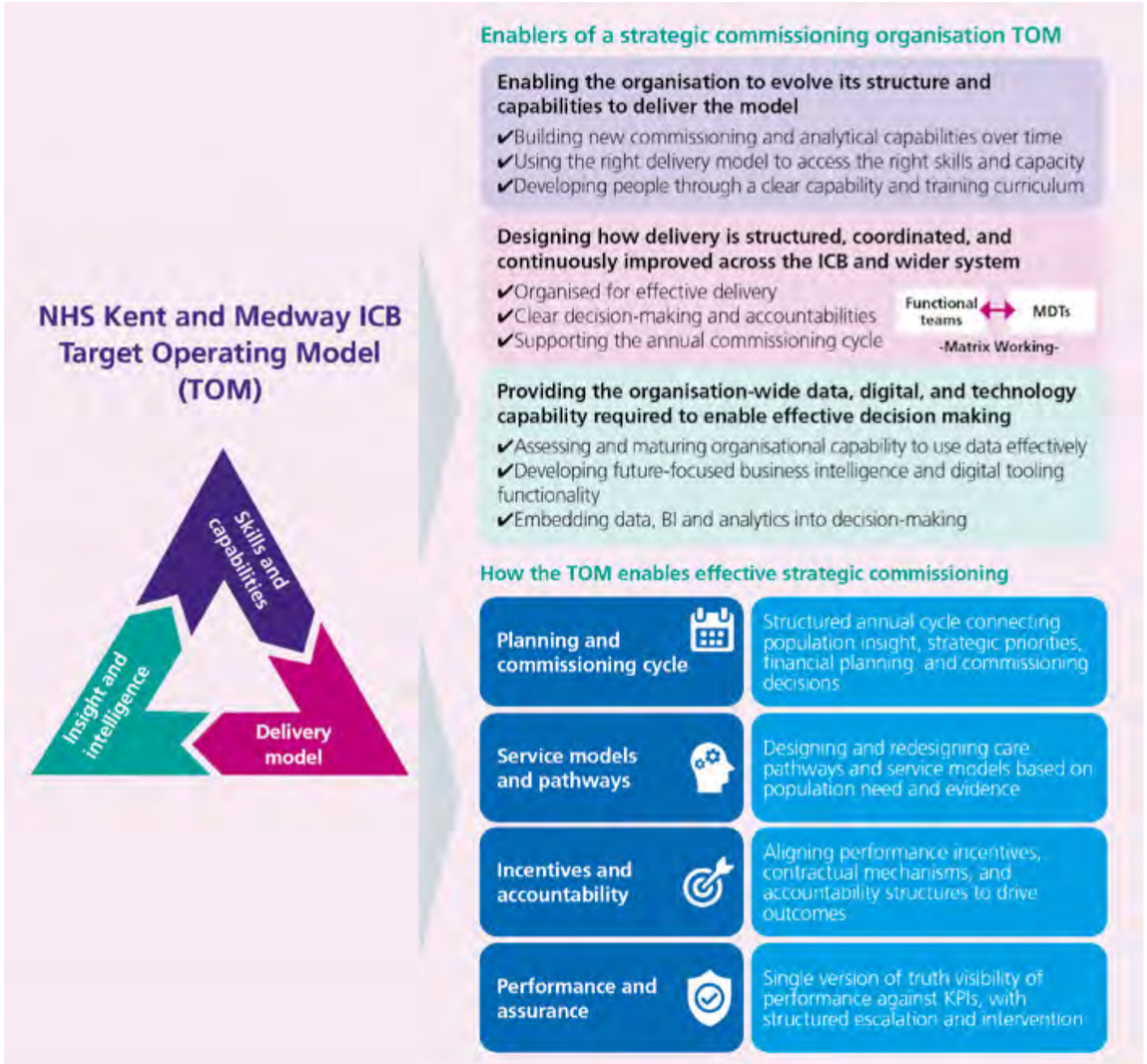
Together, these workstreams establish the skills, behaviours, governance, and multidisciplinary mechanisms required to set clear commissioning intentions and deploy resources based on robust evidence and insight.



Target Operating Model

The Target Operating Model is centred on three mutually reinforcing components: skills and capability, insight and intelligence, and the delivery model. These components cannot be developed in isolation. New ways of working require the right people and capabilities; effective commissioning decisions depend on reliable data and intelligence; and the delivery model will only work if it is supported by both. Together, they will define how the ICB moves from reactive, function-led commissioning to a more coordinated, multidisciplinary and outcome-focused model.

Through the Target Operating Model, the ICB will organise work around population need and whole pathways, connect commissioning intent to contracts and delivery, and strengthen the links between strategy, intelligence, governance, provider accountability and outcomes. The following sections set out how the four programme workstreams will bring the Target Operating Model into operation.



Capability, knowledge and skills

The ICB is starting from a challenging cultural position, as set out in a difficult but candid culture review commissioned following Freedom to Speak Up concerns. In response, the ICB has established an Organisation Development Plan (OD Plan). This will address cultural change alongside wider transformation to enable the transition toward a strategic commissioning organisation.

The OD Plan positions strategic commissioning capability and clinical leadership as the golden thread across all OD workstreams. A number of the OD Plan activities are specifically designed to create the conditions for effective commissioning multi-disciplinary team working — including leadership and culture development, the learning and development review and manager capability support. The two programmes are aligned and will be considered together as the organisation moves into implementation.

Within the OD plan's wider transformation is the strategic commissioning capability workstream, which is a critical part of the Target Operating Model to enable commissioning multi-disciplinary teams. This workstream includes a tiered strategic commissioning core skills development approach, a skills gap assessment to baseline current capability and an organisational curriculum that will define the knowledge and skill expectations required by role and grade, with specialist education and development where required.

In practice, this approach will build core strategic commissioning capabilities across the organisation, identify risks and gaps for targeted development, deliver the high-level capability needs in analytical, actuarial and commercial applications whilst supporting cultural improvement including the shift from siloed working to shared ownership and collective accountability for outcomes.

Culture and behaviour

The shift to strategic commissioning will require a change in culture and behaviour, not just changes to structure, process or governance. The ICB will need to embed a more proactive, evidence-led and delivery-focused way of working, where teams surface issues earlier, test solutions, challenge assumptions and take shared responsibility for outcomes.

A "test, learn and grow" approach will be important as commissioning multi-disciplinary teams, business intelligence products and commissioning processes are implemented. This means using early implementation to test what works, learn from live experience, refine ways of working and make course corrections in real time. The new model should create earlier routes for identifying risks, opportunities and trade-offs before they reach formal decision points. Over time, this will help build a culture of constructive challenge, shared ownership and continuous improvement, enabling the organisation to adapt as population needs, service pressures and financial constraints change.

Governance and commissioning cycle

Strengthening governance will be critical to ensuring strategic commissioning decisions are made at the right level, with the right evidence and accountability. The Strategic Commissioning Policy has been developed and is awaiting board agreement on 19 May 2026.

Once agreed, it will provide the formal basis for how the ICB applies strategic commissioning consistently across functions, including how decisions are aligned to the Five-Year Plan, informed by evidence, tested against value for money and translated into delivery through commissioning multi-disciplinary teams, contracts and provider oversight.

Further work is underway with relevant governance leads to improve how decisions are framed, assured and escalated across the organisation and system. This includes implementation of a newly developed governance framework, which will clarify decision rights, escalation routes and the interaction between commissioning multi-disciplinary teams, senior ICB forums and wider system partners, including providers, local authorities and the VCSEF sector.

The new model will support earlier identification and escalation of issues, risks and opportunities. Commissioning multi-disciplinary teams will bring forward the evidence, options, trade-offs and recommendations required before risks crystallise or decisions become urgent. This will allow issues to be resolved within commissioning multi-disciplinary teams where appropriate or escalated with a clear recommendation where formal approval or wider system agreement is required.

This will reduce duplication, avoid delayed escalation and ensure significant decisions on investment, disinvestment, service change, provider accountability and risk are taken through the right route.

Multi-disciplinary teams including business intelligence and contracting

Commissioning multi-disciplinary teams

The ICB has already restructured to deliver through four multidisciplinary teams. They will provide the forum where clinical, finance, contracting, quality, analytics, public health, transformation and commissioning expertise come together around defined population groups, pathways and areas of spend.

We have embedded clinicians within each of our commissioning multi-disciplinary teams for Urgent and Emergency Care, Elective Care, Primary Care/ Community and Neighbourhood and Mental Health/ Learning Disabilities and Autism. It is important to recognise that these leaders are from broad multi-professional clinical backgrounds, consultants, allied health professionals and nursing.

Our policy development is clinically-led and is founded upon our collaborative approach across our four regional ICBs. This will provide us with best practice and evidence which will be reviewed and adopted across our commissioning multi-disciplinary teams. Our lead clinicians will have the responsibility for understanding our clinical pathways across Kent and Medway and co-ordinating our engagement with local provider clinicians to facilitate local implementation.

Commissioning multi-disciplinary teams will improve commissioning by addressing previous gaps between functions, such as population health analysis informing contracting and procurement. We have strengthened internal functions, introduced the new deputy chief commissioning officer and consolidated our commissioning strategy and planning functions to bring together the work of our commissioning multi-disciplinary teams as the single organisational programme.

Their role will be to turn insight into action. Commissioning multi-disciplinary teams will use data and professional judgement to understand demand, identify variation, assess whether current provision is delivering value, and agree where commissioning change is required.

This includes identifying high-impact shifts such as moving care into neighbourhood and out-of-hospital models, redesigning pathways, strengthening prevention and early intervention, and applying contracting, policy and payment levers to support delivery.

By linking strategy, commissioning intentions, contracts, policy and delivery, commissioning multi-disciplinary teams will help ensure that priorities are translated into practical action, risks are surfaced earlier, and delivery is managed with clearer accountability.

It will be critical moving forward that we recognise the clear interdependencies and required alignment across our four commissioning multi-disciplinary teams, for example between Elective Care and Primary, Community and Neighbourhood Multi-Disciplinary Teams in relation to reducing clinical variation and managing referrals and between UEC and Flow and MH multi-disciplinary teams to ensure a joined-up physical and MH discussion.

Business intelligence function

A strengthened business intelligence function is central to the ICB's transition to strategic commissioning and aligns with national expectations for ICBs to strengthen analytical capability and establish in-house intelligence by 2027/28. Business Intelligence must therefore be treated not as a reporting function, but as a core part of how the ICB understands population need, prioritises resources and holds delivery to account.

The business intelligence function will bring together population health insight, activity and financial intelligence, demand and capacity modelling, benchmarking, quality and outcomes data, inequalities analysis, commissioning multi-disciplinary teams, dashboards and decision-support products. This will build on the initial work already carried out through our intranet and power business intelligence to create a more consistent view of population need, service demand, spend, performance and outcomes.

Our strategy needs to be more future-facing and will focus on opportunities associated with artificial intelligence and advanced analytics. Modern intelligence, automation and AI-enabled decision support will revolutionise commissioning decisions, support earlier intervention and strengthen provider accountability moving forward.

There is also an emerging opportunity to strengthen resilience and capability by bringing together Business Intelligence functions across Kent, Surrey and Sussex (KSS), specifically between Kent and Medway ICB and Surrey and Sussex ICB. This would support a more joined-up intelligence offer across the wider geography, enabling shared analytical capacity, common tools, methodologies, improved benchmarking, and more consistent use of data to support strategic commissioning decisions.

For commissioning multi-disciplinary teams, business intelligence products will support the identification of unwarranted variation, priority cohorts, demand and cost drivers, delivery risks and benefits. This will allow commissioning decisions to be based on evidence, rather than historic patterns of spend, individual service pressures or anecdotal information. Over time, a more integrated business intelligence model across Kent, Surrey and Sussex would also create the opportunity to compare performance, share insight and strengthen commissioning decision across systems.

Contracting, policy and payment levers

Issues identified through last year's commissioning cycle and the Financial Recovery Programme highlighted that the ICB has not always used the contractual levers, analytical grip or provider accountability needed to secure savings and demonstrate value for money.

In 2025/26 and previous years, contracts were often rolled over with limited review, benchmarking or clarity on what was being purchased, whether activity reflected population need, or whether outcomes justified the level of investment. Siloed working between commissioning, finance and contracting also weakened the link between commissioning intentions, contract drafting and contract management, meaning the levers intended by commissioning teams were not always reflected in contracts, and in some cases activity and financial assumptions were not sufficiently robust.

In response, the ICB will use its formal commissioning levers more deliberately to move from strategic intent to measurable delivery. This means strengthening the link between commissioning intentions, service specifications, contract schedules, provider expectations, payment mechanisms and performance oversight. The volumes of activity contracted-for will be based on better management of demand via identified interventions (for example reductions in outpatient follow up ratios, single points of access for elective care, straight to test pathways) and benchmarked to the best of our peers.

The Strategic Commissioning Policy has been developed and will provide the basis for how decisions are made and how the ICB balances quality, safety, access, inequalities, outcomes, affordability and value for money. Commissioning multi-disciplinary teams will then help ensure these decisions are translated into practical delivery levers, including contract variations, outcome measures, activity plans, financial schedules, performance triggers and provider improvement actions.

The ICB will also strengthen contract management where there is evidence of incomplete reporting, poor data quality, low-value activity or inconsistent policy application. A contractual reset is already underway, which includes making better use of contractual levers with independent providers and any qualified providers and requiring accurate secondary uses service (SUS) reporting as a condition of payment. This will help ensure activity is visible, policies are being followed, payments are appropriate, and value for money can be properly assessed. We will expect providers to adhere to data requests to ensure better allocation of resources.

Alongside this, stronger business case discipline, return on investment and benefits realisation will ensure investment decisions are supported by clear evidence of impact, delivery risks, outcome measures and accountability.

Our strategy will transition us away from transactional contracting towards more sophisticated approaches. This could include explicitly testing year-of-care payments in 2027/28, for example on frailty cohorts using the John Hopkins tool. Alliance-aligned contracting with transparent pricing and outcome-based incentives will evolve, with the main ICB contracts including outcomes-based payment components by 2027/28 where possible. Implementation is beginning in 2026/27 via new mental health and community contractual arrangements and via our new neighbourhood contract with PCNs.

2.4. Internal delivery plan

We are starting now to develop our commissioning intentions for 2026/27 which will be built up by our commissioning multi-disciplinary teams and aligned with the national commissioning development offer being launched this summer. This approach will develop a set of draft commissioning intentions to be agreed by the end of June and approved at our Board in July, commencing a period of engagement with our patients, providers and partners over the summer.

Outputs and themes from this engagement process will subsequently be considered, alongside learning from national tools, case studies and action-learning programmes, as we present our final set of commissioning intentions to the board in September, prior to formal communication with providers by end of September. This approach will provide us with stable foundations to build on and drive forward locally across Kent and Medway.

Once agreed we will continue to involve our communities working with VCSEF organisations and other trusted voices to embed patient perspective into our commissioning intentions and the more detailed plans that are then developed from them.

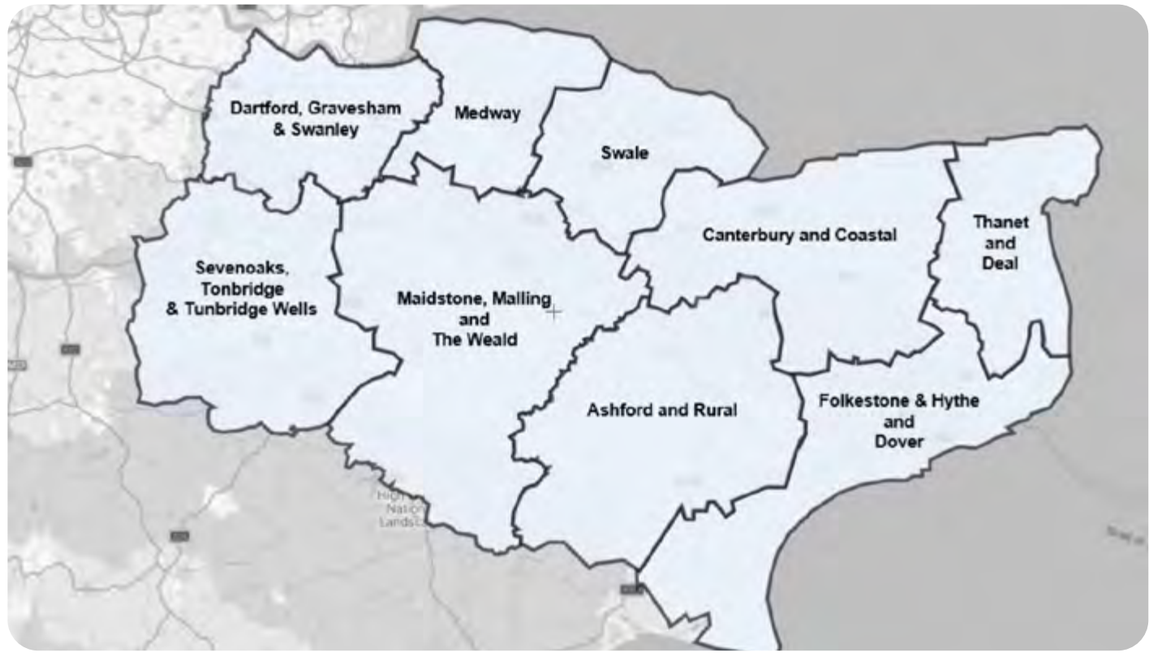
3. Part B: System architecture

Delivery of our strategic priorities will be enabled through the Kent and Medway Four Layers of Care model, organised at each neighbourhood level:

- **Primary care:** The system anchor for continuity, prevention, proactive management of complex patients, and urgent access.
- **Single neighbourhoods:** Aligned to Primary Care Networks (PCNs), commissioned with clear accountability to anticipate and manage demand through integrated neighbourhood teams spanning health, social care and voluntary sector partners.
- **Multi-neighbourhoods:** Redefining intermediate care as a seamless bridge between hospital and home through expanded community services.
- **Acute care:** Redesigning hospitals to support a community-first approach through stronger integration with neighbourhood teams, while developing Acute Centres of Excellence to deliver high quality specialist care to reduce variation and drive research and innovation.

In Kent and Medway, **45 single neighbourhood footprints have been agreed, each serving a population of around 30,000 to 50,000 residents, broadly aligned to existing PCN footprints**. These are designed to be small enough to support hyper local, relationship based care, while providing sufficient scale for sustainable delivery and effective coordination at neighbourhood level. Single neighbourhoods form the core delivery units of neighbourhood health, bringing together general practice and community partners to deliver integrated care with workforce primarily based within the neighbourhood and services shaped around the needs of the local population.

In Kent and Medway, nine multi-neighbourhood footprints have been agreed each ranging from 109,000 to 339,000 residents. These are designed to be large enough to enable collaboration, yet local enough to maintain a strong sense of place and identity, providing the right balance for effective joint planning and delivery. Each footprint brings together several single neighbourhoods to strengthen integration across health, care, and community services, support shared workforce planning, and align resources around local population needs.



Providers will lead service transformation and delivery will be coordinated through a Provider Alliance and two formal Provider Collaboratives:

- **Neighbourhood Health Collaborative**: Bringing together primary care, single neighbourhoods, multi-neighbourhoods/intermediate care at scale through shared pathways and workforce models.
- **Acute Collaborative**: Delivering the acute care model through clinical networks, centres of Excellence, and joint transformation programmes.

There will be three phases to our work programme:

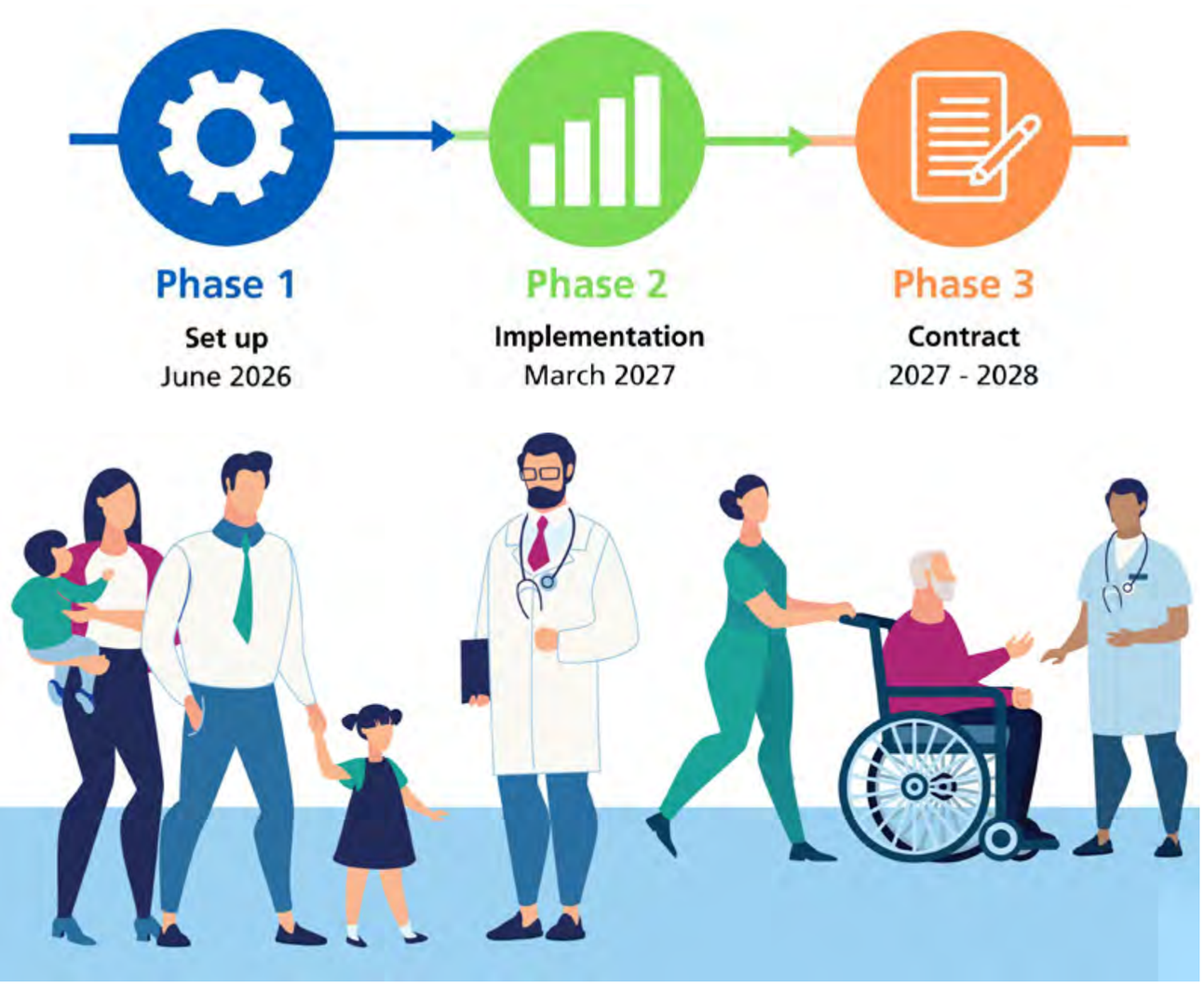
Phase 1 set up – by June 2026

Phase 2 implementation – by March 2027

Phase 3 contract – 2027/28

System resources will be redesigned to support this model, led by a managing director. A new relationship will be fostered between the alliances and the ICB to set priorities and agree pathways, overseen by the System Leadership Group.

Increasingly we will create opportunities for the collaborative and alliance structures to foster collaborative delivery via lead providers, facilitated by our procurement, contractual and payment arrangements. This will include the Single Point of Access for Elective Care, our transfer of care arrangements, and elements of our UEC pathway.



4. Three-year shift to strategic commissioning and what it means in practice

The measures set out below are intended not simply to meet national planning expectations, but to describe how Kent and Medway will move to a materially different health and care system over the next three years. This is about changing how decisions are taken, how money flows, how risk is managed and how care is experienced, rather than optimising the existing model.

Year one: 2026/27

Meaning in practice: stabilising delivery while locking in irreversible change.

Strategic commissioning

By the end of 2026/27, commissioning in Kent and Medway will no longer operate as a series of parallel functional processes. Decisions about priorities, investment and de investment will be taken in multidisciplinary settings with explicit consideration of population need, variation, affordability and delivery risk.

In practical terms, this means:

- commissioners will stop agreeing activity on the basis of last year's demand and instead contract deliberately for what the system is trying to achieve
- providers will see clearer expectations in contracts about outcomes, productivity and contribution to system flow
- difficult trade offs will be surfaced earlier, rather than being deferred into in year firefighting.

Neighbourhood care

Neighbourhood care in 2026/27 will move from concept to operational reality. Single Neighbourhood Health will become the recognised mechanism for managing the most complex and highest risk patients across Kent and Medway.

What this will mean:

- GPs, community services, mental health teams and councils will have shared clarity about who they are collectively responsible for.
- acute services will increasingly see discharge and escalation managed through agreed neighbourhood routes rather than ad hoc arrangements.
- the system begins to reduce duplication, avoidable admissions and crisis responses for known cohorts.

Outpatients

Outpatient reform in year one is about breaking the assumption that hospital clinics are always the answer.

This will mean:

- referrals increasingly routed through advice and guidance or single points of access rather than default outpatient appointments
- patients having fewer unnecessary follow ups, with more control through patient initiated follow up
- consultants and clinical teams beginning to work differently, focusing hospital time on higher value activity.

Urgent and emergency care

In 2026/27, urgent care reform is not about immediate performance miracles but about clarifying routes and reducing avoidable pressure.

In reality:

- patients will receive clearer messaging about where to go and how to access urgent care
- primary care, pharmacy and UTC roles will be more deliberately positioned
- flow improvements will start to come from better discharge coordination rather than additional beds.

Technology and productivity

Technology in year one will primarily support better decisions, not just operational reporting.

This means:

- commissioning discussions will increasingly start with data on who is driving demand and cost
- providers will see greater challenge on variation, productivity and low value activity
- early productivity gains will come from reduced waste rather than staff working harder.

Financial flows

In year one, financial reform is about restoring credibility and grip.

This will mean:

- contracts that more clearly state what the ICB is paying for and why
- reduced tolerance for poor data quality and unvalidated activity
- early re alignment of incentives, even if full payment reform takes longer.

Year two: 2027/28

Meaning in practice: shifting the balance of care and risk

Strategic commissioning

By year two, strategic commissioning becomes the default way the system operates.

In practical terms:

- medium term consequences of decisions are explicitly discussed, not just in year impact
- commissioners and providers increasingly work together on redesign rather than arguing over volume
- system leadership conversations move away from incident management towards structural change.

Neighbourhood care

In year 2, neighbourhood care expands from complex patients to broader populations.

This means:

- rising risk patients are proactively managed before they deteriorate
- mental health and children's services are increasingly integrated into neighbourhood models
- acute reliance starts to fall not because access is restricted, but because need is being met earlier.

Outpatients

By this stage, outpatient reform moves from pilots to scale.

This will mean:

- growth in elective demand no longer translates directly into growth in hospital attendances
- patients experience simpler pathways with fewer appointments and clearer responsibility
- acute capacity is freed for specialist and time critical care.

Urgent and emergency care

Urgent care reform in year two meaningfully changes patient routes.

In reality:

- ED attendances reduce for cohorts that can be safely managed elsewhere
- booking, scheduling and redirection become normalised
- winter pressure is mitigated through neighbourhood and community resilience rather than emergency escalation.

Technology and productivity

Technology becomes a core enabler of redesign rather than a reporting function.

This means:

- commissioning decisions are informed by predictive and comparative insight
- providers experience clearer expectations about productivity improvement
- decommissioning of low value activity becomes possible because alternatives exist.

Financial flows

Year two is where incentives start to change behaviour at scale.

In practice:

- outcome based and alliance aligned contracting becomes more common
- payment mechanisms increasingly reward prevention, coordination and reduction of avoidable demand
- financial disputes reduce because expectations are clearer.

Year three: 2028/29

Meaning in practice: a fundamentally different system

Strategic commissioning

By year three, commissioning is a confident, mature discipline.

This means:

- the system can make difficult decisions earlier and with greater confidence
- resources are deployed deliberately to where they have the greatest impact
- the cycle of crisis management, short term fixes and recurrent deficits is broken.

Neighbourhood care

Neighbourhood care becomes how the system works, not something additional.

In reality:

- most patients experience care closer to home, with fewer hand offs
- acute services are reserved for care that genuinely requires hospital expertise
- inequalities reduce because population based approaches target need deliberately.

Outpatients

By this point:

- traditional outpatient models are the exception, not the norm
- patients manage long term conditions through supported, community based pathways
- hospital clinics deliver specialist care rather than routine monitoring.

Urgent and emergency care

By year three:

- ED is no longer the default front door for urgent care
- flow is more predictable and less fragile
- harm associated with overcrowding and prolonged waits is materially reduced.

Technology and productivity

Technology enables anticipation rather than reaction.

This means:

- commissioning decisions are made with confidence about future impact
- productivity improvements are sustained without burnout
- innovation supports prevention, not just throughput.

Financial sustainability

By 2028/29:

- financial balance is underpinned by a different care model, not short term controls
- demand growth no longer automatically drives cost growth
- the system is more resilient to workforce, demographic and financial pressures.

This three year programme is not about incremental improvement. It is about deliberately reshaping the system so that by the end of the period Kent and Medway is commissioning and delivering care in a way that is sustainable, clinically credible and experienced differently by patients and staff.

5. Part C: Commissioning priorities across the four layers of care

The following section sets out priority areas requiring focus over the next three-years across four layers of care: Primary Care, Single Neighbourhood, Multi-Neighbourhood and Acute.

This is not intended to be an exhaustive list of all priorities or delivery actions. Rather, it provides an indicative view of the level of thinking developed to date around the ICB's commissioning intentions and three-year plans, including the emerging direction of travel, key areas of focus and the types of actions required across each layer of care.

Further work undertaken through the ICB's commissioning multi-disciplinary teams to develop commissioning intentions for 2027/28 will further the level of detail. Service reviews will be formally clinically-led and agreed with providers and partners (including scrutiny committees) in advance.

	Primary Care	Single Neighbourhood	Multi-Neighbourhood	Acute
Urgent and Emergency Care and Flow MDT	Improve core access offer in general practice by developing an action plan that responds to the NAPC review of GP across the ICB area (plan developed 2026/7). Improving use of clinical services in community pharmacy to manage demand (plan developed in 2026/27).	Implement Single Neighbourhood Health (SNH) as the core neighbourhood delivery model for management of escalation in complex populations, using the Patient Need Groups (PNG) risk stratification tool, agreed footprints and partnering within a multi-neighbourhood health model to deliver at scale. (2026/27).	Create multi-neighbourhood service model to partner SNH delivery for the complex care cohort and to reduce attendances and admissions at ED. Create a unified model of intermediate care. Standardise models for virtual wards, urgent community response and remote monitoring from current variable picture (2026/27 with implementation into 2027/28). Carry out a parallel review of future community bed requirements. Review of UTCs carried out in 2026/27 with implementation through 2027/28.	Embed and expand Home First/seven day discharge models to improve flow and productivity (starting 2026/27 and through 2027/28. Transfer of care hub model standardised as part of a revised discharge blueprint for the system. Designed in 2026/27 and implemented in 2027/28. Matched with a full review of P3 capacity joint with council partners to ensure type and volume of provision fits need (review starts 2026/27 and implemented 2027/28).

	Primary Care	Single Neighbourhood	Multi-Neighbourhood	Acute
Primary, Community and Neighbourhood MDT	Develop and communicate a clear expectation of what Kent residents can expect in each part of primary care (2026/27). Improve core access offer in general practice by developing an action plan that responds to the NAPC review of GP across the ICB area (plan developed 2026/7). Improving use of clinical services in community pharmacy to manage demand (plan developed in 2026/27). Expand urgent dental access through 2026/27 to 2028/29 according to national trajectories.	Implement Single Neighbourhood Health (SNH) as the core neighbourhood delivery model for management of escalation in complex populations, using the Patient Need Groups risk stratification tool, agreed footprints and partnering within a multi-neighbourhood health model to deliver at scale (2026/27). New SNH contract to be delivered via early use of the NHSE local variation arrangement for the PCN DES (2026/27). Model to be expanded (2027/29) to further cohorts (children, rising risk and mental health) and to make best use of specialty teams shifting roles as part of outpatient reform (2027/29).	Align fragmented community service, voluntary, community and social enterprise provider contracts into a coherent offer to support neighbourhood delivery (2027/28).	Use Patient Need Groups risk stratification to monitor acute service usage and manage discharge into multi and single neighbourhood offer (starting 2026/27). Appropriate risk stratification approaches will be used to understand mental health needs of our population.

	Primary Care	Single Neighbourhood	Multi-Neighbourhood	Acute
Elective Care and Maternity MDT	Commission improved access to women's health and perinatal support closer to home (2027/28).	Use PNG approach to optimise pre-elective management (2028/29). Target commissioning at higher-risk, complex or co-morbid needs (2027/28 and 2028/29).	Commission elective community services at scale (from 2027/28) and increase diagnostic access through additional straight-to-test pathways (2027/28 and optimising use of Community Diagnostic Centres (2027/28) rather than non-NHS capacity. Decommission fragmented services where previous historic commissioning not based on need and variation does not address specific population need. Commission new models of MSK and dermatology services to reduce demand flowing into acute settings (2027/28 and 2028/29). Commission scaled multi-disciplinary pathways across maternal medicine and pelvic health (2027/28).	Develop acute Centres of Excellence and realign outpatient capacity, including new to follow up appointment ratios and Patient Initiated Follow Up (2026/27 through to 2028/29). Start with T+O and endoscopy, rolling out to wider specialities. SPOA established (2026/27) and expanded over period to 2028/29. Agree a plan to adopt a single system waiting list approach (2026/27) and implement in stages through 2027/2029 linked to SPOA rollout. Identify outpatient specialities for 'left shift' and in support of SNH with a design phase (2026) informing gradual rollout. Co-design and develop a consistent system-wide maternity and women's health model following a review of maternity services in 2026 (2027/28 and 2028/29).
Mental Health and Learning Disabilities & Autism MDT	Clarify and strengthen the primary care role in mental health pathways, enabling proactive management of long-term mental health conditions and appropriate escalation.	Extend neighbourhood mental health models to rising risk, focussing on LTC management, Mental Health and Children and Young People cohorts using phased rollout up to 2028/29.	Standardise and integrate mental health pathways at scale, including Children and Young People to Adult transitions (beginning in 2026/27 and through to 2028/29), crisis (from 2026/27), step up and step down pathways including commissioning of a revised model (2026/27 initially consolidated in 2027/28), and placement pathways (S117, LDA) (starting in 2026/27 and expanding in 2027/28). Commission new models of ADHD and autism assessment (starting initially in 2026/27 and expanding from 2027/28 if successful).	Redesign acute mental health urgent and emergency pathways to reduce ED reliance, improve flow, and minimise length of stay and out of area placements ensuring that East Kent and Medway are supported by a MH CAC model that retains the best of current voluntary sector input (2027/28).

Key national enablers required from NHS England to accelerate progress are detailed in Appendix A

Appendix A: Key national enablers required from NHSE to accelerate progress:

Ask	Description
Functional support: Maternity improvement	Targeted support to strengthen maternity improvement, including access to national expertise, benchmarking and improvement support to reduce variation and improve safety, experience and outcomes.
Political support: Federated Data Platform adoption and utilisation	National support to drive provider and system adoption of the Federated Data Platform, including clear expectations on use, alignment with national priorities and support to overcome local resistance or variation in uptake.
Technical / enablement support: Business Intelligence (BI) function	Support to establish the Business Intelligence function required for strategic commissioning, including guidance on whether capability should be built, bought or shared across the system, and support with licensing, tooling and data access arrangements.
National Policy Support: Mandate a National Formulary	National mandation of a single formulary to reduce unwarranted variation, strengthen prescribing consistency, support better value medicines optimisation and provide ICBs with a clearer commissioning lever across providers and places.
National Pricing Support: Develop and publish a national ADHD tariff	Development and publication of a national ADHD tariff to create a consistent pricing framework for assessment, diagnosis, treatment and follow-up, supporting clearer commissioning, contracting and value-for-money discussions with providers.
National Guidance: Outcome-based risk share with providers	Clear national guidance that major contracts should include outcomes-based payment component to shorten negotiations in planning and to focus partners on defining and designing rather than establishing the principle.

Appendix B: Alignment to the national priorities:

NHSE national priority	Action outlined in the paper that links to this priority	Expected outcome of that action
1. Outpatient transformation	Elective care actions include expanding Advice and Guidance, improving referral practices, increasing Patient Initiated Follow Up, reducing unnecessary outpatient activity, standardising high-volume pathways, improving new-to-follow-up ratios, expanding straight-to-test pathways and shifting appropriate elective activity into community and neighbourhood settings.	Reduced unnecessary outpatient attendances and follow-ups, improved RTT performance, released acute capacity, faster diagnosis and treatment, improved patient experience and better value for money.
2. Reducing hospital bed-days for highest-risk cohorts	Neighbourhood health actions include implementing Single Neighbourhood Health, using PNG risk stratification to identify high-need cohorts, strengthening proactive neighbourhood management, expanding community-based support, supporting transitions out of hospital and aligning voluntary, community and social enterprise provision around neighbourhood delivery.	Fewer avoidable admissions, reduced acute bed days, improved flow, better outcomes for frailty and complex cohorts, and a stronger shift towards proactive care outside hospital.
3. Scheduling and access reform for urgent care	Urgent and emergency care actions include reforming urgent access in primary care, reconfiguring UTCs, aligning urgent care provision to neighbourhood footprints, improving NHS 111 and urgent care navigation, and enabling bookable urgent care appointments across appropriate settings.	Reduced avoidable ED attendances, improved patient routing, better use of urgent care capacity, improved four hour performance and more patients treated in the right setting first time.
4. Technology-enabled productivity improvements	Digital and technology actions include strengthening BI dashboards, demand and capacity modelling, RTT validation, Advice and Guidance, electronic triage, population health tools, FDP adoption, ambient voice technology and digital tools to support discharge, urgent care flow and productivity.	Improved productivity, reduced administrative burden, stronger data-led decision-making, improved pathway efficiency, faster identification of variation and better monitoring of delivery and benefits.
5. NHS App	Digital access actions include using digital tools to support triage, navigation, urgent care booking, outpatient communication, Advice and Guidance and improved patient access to appropriate services.	A stronger digital front door, improved patient navigation, reduced avoidable demand into higher-cost settings and better access to advice, appointments and pathway information.

NHSE national priority	Action outlined in the paper that links to this priority	Expected outcome of that action
6. Payment reform	Contracting and payment actions include strengthening commissioning levers, local payment flexibilities, activity caps, marginal rates, risk-share agreements, pathway-based payment models, stronger contract management and clearer provider accountability.	Payment mechanisms better aligned to desired service change, improved affordability, stronger provider accountability, greater grip on activity and improved value for money.
7. Quality	Quality-focused actions include targeted work on maternity, neonatal and women's health, frailty, mental health, dental services and urgent care, supported by clinical leadership through CMDTs, quality data, provider oversight and consistent pathway standards.	Reduced unwarranted variation, improved safety and patient experience, better outcomes for high-risk cohorts, reduced inequalities and stronger clinical oversight of commissioned services.
8. Capability building and focus on people	The Commissioning Development Programme includes TOM implementation, CMDTs, capability, knowledge and skills development, organisational development, culture and behaviour change, governance improvement and implementation of the commissioning cycle.	Improved strategic commissioning capability, stronger MDT working, clearer decision-making, better use of evidence and data, and a more confident, outcome-focused organisation able to deliver the five-year strategy.

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