

Report to	NHS Kent and Medway Integrated Care Board (Part 1)
Meeting date	21 July 2026
Report title	Kent and Medway General Practice Improvement Plan: Response to the National Association of Primary Care Independent Review of Under-Doctoring
Key question	How should the ICB respond to the National Association of Primary Care independent review of under-doctoring, and what assurance or approval is required to mobilise a targeted 24-month improvement plan for general practice across Kent and Medway?
Executive Lead	Ed Waller, Deputy Chief Executive and Chief Strategic Commissioning Officer – NHS Kent and Medway
Author	Sukh Singh, Commissioning Director – Primary, Community and Neighbourhood Care Dr Ash Peshen, Deputy Chief Medical Officer (Primary Care)

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☐ To 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	

Recommendation (outcome / action requested):
Meeting action required: ☒ Seek assurance ☒ Decision/approval required ☐ For noting/information Recommendation(s) to the meeting: - Note the findings of the National Association of Primary Care (NAPC) independent review, including that under-doctoring is a structural, geographically uneven and system-amplified issue rather than a simple GP headcount shortage. - Endorse the proposed direction of travel: a targeted, relational and data-informed response to strengthen general practice resilience, access, workforce stability and sustainability. - Approve the 24-month improvement plan as the ICB's formal response, including a universal core offer, targeted support for practices showing early signs of pressure, and enhanced locality intervention in high-need areas, with early interventions focused on practical resilience support, digital and telephony fixes, supervision capacity, workforce stabilisation, estates quick wins and primary-secondary care interface improvements.

- Support prioritisation of Medway, Swale and other high-need localities where deprivation, ageing populations, lower GP full-time equivalent capacity and workforce fragility combine.
- Agree that further detailed work is undertaken to quantify the specific resource, workforce, estates, digital and contractual requirements of the plan, including where targeted funding may be needed for time-limited resilience support, supervision capacity, telephony and digital recovery, estates quick wins, locality delivery capacity, additional clinical or management capacity, and primary–secondary care interface improvement. Any financial, procurement, contractual or provider commitments will be brought back through appropriate governance routes.

Executive summary:

NHS Kent and Medway ICB commissioned the National Association of Primary Care to undertake an independent review of under-doctoring across Kent and Medway. The review found that under-doctoring is not simply a shortage of GP headcount, but a structural, geographically uneven and system-amplified issue shaped by rising clinical complexity, demographic pressure, workforce configuration, supervision demands, interface inefficiencies and changing professional expectations.

Pressures are most acute where deprivation, ageing populations, lower GP full-time equivalent capacity and workforce fragility combine, particularly in Medway, Swale and parts of East Kent. The review also highlights the impact of supervision burden, primary–secondary care interface friction, loss of continuity, moral distress and burnout on effective GP capacity and retention.

The ICB response is already underway and is not limited to a future improvement plan. Work in progress includes the Single Neighbourhood Health offer, developed with Kent Local Medical Committee and launched with general practice; peer ambassador and specialist peer ambassador support; targeted practice resilience conversations; access, telephony and digital improvement support; workforce support through the Training Hub; and use of national general practice support offers where these are appropriate. The Single Neighbourhood Health offer provides a direct link between the NAPC findings and the wider neighbourhood health model by placing general practice at the heart of neighbourhood delivery, simplifying arrangements, creating greater flexibility for Primary Care Networks, and enabling additional workforce to be organised around patient need and local service delivery.

Kent and Medway has also been leading nationally in translating neighbourhood health policy into a practical general practice-led commissioning model. One of Kent and Medway's peer ambassadors, was invited to present their work at a national level at the NHS Confed Expo in a session hosted by Dr Claire Fuller, reflecting the credibility of the local approach and the opportunity to promote Kent and Medway as a place where general practice leadership is central to service transformation. This is important for recruitment and retention: neighbourhood health, if implemented well, can help create more attractive employment offers for GPs and wider primary care teams by improving clinical leadership, team-based working, continuity, supervision and professional belonging.

The proposed 24-month General Practice Improvement Plan therefore builds on existing delivery rather than replacing it. It brings the current work into a single assurance framework, with clearer segmentation, milestones and support offers. This includes targeted work to address unwarranted variation between practices, a clearer view of how many practices have been offered support and the type of support offered, and a stronger link between practice-level improvement, Primary Care Network development, Single Neighbourhood Health implementation and the emerging Primary Care Provider Collaborative.

The plan will also clarify what the system will hold itself and providers to: timely access, safe and resilient service continuity, effective use of commissioned capacity, transparent improvement against agreed milestones, participation in targeted support where risks are identified, delivery of agreed interface actions, and active escalation where recovery is not sufficient. In those circumstances, the ICB will retain the ability to use its commissioning levers, including commissioning additional capacity, developing new or expanded provision, or exploring alternative providers where this is necessary to protect patient access, quality, safety and population need.

The board is asked to endorse the proposed approach and approve mobilisation of the improvement plan, noting that detailed resource, workforce, estates, digital and contractual requirements will be developed and brought back through the appropriate governance routes before any financial commitments are made. This will include specifying what investment would purchase, such as resilience support, supervision capacity, digital and telephony recovery, estates quick wins, locality delivery capacity, additional clinical or management capacity and interface improvement capacity.

Proposed next steps:

- Share the report and improvement plan through the agreed communications and engagement handling plan, including briefings for the Local Medical Committee, Primary Care Network Clinical Directors, Trust Chief Executives, Members of Parliament, Health Overview and Scrutiny Committee members, Health and Adult Social Care members and council leaders as appropriate.
- Publish the report, action plan and supporting information on the ICB website, with a single contact route for feedback.
- Mobilise the first 90 days of the improvement plan, including segmentation and targeting, governance and reporting cadence, core offer mobilisation, Medway and Swale locality coordination, the first wave of 90-day improvement sprints and GP IT priority baselining.
- Continue engagement with practices, Primary Care Networks, the Local Medical Committee, patients, local authorities and system partners to co-design implementation and shape the next phase of delivery.

Governance pathway to date:

Meeting name:	Date:	Outcome:
Executive Committee	8 th July	Independent review received; proposed ICB response agreed.

Contact for further information

Sukh Singh, Commissioning Director - Primary Care, Community and Neighbourhood Health, NHS Kent and Medway

COMPLIANCE NOTES:**Equality, health inequalities and quality impact assessment****If this report is presented for decision/approval, please complete:**

Has an assessment been undertaken?

☐ Yes (please attach the action plan as an appendix to this paper)

☒ No/Not applicable at this stage. The paper seeks approval to mobilise a phased improvement plan and undertake further detailed work. Equality, health inequalities and quality impacts will be assessed as specific proposals, service changes, investments or locality interventions are developed through implementation.

Conflicts of interest**Are there any conflicts associated with authors or reporting officers?**

☐ Yes

☒ No

No conflicts have been identified at this stage.

FOI status**Is this report disclosable under FOI?**

☒ Yes

☐ No

The report is intended for publication alongside supporting communications materials, subject to any necessary redaction or handling of sensitive operational information.

Financial implications**Are there financial implications associated with this report?**

☒ Yes

☐ No

The plan may require targeted, time-limited investment in defined enablers rather than general growth funding. This could include practice resilience support, protected supervision capacity, additional clinical or management capacity in high-need localities, telephony and GP IT recovery, estates quick wins, locality delivery capacity and work to reduce avoidable primary–secondary care interface workload. No new financial commitments are sought through this paper; any investment requirements will be quantified and brought back through appropriate governance routes.

Legal implications**Are there legal implications associated with this report?**

☒ Yes

☐ No

There are no immediate legal decisions requested. Future proposals involving procurement, contractual change, service reconfiguration, practice mergers, list dispersal, new provision or patient engagement will require appropriate legal, procurement, consultation and commissioning governance advice.

Quality and safety implications

COMPLIANCE NOTES:

Are there quality or safety implications associated with this report?

☒ Yes

☐ No

The review identifies risks to access, continuity, resilience, workforce stability and patient experience where GP capacity, demographic need and practice fragility combine. The improvement plan is designed to mitigate these risks through targeted support, improved data, workforce and supervision infrastructure, digital and estates enablers, and clearer governance for escalation.

Patient and public engagement

Are there patient and public engagement implications associated with this report?

☒ Yes

☐ No

The immediate engagement approach focuses on transparent publication and structured engagement with general practice, Primary Care Networks, the Local Medical Committee, local authorities and system partners. Patient and public engagement will be built into any locality-specific service change, new provision, major reconfiguration or implementation proposal where required.

Kent and Medway General Practice Improvement Plan: Response to the NAPC Independent Review of Under-Doctoring

1. INTRODUCTION

Kent and Medway Integrated Care Board commissioned the National Association of Primary Care to undertake an independent review of under-doctoring across Kent and Medway. The review provides an important diagnostic foundation, but the response should not be read as starting from a blank page. A significant programme of work is already underway to strengthen general practice, respond to unwarranted variation, improve operational resilience and put general practice at the heart of neighbourhood health. This includes the launch of the Single Neighbourhood Health offer, targeted practice support through peer ambassadors and specialist support routes, GP IT recovery work, strengthened engagement with general practice, development of a Primary Care Provider Collaborative, and commissioning intentions that reinforce a universal core primary care offer with additional targeted support where need, inequality or fragility is greatest.

The review confirms that under-doctoring is not simply a shortage of GP headcount. It is a structural, geographically uneven and system-amplified issue shaped by rising clinical complexity, demographic pressure, workforce configuration, supervision demands, interface inefficiencies and changing professional expectations. This paper therefore sets out both the work already in train and the further 24-month improvement plan required to build pace, consistency and assurance. The improvement approach combines a universal core offer for all practices and Primary Care Networks, targeted support for practices showing early signs of pressure, and enhanced locality intervention in high-need areas such as Medway and Swale.

2. STRATEGIC ALIGNMENT

The proposed improvement plan supports the ICB's strategic objectives by strengthening commissioning impact, improving primary care resilience, and supporting long-term sustainability. It aligns with the objective to commission the right services each year by using segmented support, local resilience data and population need to target interventions. It also aligns with the emerging commissioning intentions for 2027/28, which describe a stronger universal core primary care offer, targeted support where patients, practices or neighbourhoods experience greatest need or service fragility, reduction of unwarranted variation, neighbourhood-ready Primary Care Networks, and clearer routes for organisational collaboration, merger or new provision where required. The plan supports strategic leadership by translating the National Association of Primary Care findings into a clear programme of delivery across access, workforce, digital, estates, neighbourhood models and engagement. It also supports cultural renewal by emphasising relational working, transparent data, peer-led improvement, co-production with practices, Primary Care Provider Collaborative development and proportionate support before escalation.

3. MAIN BODY: NAPC FINDINGS AND ICB RESPONSE

The NAPC review found that under-doctoring in Kent and Medway should be understood as a compound pressure on effective GP capacity rather than a simple headcount issue. Full-time equivalent capacity, clinical complexity, supervision requirements, workforce stability, population need and system inefficiencies all shape the amount of safe and sustainable GP capacity available to patients. The findings point to six connected themes: complexity and capacity strain; moral distress, burnout and emotional fatigue; amplification of workload and recruitment risk by deprivation, ageing populations and coastal geography; primary–secondary care interface friction; loss of continuity and relational medicine; and the importance of leadership, supervision, culture and belonging as leverage points for recruitment, retention and sustainable improvement.

Key NAPC finding	Implication for Kent and Medway	Improvement plan response
Under-doctoring is a structural capacity issue, not just a GP headcount problem.	Full-time equivalent capacity, workload complexity, supervision demand, skill mix and local context all affect safe and sustainable access.	Use segmented support, resilience data and locality intelligence to match interventions to practice need rather than applying a single uniform solution.
Pressure is geographically uneven and amplified by deprivation, ageing populations and coastal challenges.	High-need localities face greater workload, recruitment and retention risk, with Medway, Swale and parts of East Kent requiring particular focus.	Prioritise enhanced locality support, stabilisation bundles, workforce planning and targeted investment for high-need areas.
Supervision capacity is a binding constraint.	Additional Roles Reimbursement Scheme roles and trainees add value but can increase GP workload where supervision time and infrastructure are insufficient.	Treat supervision as core infrastructure through funded supervision capacity, clearer models, role optimisation and Primary Care Network-level workforce support.
Primary–secondary care interface friction creates avoidable workload.	Rejected referrals, duplicated work and unclear handoffs reduce GP capacity and contribute to frustration, moral distress and lower productivity.	Use provider contract management and agreed interface standards to reduce avoidable workload, improve pathway standards and

		strengthen joint accountability for acute-provider interface issues.
Burnout, moral distress and loss of continuity are retention risks.	Retention depends on making work feel manageable, meaningful and professionally sustainable, not only on recruitment incentives.	Strengthen retention, wellbeing, leadership support, peer networks, career development and continuity for patients with the greatest need.
Data needs to be used transparently and with local context.	Crude metrics can miss complexity, supervision burden and practice-level context, risking poorly targeted interventions.	Develop routine data packs, local resilience segmentation, transparent dashboards and practice-level action planning supported by relational engagement.

The ICB has already mobilised a broad programme of work that responds directly to the themes identified by the NAPC review. The improvement plan should therefore be understood as a way of strengthening, coordinating and assuring existing delivery, rather than as the first action taken in response to the review. Current work includes the Single Neighbourhood Health offer, targeted support for practices experiencing pressure, peer-led improvement through general practice ambassadors, GP IT recovery and resilience work, workforce support through the Training Hub, ongoing engagement with general practice, and development of the Primary Care Provider Collaborative.

Work underway	How this responds to the NAPC findings	Current or next assurance action
Single Neighbourhood Health offer	Places general practice at the heart of neighbourhood health, supports proactive care for people with the most complex needs, reduces fragmentation across multiple schemes and creates a clearer basis for continuity, multidisciplinary working and local clinical leadership.	Track practice participation, mobilisation of neighbourhood multidisciplinary team arrangements, delivery for the complex care cohort and use of investment and flexibilities through the Network Contract DES Kent Local Variation.
Targeted practice support	Responds to unwarranted variation and early signs of pressure by matching support to	Maintain a live support tracker showing the number of practices offered support and the type of support offered, including peer

	practice need rather than applying a single uniform offer.	ambassador, specialist peer ambassador, national GP support offers, Training Hub workforce support, access improvement, telephony, digital and estates support.
Peer ambassador model	Builds trust, creates practice-to-practice learning and provides clinically credible support in areas such as access, workflow, leadership, resilience and role optimisation.	Strengthen reporting on peer ambassador activity, outcomes and spread.
GP IT and digital recovery	Acknowledges recent GP IT issues as a material challenge for practices, access and confidence, while recognising the positive work undertaken to improve escalation, resilience and oversight.	Use the GPIT Steering Group to oversee recovery actions, business continuity standards, incident communication, telephony and online consultation improvement, and supplier escalation where required.
Workforce and Additional Roles Reimbursement Scheme flexibility	Addresses supervision burden, recruitment and retention by enabling workforce to be organised around neighbourhood need and by supporting practices to make best use of wider multidisciplinary roles.	Link the PCN local variation agreement and Single Neighbourhood Health offer to clearer ARRS flexibilities, Training Hub support, supervision planning and targeted additional workforce aligned to patient need and service delivery.
Engagement with general practice	Responds to the review's emphasis on trust, belonging and relational working by creating regular routes for dialogue, co-design and feedback.	Continue structured engagement through the GP Liaison Group, GPIT Steering Group, Single Neighbourhood Health launch and follow-up sessions, Chief Executive webinars, Local Medical Committee discussions, PCN Clinical Director engagement and "You Said, We Did" feedback loops.

Primary Care Provider Collaborative	Creates a stronger provider voice and delivery mechanism for primary care within neighbourhood health, supporting consistent improvement, shared learning, system partnership and future commissioning maturity.	Develop the collaborative's role in supporting the General Practice Improvement Plan, neighbourhood delivery, peer-led improvement, interface work and strategic commissioning intentions for 2027/28.
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4. IMPROVEMENT PLAN, SEGMENTATION AND PROGRAMME STRUCTURE

The improvement plan translates the review's recommendations and the work already underway into a 24-month programme that combines a universal support offer for all practices and Primary Care Networks, targeted interventions for mid-level practices, and enhanced locality support for high-need areas. It is deliberately structured to respond to the review's core message that improvement must be targeted, relational, data-informed and sensitive to local context rather than delivered as a uniform system-wide intervention. The plan also links directly to the Single Neighbourhood Health offer, which provides meaningful investment, a clearer contractual framework, ARRS workforce flexibility, and a GP-led neighbourhood platform for proactive care. This gives Kent and Medway an opportunity to promote a stronger employment and professional offer for GPs and wider primary care teams: general practice leading neighbourhood health, working within better-supported multidisciplinary teams, and shaping care around population need. The plan aims to improve access and patient experience, increase organisational resilience, improve workforce stability, enable safe digital and data use, support collaboration or organisational change where required, and embed a repeatable improvement infrastructure that persists beyond the 24-month programme.

- **Segmented support:** match intensity of support to need, from universal to targeted to intensive.
- **Peer-led improvement:** maximise take-up and trust through peer ambassadors and practice-to-practice learning.
- **Data-driven decisions:** use national dashboards and the local resilience matrix to target support and track impact.
- **Neighbourhood-ready:** strengthen the Primary Care Network footprint as the delivery unit for neighbourhood health, including complex care cohorts.
- **Digital as an enabler:** prioritise GP IT and operational digital tools that reduce workload and improve safety.
- **Support before escalation:** offer structured improvement and recovery routes before contractual action while maintaining patient safety and service continuity.
- **Co-production and proportionality:** build plans with practices and local partners, with clear, realistic expectations and minimal bureaucracy.

The first set of practical interventions will include:

- **Practice resilience and recovery:** deploy 90-day improvement sprints for practices showing early warning signs, with a short diagnostic, agreed support plan, weekly or fortnightly check-ins, and clear exit criteria.
- **Access, telephony and digital:** target practices with poorer patient access indicators for telephony optimisation, online consultation workflow redesign, business continuity checks and GP IT resilience actions.
- **Workforce and supervision:** identify supervision pinch points, support protected supervision sessions, optimise Additional Roles Reimbursement Scheme roles, strengthen job planning and provide practical management capacity support where leadership bandwidth is limited.
- **High-need locality support:** establish locality delivery cells in Medway and Swale to coordinate workforce, estates, digital, access and neighbourhood interventions around the practices and Primary Care Networks facing the greatest combined pressure.
- **Estates and infrastructure:** complete utilisation and constraint reviews for priority practices, identify quick wins such as room scheduling, minor works and shared use options, and align medium-term estates priorities with neighbourhood health development.
- **Interface workload reduction:** agree practical fixes with provider partners on rejected referrals, fit notes, prescribing queries, discharge communication, advice and guidance, and unclear handoffs that create avoidable GP workload with agreed standards reflected through provider contract discussions and escalation routes where recurrent acute-end interface issues are not resolved.
- **Organisational sustainability:** support practices to consider collaboration, shared back-office functions, federation support, merger options or new provision where recovery alone is unlikely to secure long-term resilience.
- **Commissioning and market response:** define the thresholds for when support moves from improvement to commissioning action, including actively commissioning additional capacity, developing new or expanded provision, or exploring alternative providers where existing services cannot sustainably meet access, quality, safety or population need.

5. CROSS-CUTTING WORKSTREAMS, IMPLEMENTATION AND ASSURANCE

Delivery will be organised through cross-cutting workstreams covering neighbourhood models, resilience including GP IT, workforce and additional staffing, estates and infrastructure, provider collaboration, and communications and engagement.

Neighbourhood model work defines the model of care, confirms neighbourhood footprints and leadership arrangements, develops priority cohorts and will produce 45 neighbourhood masterplans. The Single Neighbourhood Health offer is the key early delivery vehicle, with

general practice at the heart, PCN-aligned footprints, local variation to the Network Contract DES, ARRS flexibilities and additional investment to support proactive care for the complex care cohort. The Primary Care Provider Collaborative will be developed as an important part of the delivery architecture, giving primary care a stronger collective role in neighbourhood health, interface improvement, workforce planning, shared learning and future commissioning maturity. The resilience workstream will establish minimum GP IT resilience standards, incident response and escalation models, business continuity toolkits and priority improvement actions following recent GP IT disruption. Workforce work will support supervision, job planning, recruitment and retention, management capacity, Training Hub support and practical capability development. Estates work will establish a baseline of capacity, condition, utilisation and constraints, and develop mitigation plans and medium-term pipelines aligned to neighbourhood delivery. Communications and engagement will create a structured two-way approach with practices, Primary Care Networks and representative bodies, including the GP Liaison Group, GPIT Steering Group, Single Neighbourhood Health launch and follow-up sessions, Chief Executive webinars, GP Digital Hub, leadership updates, the Deputy Chief Medical Officer inbox and “You Said, We Did” feedback mechanisms. Each workstream will identify a small number of named, deliverable interventions for the first two quarters, with practice-level support plans and locality action logs showing which practices have been offered which type of support and what impact has been achieved.

Accountability and escalation: The programme will set out what practices, Primary Care Networks, providers and the ICB will be held to through a small number of agreed standards and milestones. These will include access and responsiveness, delivery against agreed improvement actions, participation in resilience diagnostics where risk is identified, safe business continuity, effective use of commissioned workforce and estates capacity, timely implementation of interface fixes, and transparent reporting through locality and programme governance. For acute-provider interface issues, the ICB will seek to move beyond informal problem-solving by defining expected standards for referrals, discharge communication, fit notes, prescribing queries, advice and guidance, and administrative handoffs, and by using contract management, quality oversight and commissioning escalation routes where recurrent issues continue to create avoidable GP workload. Where agreed support does not secure improvement, or where access, quality, safety or sustainability risks remain material, the ICB will consider escalation through contractual, commissioning and procurement routes. This may include commissioning additional short-term or recurrent capacity, developing new or expanded provision, supporting organisational change, or exploring alternative providers where this is required to secure sustainable services for patients.

Phase	Key activities and deliverables
Months 0–3: Mobilise	Confirm segmentation and targeting list; agree governance and reporting cadence; mobilise core offer; establish Medway and Swale locality delivery cell; identify first wave of mid-level 90-day sprints; confirm GP IT priorities

	and telephony baseline; agree the initial list of practices requiring resilience diagnostics, access workflow support, supervision capacity review and estates constraint assessment; create a live support tracker showing how many practices have been offered peer ambassador, specialist peer ambassador, national GP support, Training Hub workforce, access, telephony, digital or estates support; define the first set of interface standards to be taken into provider contract and quality discussions; and confirm the role of the Primary Care Provider Collaborative in supporting delivery.
Months 4–6: Stabilise	Deliver first wave of mid-level sprints; initiate intensive support for highest-risk practices; implement priority telephony and online consultation fixes; agree locality workforce surge plans where required; begin merger or collaboration feasibility for structurally fragile practices; assess areas where recovery may not be sufficient and new or expanded provision may be required; use the GPIT Steering Group to assure recovery actions and business continuity standards; agree first interface workload fixes with provider partners, focusing on referrals, discharge communication, prescribing queries and avoidable administrative handoffs; and confirm how recurrent acute-end interface issues will be escalated through contract management where agreed standards are not met.
Months 7–12: Embed	Scale Primary Care Network core offer uptake; expand locality and neighbourhood-level support; embed routine dashboard review and action planning; implement agreed staffing changes; use Single Neighbourhood Health and the PCN local variation agreement to support ARRS flexibility and additional workforce targeted to patient need; progress estates quick wins; implement agreed organisational change with patient engagement and continuity mitigations where chosen; progress development of new provision where agreed; and demonstrate how the Primary Care Provider Collaborative is contributing to peer learning, delivery assurance and neighbourhood health implementation.
Months 13–18: Spread	Deliver second wave of targeted interventions informed by measured impact; spread best practice across Primary Care Networks; strengthen neighbourhood working for complex care cohorts; further develop digital enablement; reduce repeat escalation through early warning indicators.
Months 19–24: Sustain	Evaluate outcomes and value for money; confirm business-as-usual improvement infrastructure for subsequent years; complete remaining organisational change programmes; refresh risk profile for Medway and Swale; agree next 24-month cycle priorities.

6. KEY RISKS, MITIGATIONS, AND CONTROLS

The key risks and dependencies are workforce supply constraints, change fatigue and capacity, digital variation and supplier constraints, estates lead times, interface workload, financial constraints, and workforce or viability risk for new provision. These risks will be managed through the programme governance arrangements, use of transparent data, local risk logs, documented support plans, clear accountability expectations and escalation routes where patient safety, access, quality, sustainability or contractual risk is rising. Workforce supply risk will be mitigated through retention focus, role optimisation, supervision support and organisational scale options. Change fatigue will be mitigated through peer-led delivery, reduced bureaucracy and a relational approach with practices. Digital and supplier constraints will be mitigated through prioritisation, standard specifications and clear incident escalation routes. Estates lead times will be mitigated through early feasibility work, utilisation-based quick wins and alignment with neighbourhood implementation. Interface workload will be mitigated through targeted pathway and workflow fixes with system partners. Financial constraints will be mitigated through clear business cases, time-bound investment proposals and appropriate governance. Where recovery support is insufficient, the ICB may need to actively commission additional capacity, develop new or expanded provision, or explore alternative providers, subject to legal, procurement, patient engagement, quality, workforce, estates and financial governance. Any new provision or major reconfiguration will be subject to robust feasibility assessment, workforce planning, estates appraisal, financial sustainability testing, patient engagement and commissioning governance.

7. OTHER CONSIDERATIONS

The review makes clear that a single, uniform response would be insufficient because under-doctoring is not evenly distributed and is shaped by local context, population need, practice resilience, supervision capacity, workforce configuration and wider system pressures. The recommended approach therefore combines a universal core offer with targeted support and enhanced locality intervention. It also recognises that much of the response is already underway: Single Neighbourhood Health has been launched as a GP-led neighbourhood platform; practices are being offered a range of support routes; GP IT recovery and resilience work has been strengthened following recent challenges; and engagement with general practice has been expanded through regular groups, webinars and feedback routes. Alternatives considered include a system-wide equal distribution of support, a purely contractual response, or a narrow focus on GP headcount. These options are not recommended because they risk missing the complexity of the issue, entrenching inequalities where baseline capacity differs, and failing to address the underlying drivers of pressure. Success will be assessed through improvements in access and responsiveness, practice resilience, workforce stability, digital performance, quality and safety, patient experience, reduced reliance on reactive spend, fewer destabilising contract failures, demonstrable reduction in unwarranted variation, and evidence that general practice is leading neighbourhood health as an attractive and sustainable professional model.

8. REQUIRED OUTCOMES AND NEXT STEPS

The board is asked to:

- Note the findings of the National Association of Primary Care independent review of under-doctoring in Kent and Medway, including that under-doctoring is a structural, geographically uneven and system-amplified issue rather than a simple GP headcount shortage.
- Endorse the overall direction of travel, including a targeted, relational and data-informed approach to improving general practice resilience, access, workforce stability and sustainability.
- Approve the proposed 24-month improvement plan as the ICB's formal response to the NAPC review, including a universal core offer, targeted support for practices showing early signs of pressure, and enhanced locality intervention in high-need areas.
- Support the prioritisation of Medway, Swale and other high-need localities where deprivation, ageing populations, lower GP full-time equivalent capacity and workforce fragility combine to create disproportionate risk.
- Agree that further detailed work is undertaken to quantify specific resource, workforce, estates, digital and contractual requirements, including where targeted funding may be needed for resilience support, supervision capacity, telephony and digital recovery, estates quick wins, locality delivery capacity, additional clinical or management capacity, and primary–secondary care interface improvement. This will also include the circumstances in which the ICB may actively commission additional capacity, develop new or expanded provision, explore alternative providers, or use provider contract management more directly where recurrent acute-end interface issues continue to create avoidable GP workload, with any financial, procurement or contractual commitments brought back through appropriate governance routes.

The following next steps should be noted:

- Confirm segmentation and targeting, agree governance and reporting cadence, and mobilise the core offer for practices and Primary Care Networks, including named practice resilience diagnostics, 90-day sprint candidates and support offers for access, digital, workforce, supervision and estates.
- Develop and maintain a live practice support tracker, showing the number of practices offered support and the type of support offered, including peer ambassador, specialist peer ambassador, national GP support offers, Training Hub workforce support, access, telephony, digital, GP IT and estates support.
- Use the Single Neighbourhood Health offer and PCN local variation agreement to support ARRS flexibilities and additional workforce deployment around patient need, complex care, neighbourhood multidisciplinary team delivery and local service sustainability.
- Promote Kent and Medway's leadership in GP-led neighbourhood health, including learning from the peer ambassador model and national recognition of local work, to

support recruitment, retention and a more attractive employment offer for GPs and wider primary care teams.

- Confirm the development route, purpose and early priorities for the Primary Care Provider Collaborative, including its role in neighbourhood health delivery, peer-led improvement, interface work, shared learning and commissioning intentions for 2027/28.
- Establish the Medway and Swale locality delivery cell and identify the first wave of mid-level 90-day improvement sprints.
- Confirm GP IT priorities, telephony baseline, incident communication routes and resilience actions.
- Define the accountability framework for the programme, including what practices, Primary Care Networks, providers and the ICB will be held to, the thresholds for escalation, and the process for considering additional commissioned capacity, new provision or alternative providers where required.
- Agree the first set of practical interface workload reductions with provider partners, including actions on rejected referrals, discharge communication, prescribing queries and avoidable administrative handoffs, and confirm how these standards will be reflected through provider contract discussions, quality oversight and escalation routes where recurrent issues are not resolved.
- Continue engagement with practices, Primary Care Networks, the Local Medical Committee, patients, local authorities and system partners to co-design implementation and shape the next phase of delivery.

9. SUPPORTING DOCUMENTATION

The following documents are available to support the content of this paper:

- National Association of Primary Care independent review of under-doctoring in Kent and Medway.