KENT COUNTY COUNCIL

KENT HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Kent Health and Wellbeing Board held in the Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 30 September 2026.

PRESENT: Mrs G Foster, Mr J Henderson (Chair), Mr P Webb, Mr M Mulvihill, Dr B Bowes (Vice-Chair), Cllr M Blakemore, Dr A Ghosh, Mr R Goatham, Cllr K Moses, Mr C Neill, Ms H Woodland and Mr S Smith (Substitute for Ms C McInnes)

IN ATTENDANCE: Ms H Gillivan (Director for Adults and Integrated Commissioning), Mr M Badze (Kent Marmot Coastal Region Coordinator), Dr M Gogarty (Strategic Lead Public Health Consultant) , *Ms A Kitt (Deputy Director Neighbourhood Health)* Ms J Mookherjee (Consultant in Public Health) *Dr A Peshen (Deputy Chief Medical Officer) and Ms N Rennie (NHS)*

UNRESTRICTED ITEMS

85. Apologies and Substitutes
(Item 1)

Apologies were received from Councillor Perkins; and Christine McInness. Simon Smith was in attendance on behalf of Christine McInness.

86. Declarations of Interest by Members in items on the agenda for this meeting
(Item 2)

There were no declarations of interest.

87. Minutes of the Meeting held on 23 July 2026
(Item 3)

It was RESOLVED that the minutes of the meetings held on 23 July 2026 were an accurate record and that they be signed by the Chairman.

88. Director of Public Health Verbal Update
(Item 4)

1. Dr Ghosh, Director of Public Health, provided an update on the following:

(a) Dr Ghosh advised that the meeting had been intended to launch the refreshed Health and Wellbeing Board, but that the previous arrangements remained in place pending agreement from Full Council of the revised Terms of Reference. He described the current Board as a “prototype” and noted that its four priorities were mental health, the Marmot Coastal

Region, the Better Care Fund and neighbourhood health. Three existing workstreams or working groups would also sit under the Board.

Dr Ghosh said that the refreshed Board was intended to be the most senior strategic partnership for health and wellbeing in Kent, taking a broader, system-wide approach encompassing the wider determinants and building blocks of health alongside the priorities of key partners. He also noted that, as part of consideration of the Terms of Reference, future meetings could potentially be divided into a public-facing part and a closed part to enable discussion of more sensitive matters.

(b) Dr Ghosh reported that, prior to the meeting, the National Domestic Abuse Commissioner, Dame Nicole Jacobs, had visited an Oasis-run centre in Gravesham supporting women experiencing domestic abuse. He advised that the Commissioner had been impressed by the work undertaken in Kent, including the support provided to both female and male victims, and had expressed particular interest in Kent as an example of practice nationally.

(c) Dr Ghosh advised that his Annual Public Health Report, a statutory report of the Director of Public Health, was due to be published within the following month and would focus on mental health. The report would be produced in a multimedia, web-based format and would include films and perspectives from service users, residents and service providers.

(d) Dr Ghosh reported on the development of age-friendly communities in Kent, noting that Ashford, Faversham and Sevenoaks had been designated as members of the UK Network of Age-friendly Communities. Innovation micro-grants of up to £4,000 would be available to VCSE organisations in Ashford to establish or enhance initiatives supporting age-friendly communities, with similar grants in Faversham and Sevenoaks to follow. Recruitment was also underway in Ashford for age-friendly ambassadors from the local population aged over 50 to support signposting and community engagement and to represent the voice of older people in decision-making.

(e) Dr Ghosh advised that a stroke prevention pilot had commenced that month at Darent Valley Hospital and Gravesend Gurdwara. The pilot involved testing for atrial fibrillation by healthcare assistants, alongside health promotion interventions delivered by volunteers.

(f) Dr Ghosh reported that a Carers' Health Needs Assessment had been completed, with particular emphasis on informal carers. The assessment considered the health and wellbeing needs of unpaid family carers across Kent and would inform future commissioning, policy development and multidisciplinary partnership working.

(g) In relation to substance misuse, Dr Ghosh advised that direct routes into treatment were being progressed with Forward Trust for people with liver failure, improving joint working with acute trusts and supporting the detection of cancer. Work was also underway to examine non-fatal

overdoses as part of efforts to prevent drug-related deaths, including improvements to data systems to enable support to be provided more quickly.

(h) Dr Ghosh advised that a nationally funded gambling harms reduction programme had commenced, including a small grants scheme providing grants of between £5,000 and £8,000 for communities.

(i) In relation to sexual health, Dr Ghosh advised that new contracts with KCHFT and Maidstone and Tunbridge Wells NHS Trust had been awarded from 1 April. Work was underway with providers to review activity quotas and oversee mobilisation and delivery of the new contracts. An evaluation of online sexual health services was also nearing completion, comprising a retrospective review of service performance and changing population need, together with a forward-looking horizon scan to inform future service development.

(j) Dr Ghosh reported that a Marmot indicator set had been developed to inform the Marmot Coastal work, in collaboration with Professor Sir Michael Marmot's team, the Marmot Steering Group and project leads across KCC. A set of robust and meaningful indicators had been identified to provide a "North Star" for measuring health inequalities and to help inform work relating to neighbourhood health.

(k) Finally, Dr Ghosh advised that a Secondary-Age Children's Health Needs Assessment had been completed and published on the Kent Public Health Observatory. The assessment considered the emotional health and wellbeing needs of secondary-age children, in keeping with the wider series of health needs assessments relating to children.

2. Further to questions and comments from Members the discussion included the following:

(a) The Chair welcomed the inclusion of mental health as a priority and, drawing on his experience of supporting an individual with mental health issues, emphasised the importance of enabling people with mental health conditions to live as full a life as possible, including through employment. He expressed his appreciation to employers who supported people with mental illness in the workplace.

(b) Members welcomed the priority given to mental health and noted the positive feedback received in relation to services, reflecting the work undertaken by staff and further work planned in this area.

(c) In relation to the stroke prevention pilot, a question was raised as to whether, following completion of the pilot, there was potential to involve students from medical universities in Kent as part of their training. It was confirmed that this could be considered once the results of the pilot were available.

3. It was RESOLVED that the verbal update be noted.

89. Priorities of the Kent Health and Wellbeing Board - Better Care Fund
(Item 5)

Helen Gillivan (Director Adults and Integrated Commissioning) was in attendance for this item

1. Ms Gillivan introduced the report, which had been jointly developed by KCC and the ICB and set out the implications of the new national Better Care Fund requirements. She advised that the Better Care Fund currently comprised almost £239 million across KCC and the ICB and supported the integration of health and social care, including prevention, intermediate care, reablement, hospital discharge and residents' independence.

2. The 2026/27 framework represented the first stage of national reform following the 10-year health plan, with an increased emphasis on integration, preventative care and neighbourhood health. In response, KCC and the ICB had been working collaboratively to revise the existing Section 75 Partnership Agreement to strengthen joint governance arrangements, subject to the respective KCC and ICB governance processes.

3. The proposed arrangements included a new Section 75 Partnership Board and supporting Better Care Fund Programme Board, which would provide oversight of expenditure, delivery, performance, risk, impact, productivity and value for money. KCC and the ICB were also jointly reviewing all Better Care Fund schemes during the year to ensure that they delivered the benefits required under the new framework.

4. Ms Gillivan advised that the Health and Wellbeing Board would retain strategic oversight of the Better Care Fund and would receive quarterly reports on performance, expenditure and delivery. The Board would also be asked to review and approve future Better Care Fund plans and any annual reports required as part of the national process.

5. Members were asked to note the national changes, the proposed governance arrangements through the Section 75 Agreement and the future reporting arrangements to the Health and Wellbeing Board.

6. Further to questions and comments from Members the discussion included the following:

   (a) A question was raised regarding how the Board would ensure that Better Care Fund schemes delivered the expected outcomes, value for money and productivity, and how underperformance, gaps or omissions would be addressed. It was explained that the strengthened governance arrangements, including the supporting Programme Board, would enable KCC and the ICB to monitor expenditure and the measurable impact of individual schemes, collectively review performance and escalate identified risks to the Health and Wellbeing Board. The importance of establishing clear expectations and measures against which performance could be assessed, including how failure to achieve expected outcomes would be addressed, was emphasised.

(b) A question was raised regarding whether the national requirements placed restrictions on how Better Care Fund funding could be used within Kent and how differences between KCC and the ICB regarding expenditure or priorities would be managed. Ms Gillivan advised that national requirements governed the use of the funding and compliance was assessed through the national reporting process. She explained that KCC and the ICB each contributed funding and were required to ensure that the new national requirements were met, which had prompted the current review. Ongoing discussions between KCC and the ICB sought to ensure that their collective investment achieved the best outcomes for Kent residents.

7. It was RESOLVED that the Kent Health and Wellbeing board agreed to:

(a) Note the changes to the Better Care Fund national policy and planning requirements for 2026/27 and their implications for Kent.

(b) Note the submission of Kent's 2026/27 BCF assurance return

(c) Note the proposed joint governance arrangements to be established through the revised Section 75 Agreement

(d) Note that quarterly Better Care Fund reports will be provided to the Board through the proposed governance structure, with material issues escalated to the Health and Wellbeing Board where appropriate.

(e) Note that future Better Care Fund plans and annual reports will be presented to the Health and Wellbeing Board for approval in accordance with national Better Care Fund requirements

90. Priorities of the Kent Health and Wellbeing Board - Kent Marmot Coastal Region Update
(Item 6)

Munya Badze (Kent Marmot Coastal Region Coordinator) was in attendance for this item.

1. Dr Ghosh introduced the report, which provided an update on the Kent Marmot Coastal Region, one of the proposed priorities for the Health and Wellbeing Board, and invited consideration of how the Marmot principles could support neighbourhood health planning and the reduction of health inequalities.

2. Dr Ghosh highlighted the extent of health inequalities within Kent's coastal communities. By way of illustration, he advised that average life expectancy reduced by approximately eight years between Sevenoaks and Swale, five years between Sevenoaks and Thanet, and four and a half years between Sevenoaks and Folkestone. He emphasised that these inequalities were particularly pronounced in coastal areas and underpinned the purpose of the Marmot Coastal Region programme.

3. The Kent Marmot Coastal Region had been launched on 13 March with Sir Michael Marmot. At the launch, KCC had committed, over the following 18 months, to supporting 200 young people who would otherwise not be in education, employment or training into education, employment or training; 150 people on probation living in Kent's coastal areas into education and employment; and 100 people experiencing additional disadvantage into employment, including care leavers, unpaid carers and people with mental ill health.

4. Dr Ghosh advised that the initial focus had been on establishing the programme, raising awareness and developing engagement among individuals and organisations. Governance arrangements included a Steering Group, an Advisory Group chaired by Sir Michael Marmot and a number of supporting working groups.

5. A set of Marmot Coastal indicators had been developed to establish the current position, measure progress and assess the impact of the programme. Dr Ghosh advised that the programme was now moving from development into delivery through a series of accelerator programmes specifically focused on achieving the commitments made at the launch. The first, the Sheppey Career Readiness Initiative, was underway and supported young people at risk of becoming not in education, employment or training.

6. Dr Ghosh concluded by emphasising the intention for Marmot principles to be embedded across the wider system, particularly within neighbourhood health plans

7. Mr Badze highlighted the alignment between the Marmot work and the wider determinants of health, particularly skills, employment, apprenticeships and training.

8. He advised that the work was connected to national networks, including the Coastal Navigator Network and the South East Coastal Data Network, which supported policy development, the sharing of best practice and learning, and collaboration to improve health outcomes in coastal communities. This included contributing to a review of the 2021 Chris Whitty report, five years on.

9. Mr Badze emphasised the importance of skills and employment in delivering the programme's commitments and the need for greater engagement from local authorities, district councils and wider partners to provide workplace experience and employment opportunities. He noted that, through partnership working and evaluation, this could support improved employment pathways and health outcomes for coastal communities.

10. Further to questions and comments from Members the discussion included the following:

    (a) A question was raised regarding the Sheppey Career Readiness Initiative, including the number of young people participating, how they

were being identified and engaged, and the support available through the programme. It was reported that the initiative was working with local youth organisations, employers, healthcare professionals, the DWP and voluntary sector organisations, drawing on established links within the local community. At that stage, 12 young people had signed up to the programme and work was underway to provide mentoring and work experience opportunities. The 14-month programme had a total budget of £135,000 from the Public Health Grant and included early engagement, mentoring, soft-skills development, work experience and support for employers to make adjustments to recruitment practices. The programme aimed to engage and sustain 8 to 10 employers within communities of practice, support at least five employers to make adaptations to their recruitment arrangements, and enable 35 young people who were not in education, employment or training to enter employment by the end of the programme

(b) A question was raised regarding plans to extend the accelerator approach to other coastal districts and whether further schemes would be developed alongside the Sheppey initiative or following its evaluation. It was reported that a further accelerator programme in Dover was under consideration and that a commissioning strategy had been developed to enable organisations to apply for small grants aligned with the programme's three core commitments. The intention was to complete the commissioning process and have delivery partners in place by March, with delivery commencing in the following financial year across the Marmot coastal areas.

(c) A question was raised regarding the incentives and benefits for businesses participating in the Marmot programme. It was explained that there was no direct financial incentive, with participation instead providing opportunities for businesses to demonstrate social responsibility, enhance their reputation and support pathways into employment for young people. The work also aligned with wider employment and economic strategies, and it was noted that supporting the health and wellbeing of current and future employees could provide benefits to businesses through a healthier workforce and population.

(d) The growing engagement of employers, charities and community groups demonstrated the value and increasing reach of the Marmot Coastal programme. Reference was made to a local charity which had established a skills hub to provide young people who were not in education, employment or training with opportunities to build confidence, develop skills and gain work experience. The potential for such initiatives to provide people facing disadvantage, including those with previous criminal or substance misuse backgrounds, with opportunities to move into employment was also highlighted.

11. It was RESOLVED that the Kent Health and Wellbeing board note the progress made since the launch of the Kent Marmot Coastal Region

91. Priorities of the Kent Health and Wellbeing Board - Whole System Mental Health and Wellbeing : A prevention approach
(Item 7)

Jess Mookherjee (Consultant in Public Health) was in attendance for this item

1. Ms Mookherjee introduced the report, which set out an emerging whole-system approach to mental health and wellbeing in Kent and sought the Board's support for mental health as a cross-cutting priority for prevention and health inequalities.

2. She advised that there was already significant activity across Kent, including needs assessment work, neighbourhood health, Health Alliances, Live Well Kent, voluntary and community sector provision, work with children and young people, the Marmot Coastal Programme and the Suicide and Self-Harm Prevention Strategy. The key challenge was whether this activity collectively formed a coherent system for Kent residents, particularly at a time of organisational change, complex demand and significant pressure on resources.

3. Ms Mookherjee emphasised that mental health could not be regarded solely as the responsibility of specialist mental health services. While effective specialist and crisis services remained important, prevention required consideration of the wider factors affecting mental wellbeing, including housing, employment and financial security, substance misuse, physical health, loneliness and social connection, education, transport and community infrastructure. Mental health was therefore considered to be an issue requiring a whole-system approach.

4. She identified prevention as an area in which the Board could add particular value, including consideration of whether community infrastructure enabled people to remain well and access support at an early stage, and whether neighbourhood arrangements effectively connected residents to that support. She highlighted the importance of maintaining a focus on prevention when organisations faced financial pressures and referred to the future sustainability of community-based provision, including Live Well Kent.

5. Ms Mookherjee clarified that the Board was not being asked to determine individual commissioning or funding decisions. However, she identified a strategic issue around ensuring that separate financial and commissioning decisions made by individual organisations did not have the cumulative effect of unintentionally weakening preventative provision. Consideration should therefore be given to whether an appropriate forum existed for collective commissioning and planning discussions and, if not, whether one should be established with reporting to the Health and Wellbeing Board.

6. Ms Mookherjee also highlighted inequalities between different places within Kent and noted that mental ill health was not evenly distributed. Needs assessments, the Marmot Coastal work and local intelligence provided an increasing understanding of where need and disadvantage intersected. She emphasised that a whole-system approach did not necessarily mean

applying the same interventions in all areas and referred to the need to address inequalities both within coastal communities and elsewhere in Kent.

7. Collective responsibility was also highlighted, with the Suicide and Self-Harm Prevention Strategy identified as an example of an area requiring contributions from a wide range of partners, including housing, employers, schools, universities, the NHS, councils, the voluntary sector, police and criminal justice partners. Ms Mookherjee advised that the same principle applied more widely to mental wellbeing.

8. Ms Mookherjee advised that the intention was not to create an additional layer of strategy or bureaucracy, but to better coordinate existing activity. The next stage would draw on needs assessments, the forthcoming system review and work being undertaken by KCC to identify a small number of shared priorities, clarify governance and accountability, and develop a proportionate set of measures through which the Board could assess progress.

9. In conclusion, Ms Mookherjee asked the Board to consider whether existing activity collectively provided a coherent preventative mental health system and where greater collective action could improve its effectiveness. The Board was asked to support the proposed direction of travel, recognise mental health and wellbeing as a cross-cutting issue, support continued collective leadership on suicide and self-harm prevention, and enable a more developed whole-system framework to be brought back following completion of the ongoing assessment work.

10. Dr Ghosh welcomed mental health as a priority for the Board and noted that, while significant good practice and activity already existed, the overall approach was not yet fully cohesive or comprehensive. He considered that the current developments presented an opportunity to strengthen the collective approach over the following 12 months, which could require challenging discussions between partners, with the Board providing an appropriate forum for those discussions.

11. Further to questions and comments from Members the discussion included the following:

    (a) Members endorsed the importance of mental health as a priority and welcomed the proposed joint approach. However, concern was expressed about the potential impact of reductions in preventative funding, particularly on voluntary and community organisations supporting young people and those with additional needs. Reference was made to a local youth club which had remained operational following support from the community and local businesses and was providing skills and employment opportunities for young people. The wider financial pressures facing community organisations were highlighted, together with concern that additional expectations could be placed on the sector without corresponding resources.

(b) A Member emphasised the importance of effective multi-agency working and communication, noting that failures in collaboration could result in gaps in support where individual agencies assumed that responsibility rested with another organisation. It was highlighted that such breakdowns were often identified only following serious incidents or tragedies. The Member considered that a key role for the Board should be to encourage effective communication, collaboration and shared responsibility across partner organisations, with a greater emphasis on early intervention and prevention rather than identifying lessons after an incident had occurred.

(c) A Member emphasised the importance of a greater focus on mental health within education settings. While recognising the value of services such as youth clubs and Live Well Kent, it was noted that engagement with these services was optional, whereas schools provided regular contact with children and young people. The Member highlighted the role of teachers and teaching assistants in identifying potential mental health concerns and the importance of ensuring that they received appropriate support to fulfil this role.

(d) The importance of mental health being recognised as a priority was welcomed, together with the work undertaken to develop the proposed approach. The need for wider partner engagement was highlighted, including with Kent Police, recognising the role that partner organisations could play in responding to mental health issues at an early stage and the importance of mental health becoming a shared priority across the system.

(e) The importance of cultural change in relation to mental health was emphasised, including challenging perceptions that mental ill health was not a genuine condition or that individuals should simply manage such difficulties themselves. It was suggested that the Council, working with partners and providers, had an important role in helping to change attitudes within organisations and the wider community, recognising that mental ill health was not the fault of the individual and could be addressed through changes in the way the wider system responded.

(f) The proposed approach was supported, alongside the need for an open discussion about its long-term sustainability and the resources required to deliver it. It was emphasised that, without sufficient investment and funding, there was a risk that progress could not be sustained, and that consideration should therefore be given to opportunities for further investment.

12. It was RESOLVED that the Kent Health and Wellbeing Board:

(a) NOTE the increasing prevalence and complexity of mental health need in Kent, and the close relationship between mental health, deprivation, physical ill health, housing insecurity, social isolation, substance use, trauma, homelessness and exclusion.

(b) ENDORSE the direction of travel towards a whole-system, prevention-led approach to mental health and wellbeing, delivered through neighbourhood health, primary care, local communities, local authority services, the voluntary and community sector, employers and specialist health and care services.

(c) RECOGNISE the Kent and Medway Suicide and Self-Harm Prevention Strategy 2026–2030 as a key component of this approach, and encourage continued collaboration across partner organisations to reduce suicide and self-harm.

(d) ENDORSE the principle that mental health and wellbeing should be a cross-cutting strategic priority within the Board's ongoing work on prevention, health-inequalities, neighbourhood-health and health-and economy agenda, including the Marmot Coastal Region, housing, employment, skills, regeneration, transport, nature and community infrastructure.

(e) NOTE that further work is being undertaken to develop a whole-system mental health delivery framework, with proposals to be reported to a future meeting of the Health and Wellbeing Board.

92. Governance of the Kent Health and Wellbeing Board - Kent and Medway Health Inequalities Group
(Item 8)

1. Dr Ghosh introduced the report, which provided an update on the establishment of the Kent and Medway Health Inequalities Group, formerly the Integrated Care Partnership Inequalities Subcommittee, and outlined its role, purpose and proposed governance arrangements following changes to the Integrated Care Partnership structure.

2. He advised that the previous Integrated Care Partnership arrangements had included work focused on health inequalities, prevention, and health and the economy. As the Integrated Care Partnership was being stood down, it was proposed that these areas of work would sit under the Health and Wellbeing Board as workstreams rather than formal subcommittees, with their existing administrative arrangements remaining in place.

3. Dr Ghosh advised that the Health Inequalities Group and Prevention Group would initially continue separately, with the intention that they could be brought together within the following three to six months. The Health Inequalities Group was well attended and operated as a community of practice, bringing together those working on health inequalities to share knowledge, concerns and good practice.

4. The purpose of the Health Inequalities Group remained to provide system leadership to reduce health inequalities and advance health equity across Kent and Medway. This included developing a shared understanding of inequalities, identifying opportunities for coordinated action, building and sharing evidence of effective practice, influencing policy and decision-making, and promoting action on the wider determinants of health.

5. The Group's areas of focus included the wider determinants of health, populations experiencing deprivation, locally identified groups at greater risk of health inequalities, and inclusion health populations experiencing multiple disadvantage. Dr Ghosh advised that the Group would continue under its existing arrangements in the immediate term, with the intention of considering its future merger with the Prevention Group.

6. It was RESOLVED that the Kent Health and Wellbeing Board:

(a) NOTE the establishment of the Kent and Medway Health Inequalities Group and its revised governance arrangements.

(b) NOTE the role of the Group as a system-wide forum that advocates for the reduction health inequalities and improving health equity across Kent and Medway

(c) NOTE that periodic updates and recommendations will be brought to the Health and Wellbeing Board by the Kent and Medway Health Inequalities Group

93. Governance of the Kent Health and Wellbeing Board - Kent and Medway Prevention Group Review

(Item 9)

1. Dr Ghosh introduced the report, which summarised the findings of the Kent and Medway Prevention Group Review and sought support in principle for the continuation and further development of a dedicated prevention-focused partnership forum. He advised that the Group would have a two-way relationship with the Health and Wellbeing Board, both reporting its work to the Board and taking forward relevant activity requested by the Board.

2. Dr Ghosh explained that there was some overlap between the work of the Prevention Group and the Health Inequalities Group, as preventative interventions were often required to address health inequalities. This supported the intention to consider bringing the two groups together in the future. However, while operating separately, the Prevention Group had adopted a different approach, with defined priorities and a work programme rather than a community of practice model.

3. The Group's initial work had focused on the "Vital Five", comprising smoking, hypertension, obesity, mental health, and alcohol and drugs, alongside the wider determinants of health and social prescribing. As the work progressed, it had become apparent that much of this activity would continue irrespective of the Group, prompting a review of its purpose and future role.

4. Dr Ghosh advised that the review had identified strong support for retaining a dedicated prevention function, while highlighting the need for greater clarity of purpose, added value, priority setting and action-focused meetings. A mapping exercise had found that the Group did not duplicate other existing forums. It was therefore proposed that its future focus should

be on areas where it could provide additionality and support activity at scale across Kent and Medway that was not already being addressed elsewhere.

5. The future priorities were due to be considered at the Group's next meeting. Dr Ghosh indicated that he was particularly keen to consider a focus on population need groups five to nine, representing the rising-risk population within neighbourhood health, as an area where the Group could add value through a dedicated focus on prevention and link into neighbourhood health governance.

6. Further to questions and comments from Members the discussion included the following:

   (a) A question was raised regarding the importance of the Board understanding the Prevention Group's objectives and how its success would be measured. Dr Ghosh confirmed that the Group's purpose would be clarified at its next meeting and reiterated his preference for its work to complement neighbourhood health, particularly through a focus on population need groups five to nine. These represented rising-risk groups where preventative action could help avoid progression into the highest-risk groups. The intention was to identify evidence-based interventions for these groups and link with neighbourhood health governance to support their implementation.

   (b) It was queried why the proposed merger of the Health Inequalities Group and Prevention Group would not be progressed immediately. Dr Ghosh advised that members of both groups supported a merger, but that their current approaches differed, with the Health Inequalities Group operating as a community of practice and the Prevention Group focusing on action plans and delivery. Further consideration was therefore required as to how the groups could be brought together while retaining the aspects of each that members valued.

7. It was RESOLVED that the Kent Health and Wellbeing board:
   (a) NOTE the findings of the Prevention Group review

   (b) ENDORSE in principle the continuation of a dedicated multi-agency Prevention Group for Kent and Medway, subject to further work to clarify the future purpose, priorities, governance arrangements and membership

   (c) NOTE that a further update will be provided following completion of the mapping exercise and subsequent Prevention Group discussions.

94. Governance of the Kent Health and Wellbeing Board - Strategic Partnership for Health and Economy: Providing System Leadership on Health, Work and Inclusive Growth
(Item 10)

1. Dr Ghosh introduced the report on the Strategic Partnership for Health and Economy (SPHE), which set out its role, progress and future direction and

sought the Board's support for its continued role in aligning health, employment, skills and economic development activity across Kent and Medway. He highlighted the strong relationship between health and economic development and the alignment of the Partnership's work with the Marmot Coastal Region.

2. Dr Ghosh advised that SPHE was an established advisory partnership with existing governance arrangements. It would continue to report to the Kent and Medway Economic Partnership (KMEP) in relation to economic matters and would report to the Health and Wellbeing Board in relation to health, with reporting to both where appropriate. The Partnership did not hold a budget or replace the formal decision-making responsibilities of individual partner organisations, but provided a forum for collaboration, strategic alignment and shared leadership.

3. The Partnership's work included the Kent and Medway Integrated Work and Health Strategy, Get Kent and Medway Working Plan, Connect to Work, Work Well Kent, the Marmot Coastal Region, the Health and Economy Lived Experience Project and the HOPES research collaboration. Dr Ghosh advised that the Partnership provided a strategic forum for considering how opportunities aligned with agreed health and economic priorities, complemented existing activity, responded to the needs of particular places and communities, and could be supported by available capacity and resources.

4. Dr Ghosh highlighted the Health and Economy Lived Experience Project, through which eight representatives were engaged in training with further recruitment underway. He also referred to the HOPES research collaboration with Canterbury Christ Church University and partners across Kent and Medway, which was funded through the National Institute for Health Research and focused on preventing young people from becoming not in education, employment or training.

5. Dr Ghosh concluded that SPHE would be one of the three existing workstreams operating under the Health and Wellbeing Board.

6. It was RESOLVED that the Kent Health and Wellbeing Board:

(a) NOTE the progress made by SPHE in bringing together partners across health, employment, skills and economic development and commencing work streams to provide support and information to residents and employers;

(b) ENDORSE SPHE's role in providing strategic coordination and system leadership across the health, work and inclusive growth agenda; recognising its contribution to addressing the wider determinants of health and reducing health inequalities

(c) AGREE that the SPHE should continue to provide a forum for strategic alignment across relevant health, employment, skills and economic development initiatives, and support the Health and Wellbeing Board in shaping the strategic direction of work across health and economy

(d) NOTE that SPHE will develop a shared outcome and evidence framework and that future updates will be provided to the Health and Wellbeing Board on SPHE's activity, priorities and collective impact.

95. Early Draft of the Kent Neighbourhood Health Plan
(Item 11)

Dr Mike Gogarty (Interim Strategic Lead for Public Health), Natalie Rennie (NHS), Abigail Kitt (Deputy Director Neighbourhood Health) and Dr Ash Peshen (Deputy Chief Medical Officer) were in attendance for this item.

1. Dr Gogarty introduced the early draft Kent Neighbourhood Health Plan and invited the Board's feedback to inform its ongoing development. He emphasised that the Plan had deliberately been brought to the Board at an early stage to enable Members to influence its development rather than being presented with a completed proposal.

2. He advised that the NHS Neighbourhood Health Framework provided both a requirement and an opportunity to develop a local Neighbourhood Health Plan focused on the needs of the Kent population. The Plan was required to be developed by March and would need to reflect NHS priorities, KCC priorities and local partnership priorities, recognising that the latter would vary between different areas.

3. Dr Gogarty reported that the initial draft had been developed collaboratively by NHS colleagues, the new provider alliance, and Public Health colleagues from KCC and Medway. It had also been informed by an internal KCC officer group considering the opportunities for the Council within neighbourhood health.

4. Engagement had taken place with district and local partnership alliances to understand how neighbourhood health could support local priorities and opportunities. Discussions had also been held with the Kent Housing Group and VCSE alliances and partnerships, while work with Healthwatch was drawing on available resident and service-user insight to inform the Plan.

5. Dr Gogarty reiterated that the Plan remained at a very early stage and required further development and refinement. This was the first time it had been considered through a formal governance process and, as it developed, it would also need to progress through relevant partner governance arrangements, particularly within the NHS and ICB.

6. The Board was invited to comment on the proposed approach and methodology, provide feedback on the early draft to inform its next stage of development, and consider how it wished to remain involved in the development of the Plan.

7. Further to questions and comments from Members the discussion included the following:

(a) A question was raised regarding the governance arrangements for approval of the Neighbourhood Health Plan, specifically whether the Board would have an opportunity to consider and approve the final plan following the separate development of the Kent and Medway elements and their subsequent alignment by the ICB. Dr Gogarty advised that the final documents could be brought back to the Board. He explained that the ICB would ultimately consider a plan bringing together the Kent and Medway elements, reflecting its responsibility across the wider geography, whereas the Board's responsibility related to Kent. He noted that many of the challenges and opportunities were shared across both areas and that close working with Medway was therefore appropriate. It was also noted that a combined approach could provide continuity should local government reorganisation progress.

(b) Mr Chris Neill (Deputy Chief Executive and Chief Strategic Commissioning Officer, NHS Kent and Medway) confirmed that he was content for the final documents to be shared with the Board and emphasised the importance of doing so. He highlighted the collaborative development of the Plan, including the involvement of KCC colleagues, and noted the opportunities to further integrate work across partner organisations. He also referred to significant changes taking place within NHS community-based services through the development of neighbourhood models involving services such as pharmacies and general practices. Early progress in relation to frail older people was highlighted, with nearly 30% of the target cohort reported to have received one or more interventions through neighbourhood-based working.

(c) A question was raised regarding the scale of transformation required to deliver neighbourhood health and the challenges of securing commitment from large organisations already facing significant financial, clinical and operational pressures. Concern was expressed that successful delivery would require the leadership of partner organisations to support the necessary changes and work collectively towards more effective community-based care. Dr Peshen acknowledged the challenge and emphasised that the focus needed to remain on improving care and outcomes for residents. He advised that organisations increasingly recognised that they could not achieve the required changes independently and that neighbourhood health required GPs, community services, social care and acute services to work together. He highlighted the importance of demonstrating that new approaches worked in practice, noting that neighbourhood-based working undertaken over the previous three months had resulted in more than 20,000 interventions and that reactive care had generated 960 additional bed days. He emphasised that, while these measures demonstrated progress, the underlying purpose remained to improve outcomes for patients and residents.

(d) Dr Gogarty added that neighbourhood health needed to reflect local communities and build on existing district partnerships and alliances, whose profile had been strengthened under Dr Ghosh's leadership. He highlighted the opportunity to strengthen links between Primary Care

Networks and local partnerships, building on good engagement already evident in some areas, and to use these arrangements to deliver evidence-based interventions that supported people to remain out of hospital and residential care.

(e) Dr Ghosh commented that responsibility for neighbourhood health extended beyond primary care, GPs and pharmacies to community and voluntary organisations, Public Health, KCC, and district and borough councils. He emphasised that the collective involvement and shared commitment of partners would be important in driving progress and improving neighbourhood health outcomes.

(f) A question was raised regarding the financial implications of the transition to neighbourhood health, including the scale of investment required, existing commitments within the Better Care Fund and whether funding would need to be redirected from existing services. Mr Neill acknowledged the significant financial pressures facing the Kent and Medway NHS system and explained that the approach involved moving away from commissioning individual services towards considering whole populations and care pathways through the four layers of care model. Work had already commenced in areas such as urgent care, with investment in preventative services and rapid community response, including the provision of same-day general practice appointments as an alternative to A&E attendance. Mr Neill advised that an element of services was currently being run in parallel while the new model was developed and scaled up. He highlighted the establishment of the neighbourhood alliance, the development of the Plan and the enhanced service agreement with general practices across Kent as providing the infrastructure for this transition. He confirmed that, over time, the intention was to shift funding from acute and specialist services into community-based provision, with the neighbourhood model providing the mechanism through which that investment would be directed. Mr Neill further advised that early evaluation was indicating an impact from the approach. He referred to the development of increased urgent response capacity within community nursing, general practice and pharmacy services, with partners working differently to intervene earlier, prevent people reaching crisis and reduce the need for A&E attendance. He also noted that Kent and Medway's approach had received positive recognition during a recent visit from Professor Claire Fuller, particularly in relation to the development of urgent response capacity within community settings.

8. It was RESOLVED that the Kent Health and Wellbeing Board note the progress made in developing the Neighbourhood Health Plan, and comment on the attached developing draft at this early stage

96. Kent Health and Wellbeing Board Terms of Reference
(Item 12)

1. Dr Ghosh introduced the revised Terms of Reference for the Health and Wellbeing Board. He advised that the refreshed Board had originally been

intended to launch at this meeting; however, the process had been delayed following the pause in Local Government Reorganisation, as the previous draft had been developed with regard to the proposed future unitary geography.

2. He explained that the substantive Terms of Reference remained unchanged, with only limited amendments to the proposed membership. These included representation from Kent General Practitioners on behalf of the Primary Care Alliance; removal of a duplicate reference to the Primary Care Alliance from the provider representation; Health Alliance representation from East, West and North Kent rather than the proposed future unitary areas; and Chief Executive representation to be determined by the Joint Chiefs.

3. Dr Ghosh advised that, subject to the Board's agreement, the revised Terms of Reference would proceed to the Selection and Member Services Committee in October and Full Council in November for approval, following which the new membership could be invited.

4. It was RESOLVED that the Kent Health and Wellbeing Board:

   (a) Note the draft Terms of Reference

   (b) Consider and comment on the draft Terms of Reference, including whether any amendments should be recommended for consideration prior to submission to the Selection and Member Services Committee.

   (c) Note that any revisions to the Terms of Reference endorsed by the Board will be subject to consideration by the Selection and Member Services Committee prior to formal approval and adoption by Full County Council.

97. Work Programme
(Item 13)

1. It was RESOLVED that the Work Programme be noted

(a) **FIELD**
(b) **FIELD_TITLE**