KENT HEALTH AND WELLBEING BOARD

Wednesday, 30th September, 2026

2.00 pm

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

KENT HEALTH AND WELLBEING BOARD

Wednesday, 30 September 2026 at 2.00 pm
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Georgina Little**
Telephone: **03000 414 034**

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item No	
1	Apologies and Substitutes
2	Declarations of Interest by Members in items on the agenda for this meeting
3	Minutes of the Meeting held on 23 July 2026 (Pages 1 - 12)
4	Director of Public Health Verbal Update
5	Priorities of the Kent Health and Wellbeing Board - Better Care Fund (Pages 13 - 18)
6	Priorities of the Kent Health and Wellbeing Board - Kent Marmot Coastal Region Update (Pages 19 - 22)
7	Priorities of the Kent Health and Wellbeing Board - Whole System Mental Health and Wellbeing : A prevention approach (Pages 23 - 36)
8	Governance of the Kent Health and Wellbeing Board - Kent and Medway Health Inequalities Group (Pages 37 - 44)
9	Governance of the Kent Health and Wellbeing Board - Kent and Medway Prevention Group Review (Pages 45 - 56)
10	Governance of the Kent Health and Wellbeing Board - Strategic Partnership for Health and Economy: Providing System Leadership on Health, Work and Inclusive Growth Report to follow
11	Early Draft of the Kent Neighbourhood Health Plan (Pages 57 - 136)
12	Kent Health and Wellbeing Board Terms of Reference Report to follow

13 Work Programme (Pages 137 - 142)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Benjamin Watts
Deputy Chief Executive
03000 416814

Tuesday, 22 September 2026

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 Thursday, 23 July 2026.

PRESENT: Mrs G Foster, Mr J Henderson, Mr M Mulvihill, Mr E Waller, Cllr M Blakemore, Dr A Ghosh, Mr R Goatham, Cllr H Perkin and Ms H Woodland

ALSO PRESENT: Dr K Langford (Chief Medical Officer, NHS Kent and Medway)

IN ATTENDANCE: Dr M Gogarty (Strategic Lead Public Health Consultant), Mr R Streatfield (KCC Member - item 9)

UNRESTRICTED ITEMS

74. Membership Update

(Item 1)

It was noted that the following Members had joined the Board:

- Mr Henderson (Cabinet Member for Environment, Coastal Regeneration and Public Health)

- Mrs Foster (Cabinet member for Adult Social Care)

- Mr Webb (Cabinet Member for Children's Services) who will be representing the Leader; and

- Helen Woodland (Corporate Director for Adult Social Care and Health)

75. Appointment of Co-opted Member(s)

(Item 2)

It was RESOLVED that Dr Bob Bowes be re-appointed as a co-opted member of the Kent Health and Wellbeing Board.

76. Election of Chair

(Item 3)

1. Mrs Foster proposed and Mr Mulvihill seconded that Mr Henderson be elected as Chairman of the Kent Health and Wellbeing Board. No Other nominations were received.

2. Following the election of Chair, Mr Henderson took his seat.

3. It was RESOLVED that Mr Henderson be elected as Chairman of the Kent Health and Wellbeing Board.

77. Election of Vice-Chair
(Item 4)

1. Mrs Foster proposed and Mr Mulvihill seconded that Dr Bowes be elected as Vice-Chairman of the Kent Health and Wellbeing Board. No other nominations were received.

2. It was RESOLVED that Dr Bowes be elected as Vice-Chairman of the Kent Health and Wellbeing Board.

78. Apologies and Substitutes
(Item 5)

Apologies were received from Dr Bowes, Councillor Moses and Christine McInness

79. Declarations of Interest by Members in items on the agenda for this meeting
(Item 6)

There were no declarations of interest.

80. Minutes of the Meeting held on 4 March 2026
(Item 7)

It was RESOLVED that the minutes of the meetings held on 4 March 2026 were an accurate record and that they be signed by the Chairman.

81. Director of Public Health Verbal Update
(Item 8)

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

   (a) It was advised that, although a heatwave was not currently being experienced, conditions could change and further periods of extreme heat remained possible. He noted that temperatures above 30°C, and particularly those approaching 40°C, posed health risks to all individuals and not only to the very young or older population groups. Members were encouraged to enjoy warm weather responsibly, with key public health messages being to keep cool, stay hydrated and be prepared for periods of extreme heat.

   (b) The Meningitis B (MenB) vaccination programme had commenced following the MenB outbreak in Kent. Dr Ghosh advised that the programme was available to all Year 13 students, irrespective of university plans, individuals under 25 commencing university for the first time in autumn 2026, and those under 25 entering residential further education for the first time. Eligible individuals could book vaccinations through the NHS National Booking Service or participating community pharmacies, with evidence of a university or residential college place required. The first doses were being offered from the week commencing 20th July 2026 until 31 December 2026, with second

doses available until 31 March 2027. He highlighted that two doses, administered at least four weeks apart, were required to achieve full immunity. The current arrangements comprised a one-off vaccination campaign. The Government and the Joint Committee on Vaccination and Immunisation (JCVI) were reviewing the epidemiology of the outbreak and would determine any longer-term vaccination policy, with no further campaign currently announced.

(c) To conclude, Dr Ghosh provided an update on neighbourhood health transformation following a visit to Kent and Medway by Professor Claire Fuller, National Medical Director and national lead for the Neighbourhood Health Model. He noted that Professor Fuller, author of the Fuller Stocktake, had met with system leaders to review progress and future plans.

Dr Ghosh reported that the visit had highlighted the leadership team's strong understanding of both the challenges facing the health and care system and the opportunities presented by neighbourhood health. He observed that the scale of ambition represented a significant transformation across primary, secondary and community care.

The Board was advised that a proactive and anticipatory primary care model was emerging, supported by innovative approaches, strong clinical leadership and a clear commitment to shifting care upstream and closer to communities. Dr Ghosh noted that the system had been challenged to reimagine service delivery and operational arrangements across neighbourhood footprints.

He further highlighted the potential role of Health and Wellbeing Boards in supporting delivery and accountability for the Neighbourhood Health Model through strengthened oversight, alignment across partner organisations and a continued focus on improving outcomes for local communities.

Dr Ghosh also noted that there was a clear implementation timetable in place and highlighted the expectation that, by 1 April 2028, local authority services should be visibly aligned with neighbourhood delivery models, coinciding with local government reorganisation implementation arrangements.

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

(a) In response to a question regarding how the NHS was building future resilience to climate change and extreme weather, and recognising that such conditions may increasingly become the norm rather than exceptional events, Mr Waller, Deputy Chief Executive and Chief Strategic Commissioning Officer, advised that the ICB was actively assessing and quantifying the effects of recent heatwaves. He noted

that, should current weather patterns continue, adaptation to extreme heat would need to become an integral part of NHS planning processes. This work encompassed both physical and logistical considerations, including the resilience of healthcare infrastructure, estate facilities and air-handling systems, as well as wider service pressures arising during periods of extreme heat. Examples included the impact on care home residents, the role of primary care in supporting vulnerable individuals within communities and preventing avoidable hospital admissions, and the potential need to manage summer heat events in a similar way to winter pressures through enhanced escalation planning and service responses.

(b) The Chair welcomed the updates provided. In relation to extreme heat, he noted that advances in long-range weather forecasting could support future planning and preparedness by providing greater confidence in predicting periods of sustained hot weather. Regarding the MenB vaccination programme, he highlighted the positive response of schools, citing Dane Court School's proactive action following concerns about a potential case, and expressed reassurance that no case had been identified. Mr Henderson also reflected on meeting Professor Claire Fuller during her visit to Kent and Medway, noting the value of hearing her observations from across the country and discussing Kent's characteristics, including its tourism offer and local context.

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

82. Kent Health and Wellbeing Board Terms of Reference (ToR) and Priorities
(Item 9)

1. Mr Henderson and Dr Ghosh introduced a report on the report on the future role and operation of the Kent Health and Wellbeing Board, which invited members to consider and endorse proposed revisions to the Board’s Terms of Reference. The proposed changes reflected the Board’s evolving leadership role, particularly in relation to the development of a Local Neighbourhood Health Plan, changes within the NHS, and the increasing importance of partnership working to improve health outcomes and reduce inequalities across Kent.

2. Dr Ghosh advised that the meeting marked the final meeting of the Health and Wellbeing Board in its current form, with a refreshed Board expected to be relaunched at its next meeting in September. He noted that supplementary papers had been provided setting out the findings from workshops and engagement undertaken earlier in the year on the future role and structure of the Board, and that these had informed the revised Terms of Reference where appropriate.

3. The Board was reminded that following the establishment of the Integrated Care Board (ICB) and Integrated Care Partnership (ICP) in July 2022, the ICP had become the principal multi-agency strategic forum for health and

wellbeing across Kent, resulting in the Health and Wellbeing Board meeting only annually. Dr Ghosh explained that, with the ICP due to be abolished, the Health and Wellbeing Board would resume a central role as the primary forum for strategic health and wellbeing discussions across Kent.

4. Dr Ghosh highlighted the principal changes proposed within the revised Terms of Reference. These included confirming the Health and Wellbeing Board as Kent's principal strategic health and wellbeing partnership; strengthening its role in overseeing delivery of the Neighbourhood Health Model and Kent's Neighbourhood Health Plan; clarifying its relationship with the Health Overview and Scrutiny Committee; introducing annual priority-setting and performance reporting arrangements; enabling functions to be delegated to sub-committees; refreshing membership to reflect the Board's enhanced strategic role; and increasing the frequency of meetings to at least quarterly. The Board was advised that, as a statutory committee of the Council, the revised Terms of Reference would be required to proceed to the Selection and Member Services Committee and subsequently to Full Council for formal approval.

5. Prior to opening the discussion, Mr Henderson (Chair) highlighted that, in addition to noting the report, members were being asked to endorse the revised Terms of Reference for the Health and Wellbeing Board. He emphasised the importance of ensuring that the proposed arrangements accurately reflected the Board’s role, responsibilities and functions within the evolving health and care system. Mr Henderson invited members to propose and discuss any amendments in turn before determining whether they should be considered for incorporation into the revised Terms of Reference. The Board was reminded that any revisions endorsed at the meeting would be subject to further consideration by the Selection and Member Services Committee before being referred to Full Council for formal approval and adoption.

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

   (a) An amendment was proposed to increase elected member representation from Kent district, borough and city councils from three to four members, reflecting anticipated local government reorganisation arrangements and providing representation from each future local authority area

   (b) It was proposed that the membership provisions relating to NHS representation be amended to align with current NHS collaborative arrangements across Kent, with representatives nominated through the relevant provider collaboratives, including the Primary Care Alliance and acute provider collaboratives. This would ensure that Board membership reflected existing NHS partnership structures and ways of working.

(c) It was suggested that the effectiveness of the refreshed Health and Wellbeing Board would be strengthened through a more collaborative approach to agenda setting, reflecting feedback from the earlier workshops. Involving Board members collectively in developing future agendas would help ensure discussions were aligned with strategic priorities and enable the Board to reach stronger conclusions. In response, Dr Ghosh advised that agenda-setting arrangements were already established for committees and suggested that similar mechanisms could be adopted for the Health and Wellbeing Board to provide members with opportunities to contribute to the development of future agendas.

(d) An amendment was proposed to the voting provisions within the Terms of Reference to clarify that decisions of the Health and Wellbeing Board could not override the statutory powers, responsibilities or governance arrangements of individual partner organisations. It was noted that, whilst the Board could reach collective decisions, these could not compel Kent County Council, NHS bodies or other statutory organisations to act outside their own decision-making and accountability frameworks.

(e) Mr Streatfield, with the agreement of the Chair, addressed the Board and welcomed the proposed revisions to the Terms of Reference. He proposed that consideration be given to including a specific focus within the Board's mental health priority on combat veterans' mental health and access to health services. He highlighted concerns regarding the barriers some veterans faced in accessing support and noted the opportunities presented by existing local initiatives and services, including Op Courage and the Valour Hub. Mr Streatfield also indicated his willingness to support this work through future involvement or a dedicated sub-committee structure. The Chair and Members expressed support for the proposal.

(f) A query was raised regarding how proposed amendments to the Terms of Reference, including those of a more substantive nature, would be reflected through the governance process and whether there would be an opportunity for further review before formal approval. Members were advised that the Board's role at this meeting was to endorse the proposed amendments for onward consideration rather than to approve the final Terms of Reference. It was noted that the revised Terms of Reference would be considered through the Council's governance process, including by the Selection and Member Services Committee, and that should significant amendments arise during that process, further discussions would take place and progression to Full Council could be deferred to enable appropriate consideration before formal adoption.

7. The Chair thanked members for their comments and noted that the amendments proposed during the meeting would be considered for incorporation into a revised draft of the Terms of Reference. Members were reminded that the Board was being asked to endorse the proposed Terms of Reference, which would subsequently be considered through the Council's governance process, including by the Selection and Member Services Committee and Full Council, before any changes could take effect.

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

(a) Note the evolving national and local context for Health and Wellbeing Boards, including the Board's anticipated leadership role in the development and oversight of the Kent Neighbourhood Health Plan and Better Care Fund arrangements;

(b) Endorse the proposed future role, membership and ways of working for the Kent Health and Wellbeing Board as set out in this report;

(c) Endorse the proposed changes to the Terms of Reference attached at Appendix 1; and

(d) 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

83. Development of the Neighbourhood Health Plan
(Item 10)

Dr Mike Gogarty, Strategic Lead for Public Health, was in attendance for this item.

1. Dr Mike Gogarty introduced the report on the development of the Kent Neighbourhood Health Plan and welcomed the Department of Health and Social Care's recognition of Health and Wellbeing Boards as the key bodies responsible for leading the development and delivery of local approaches to improving health and wellbeing. He advised that this presented both an opportunity and a challenge for the Board.

2. He noted that the current Kent Joint Health and Wellbeing Strategy was aligned with the Kent and Medway Integrated Care Strategy and remained the principal strategic framework for addressing health and wellbeing challenges across Kent. Whilst those challenges had remained largely unchanged, Dr Gogarty highlighted the need to incorporate emerging NHS requirements and develop an approach that balanced national priorities, county-wide challenges and local needs. He emphasised the importance of addressing the wider determinants of health, including socioeconomic, environmental, lifestyle and access-related factors.

3. Dr Gogarty explained that the original neighbourhood health model had been driven largely by the need to reduce avoidable hospital admissions and support people more effectively within community settings. He noted that the national Neighbourhood Health Framework had since broadened in scope to encompass prevention, improved access to primary care, reduced waiting times, population health improvement and action on health inequalities. He highlighted the importance of ensuring that mental health, children, young people and families remained a strong focus within local delivery arrangements.

4. The Board was advised that NHS partners were reorganising services to support more proactive and preventative models of care, identifying those at greatest risk of ill health and intervening earlier to avoid hospital admissions. Dr Gogarty emphasised that the focus on admission avoidance remained central to NHS priorities and aligned closely with the County Council's ambition to support independence and reduce reliance on residential care. He noted that achieving these objectives would require close alignment between health and social care services.

5. Dr Gogarty advised that the Kent Neighbourhood Health Plan, which was required to be in place by April 2027, would set out how the NHS reform priorities of prevention, community-based care and improved access to services would be delivered alongside local priorities relating to health inequalities and wider determinants of health. The Plan would align with the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, include arrangements for the Better Care Fund, and set out the contribution of partners including district councils, housing providers, voluntary and community sector organisations and family hubs.

6. He noted that the proposed multi-neighbourhood geographies had been developed prior to local government reorganisation and may require further review as future arrangements became clearer. He also advised that engagement was underway with Health Alliances, district partners, housing organisations and the voluntary and community sector to ensure local priorities informed the development of the Plan.

7. In concluding, Dr Gogarty stressed the importance of progressing the Plan at pace despite local government reorganisation. He advised that the Plan should be concise, practical and focused on delivery, providing a sustainable framework for improving health and wellbeing outcomes whilst remaining sufficiently flexible to operate effectively through future system changes.

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

   (a) In response concerns regarding the achievability of delivery by April, given the anticipated September establishment of the Health and

Wellbeing Board and the limited implementation period thereafter, Mr Gogarty confirmed that the timetable remained achievable.

(b) With regard to capacity implications for officers in the context of Local Government Reorganisation, Dr Ghosh acknowledged those concerns and provided reassurance that established neighbourhood health governance arrangements, including a delivery group and steering board, were already in place and would continue to progress work between formal Board meetings. He further noted that additional Health and Wellbeing Board meetings could be held to support delivery of the Plan.

(c) Mr Waller, Deputy Chief Executive and Chief Strategic Commissioning Officer, emphasised that success should be measured by the extent to which outcomes for people receiving services had improved, rather than by the quality of the Plan document itself. He noted that Kent and Medway had become the first area in England to utilise provisions within the GP contract to commission a new model of intervention for complex care cohorts, securing participation from all GP practices across the area. This approach was expected to provide more proactive support for approximately 90,000 residents, helping to improve health outcomes, reduce avoidable hospital admissions, and enable more people to remain living independently at home.

(d) Concern was raised that, whilst the document stated that health needs had not changed, there was evidence of increasing demand for mental health interventions linked to factors including the cost of living, loneliness and digital isolation. It was suggested that these issues were not sufficiently reflected in the document, and clarification was sought on how wider determinants and external influences affecting people's health and wellbeing would be captured. In response, Dr Ghosh acknowledged that health needs had changed and advised that any suggestion in the document that they were static was unintended.

(e) Support was expressed for the Plan as a foundation for developing the neighbourhood model. However, it was suggested that greater emphasis should be placed on non-statutory factors affecting people's lives, including debt and housing, and on how agencies providing these services would be involved. It was noted that influencing outcomes such as hospital admissions and entries into care homes began well before individuals came into contact with statutory health or social care services.

(f) Mr Henderson (Chair)noted that Ashford Borough Council, alongside Kent County Council through the No Use Empty programme, was supporting the creation of housing within town centres to enable residents to live closer to local services and community facilities. He advised that this work aligned with the objectives of the Plan and stated that all relevant portfolios would be ready to support its delivery.

9. It was RESOLVED that the Kent Health and Wellbeing Board commented on and agreed the outlined approach to the development of the Kent Neighbourhood Health Plan.

84. Update on the Marmot Review
(Item 11)

1. Dr Ghosh provided an update on the Marmot Coastal Region programme and noted that Kent was the first Marmot Coastal Region. He advised that the initiative had been informed by research into Marmot regions across the country, engagement with stakeholders, and findings from the Chief Medical Officer's report on coastal inequalities. Further work undertaken by Public Health in 2021 had identified similar inequalities along Kent's coastline, leading to the decision to focus the programme on coastal communities.

2. Dr Ghosh explained that the Marmot approach comprised eight principles and that the initial focus had been placed on work and pathways into employment, as a key wider determinant of health. He noted that this aligned closely with subsequent national policy developments, including the Kent and Medway Connect to Work initiatives, and that the programme was intended to expand to encompass the wider Marmot principles over time.

3. It was noted that the programme covered the coastal districts of Swale, Canterbury, Thanet, Dover and Folkestone & Hythe, together with Ashford due to its links with neighbouring coastal areas. The programme's four objectives were to achieve strategic alignment, identify high-impact actions, promote culture change around wider determinants of health and health inequalities, and build momentum for sustained change.

4. Dr Ghosh outlined the governance arrangements, which included a steering group comprising representatives from local authorities, the NHS, education, VCSE organisations, the Department for Work and Pensions and the Institute of Health Equity. An Expert Advisory Board, chaired by Sir Michael Marmot, provided strategic oversight, supported by a working group responsible for day-to-day delivery. The steering group was accountable for reporting progress to the Health and Wellbeing Board.

5. Members were reminded that the Marmot Coastal Region had been formally launched in Dover in March 2026 by Sir Michael Marmot. Dr Ghosh advised that, as part of the programme, Kent County Council had committed by April 2028 to support at least 200 young people into education, employment or training, assist 150 people on probation into education and employment, and support a further 100 people facing

additional disadvantages, including care leavers, carers and people with mental ill health, into work.

6. Dr Ghosh advised that delivery was being progressed through a three-tier approach comprising long-term culture change, system alignment and the Marmot Accelerator Programme. He noted that the Institute of Health Equity had produced the recently published Kent Report, including a data-led analysis and deep dive into work, income and health. Work was also underway to align existing programmes addressing employment and pathways into work to maximise impact and avoid duplication.

7. The Marmot Accelerator Programme focused on local innovation projects designed to support people with high levels of need into employment and improve work-related skills. Dr Ghosh advised that commissioning would be delivered in two phases, with an initial focus on preventing young people from becoming not in education, employment or training, together with a grant scheme for local organisations. The second phase would focus on projects supporting delivery of the programme pledges relating to probation services and people facing additional disadvantages.

8. Dr Ghosh further reported that the first Marmot Accelerator project had commenced on the Isle of Sheppey in June through the Breaking Barriers initiative. The Sheppey Career Readiness Initiative aimed to support 36 young people who were not in education, employment or training into those opportunities over a 12-month period.

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

   (a) Support was expressed for the practical projects being delivered through the Marmot programme, particularly the Sheppey initiative, and it was noted that the partnership workshops had provided valuable opportunities for agencies to work together and consider both existing activity and gaps in provision. It was further noted that one of the Marmot principles related to tackling racism, and concern was raised that there was a perception among some communities that racism was increasing. It was expressed that a more proactive approach be taken to tackling racism within communities and for this to be reflected in the further development of the Marmot programme.

10. It was RESOLVED that the Kent Health and Wellbeing Board noted the key components of the Kent Marmot Coastal Region and discussed how to support the initiative.

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From: Georgia Foster, Cabinet Member for Adult Social Care

Helen Woodland, Corporate Director Adult Social Care and Health

To: **Kent Health and Wellbeing Board** - 30 September 2026

Subject: Better Care Fund

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Summary:

The Better Care Fund (BCF) is a national programme that brings together NHS and local authority funding to support the integration of health and social care. This report provides an update on the new national requirements, the current position in Kent and the proposed governance arrangements for strengthening oversight of BCF expenditure, performance, risk and delivery. It also outlines the work that will be undertaken during 2026/27 to review existing schemes and develop the BCF plan for 2027/28.

Introduction

The Better Care Fund is a national programme in England that brings together NHS and local authority funding through pooled budgets to support the integration of health and social care.

The BCF comprises contributions from local government and integrated care boards, determined through national funding arrangements. Funding is allocated across a range of locally agreed schemes, which must support the BCF national conditions and contribute demonstrably to improved outcomes, integration, productivity and value for money.

BCF plans and expenditure must be developed and agreed jointly by the relevant local authority and integrated care board and approved by the Health and Wellbeing Board.

The BCF has historically supported prevention, hospital discharge and wider system stability. For 2026/27, there is an increased emphasis on integrated neighbourhood health and care, preventing avoidable hospital and long-term care home admissions, reducing discharge delays, and helping people regain and maintain their independence.

Current arrangements in Kent

BCF funding in Kent is held in a pooled budget hosted by Kent County Council (KCC) under a Section 75 Partnership Agreement with NHS Kent and Medway Integrated Care Board (ICB). Each BCF-funded scheme has a designated lead organisation, either KCC or the ICB, which is responsible for managing its delivery, performance and expenditure against the agreed allocation.

The Kent BCF pooled budget for 2026/27 totals £238,857,022. This comprises funding of £153,117,150 from NHS Kent and Medway ICB of which £51,492,794 is dedicated to Adult Social Care.

The funding supports a range of health, social care, housing, voluntary and community sector services. These include prevention, intermediate care and reablement, hospital discharge, support for carers, assistive technology and equipment, housing adaptations, and services that enable people to remain independent at home.

All funding within the current BCF plan is committed to existing services. There is no additional or uncommitted funding available; consequently, any changes to the plan would require existing allocations to be reprioritised or redistributed.

The 2026/27 BCF assurance return was jointly agreed by KCC and NHS Kent and Medway ICB and submitted to the National BCF Team on 19th May 2026. The return was subsequently approved on 29th June 2026.

Historically, BCF planning and approval have progressed through separate KCC and ICB governance processes. Reporting deadlines have not always aligned with scheduled meetings of the Health and Wellbeing Board. Where necessary, time-critical plans have therefore been approved by the Chair under the relevant delegated arrangements.

The repurposed Health and Wellbeing Board provides an opportunity to strengthen collective oversight, improve alignment between partners and establish a more consistent approach to BCF planning, performance and assurance.

Changes to the Better Care Fund for 2026/27

Following publication of the 10 Year Health Plan for England, the Government is reforming the BCF to create a more consistent and effective approach to funding services that need to be planned and delivered jointly.

The 2026/27 framework represents the first stage of this reform. It requires ICBs and local authorities to plan, agree and assure BCF expenditure jointly, working with local partners and continuing to secure approval through Health and Wellbeing Boards.

BCF plans are expected to align more closely with the development of neighbourhood health and care services and with wider local commissioning strategies. This includes strengthening the contribution of intermediate care, reablement and community-based services to preventing avoidable admissions, supporting timely hospital discharge and enabling people to remain independent.

The framework also places greater emphasis on demonstrating the impact of BCF-funded services, improving productivity and securing value for money. Local systems must be able to explain how individual schemes contribute to the agreed objectives and outcomes of the fund.

For 2026/27, local authorities and ICBs are required to agree specific local goals for reducing non-elective hospital admissions among people aged 65 and over and reducing hospital discharge delays. They must also monitor and drive improvement in reablement outcomes and the prevention of avoidable long-term residential and nursing care admissions.

National funding conditions

The 2026/27 BCF framework establishes three national funding conditions.

Integrated and preventative care

KCC and NHS Kent and Medway ICB must maintain a jointly agreed plan that demonstrates how BCF funding supports more integrated and preventative care. The plan must align with relevant neighbourhood health and social care services and explain the contribution made by BCF-funded schemes to intermediate care, prevention, hospital discharge and independence.

Expenditure and grant conditions

KCC and NHS Kent and Medway ICB must comply with the applicable national grant and funding conditions and deliver expenditure in accordance with the approved assurance return. The ICB must maintain the required NHS minimum contribution to adult social care, and the designated NHS and local government contributions must be placed in one or more pooled funds under Section 75 of the NHS Act 2006.

Governance, reporting and engagement

KCC and NHS Kent and Medway ICB must maintain effective joint governance for the BCF. This must include oversight of expenditure, delivery, performance, impact, productivity and value for money, together with action to address areas that are not delivering as planned.

The Council, ICB and Health and Wellbeing Board must also engage with national and regional BCF assurance, reporting, oversight and support arrangements.

Implications for Kent

The new framework requires Kent to demonstrate more clearly how BCF-funded activity contributes to national conditions, local priorities and agreed outcomes. It will no longer be sufficient to rely solely on the historic purpose of a scheme; there must be evidence of its current impact, strategic alignment and value for money.

During 2026/27, KCC and NHS Kent and Medway ICB will undertake a joint review of existing BCF-funded schemes. The review will identify schemes that are delivering demonstrable benefits and consider where further information, improvement or change may be required.

The review will consider each scheme’s contribution to BCF outcomes, measurable impact, financial and operational performance, productivity, value for money and alignment with neighbourhood health and care. It will also consider relevant contractual commitments and the potential effect of any change on service continuity, residents and system partners.

As all current funding is committed, any proposed changes will require the reprioritisation or redistribution of existing resources. Proposals will therefore be considered jointly through the new governance arrangements before being presented through the appropriate KCC, ICB and Health and Wellbeing Board approval routes.

Performance and outcomes

Kent's BCF performance framework will cover the national outcome measures relating to non-elective admissions, hospital discharge, long-term care admissions and reablement.

- Reduce non-elective hospital admissions for people aged 65+.
- Improve discharge performance and reduce delays from hospital.
- Reduce long-term admissions of people aged 65+ into residential and nursing care.
- Improve reablement outcomes, specifically the proportion of people aged 65+ discharged into reablement who remain living independently in the community 12 weeks later

Performance information will be considered alongside delivery and financial information so that the impact and value for money of individual schemes can be assessed. Where performance is not on track, the relevant lead organisation will be required to identify the reasons and present appropriate recovery or improvement action.

Proposed joint governance

Subject to the approval of the revised Section 75 Partnership Agreement (Key Decision **26/00059**) through KCC and ICB governance processes, it is proposed that a new Section 75 Partnership Board will provide joint strategic oversight of the Kent BCF. The Partnership Board will oversee the use of the pooled fund, monitor delivery against the approved plan and consider performance, financial position, risk, impact, productivity and value for money.

A supporting BCF Programme Board will undertake more detailed oversight of individual schemes, coordinate performance and financial reporting, monitor delivery and ensure that issues requiring strategic consideration are escalated to the Partnership Board.

The Health and Wellbeing Board will retain strategic oversight of the BCF. It will receive quarterly reports on performance, finance, delivery and risk and will be asked to approve the annual report and future BCF plans before submission through the relevant national assurance process.

The Section 75 Partnership Board will operate as a joint KCC–ICB body. It will report through the relevant governance arrangements of both organisations, with material issues and proposed changes to expenditure escalated to the appropriate decision-making body.

National and regional oversight

Regional BCF leads will oversee and support local areas through reporting arrangements determined at regional level. Further detail about the frequency and format of regional reporting will be incorporated into Kent's governance and reporting arrangements once confirmed.

The National BCF Team and regional BCF leads may seek assurance or initiate escalation where national conditions have not been met or where there is a material risk to performance or delivery.

The national assurance return for 2026/27 was required in May 2026. Kent will also participate in subsequent regional monitoring and complete any further national reporting required during or at the end of the financial year.

Risks

Failure to comply with the national funding conditions could result in additional regional or national scrutiny, conditions being placed on the use of funding, or escalation through the national BCF arrangements. This risk will be mitigated through the revised Section 75 Partnership Agreement, strengthened joint governance and regular monitoring of compliance.

Performance against the national outcome measures may be affected by wider pressures across the health and care system, including levels of hospital demand, workforce capacity, provider sustainability and the availability of suitable community-based provision. Joint performance monitoring will enable emerging issues to be identified and appropriate improvement action to be agreed.

There is also a risk that some historic schemes may not be able to demonstrate clearly their current contribution to BCF objectives or value for money. The joint scheme review will provide a consistent evidence base for future commissioning and funding decisions.

As all BCF funding is committed, reprioritisation could affect established services, contractual arrangements and system capacity. Any proposed change will therefore require an assessment of financial, legal, operational and equality implications, together with the potential impact on residents and partner organisations.

Financial implications

The Kent BCF pooled budget for 2026/27 totals £238,857,022, all of which is committed to existing schemes. No additional or uncommitted funding is currently available.

The proposed governance arrangements do not in themselves create additional BCF funding. Any future changes to scheme allocations will require existing resources to be reprioritised and will be subject to the relevant financial, legal and governance approvals.

The new arrangements will strengthen oversight of expenditure, financial performance, productivity and value for money. They will also provide a joint process for considering financial pressures, forecast variations and proposals to redistribute resources.

Legal implications

The BCF pooled fund is governed through a Partnership Agreement made under Section 75 of the NHS Act 2006. The agreement is being revised to reflect the proposed joint governance arrangements and the requirements of the 2026/27 national framework.

Future reporting to the Health and Wellbeing Board

The Section 75 Partnership Board will provide quarterly reports to the Health and Wellbeing Board. These will cover performance against agreed outcomes, expenditure and forecast position, delivery, risk, value for money and any corrective action required.

BCF leads will also update the Board on material national and regional developments and their implications for Kent.

An annual BCF report will be presented to the Health and Wellbeing Board for approval before any required submission to the National BCF Team. The 2027/28 BCF plan will be

developed jointly through the new governance arrangements and presented to the Board for approval.

Recommendation

The Health and Wellbeing Board is asked to:

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

2. Note the submission of Kent's 2026/27 BCF assurance return

3. Note the proposed joint governance arrangements to be established through the revised Section 75 Agreement

4. 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.

5. 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

Report Author	
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From: Jamie Henderson, Cabinet Member for Coastal Regeneration and Public Health

Dr Anjan Ghosh, Director of Public Health

To: **Kent Health and Wellbeing Board** - 30 September 2026

Subject: Kent Marmot Coastal Region - update

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Summary

This briefing provides a short update on progress of the **Kent Marmot Coastal Region** and highlights key issues for discussion by the Health and Wellbeing Board.

Since its launch in March 2026, the Kent Marmot Coastal Region has established supporting programme governance and partnership arrangements, has benefited from the publication of reports and data sets, continued the development of a coastal indicator set, commenced delivery of the Marmot Accelerator Programme, and enhanced the alignment of existing work and skills programmes around a shared focus on reducing health inequalities in coastal communities.

The initiative seeks to address health inequalities and the well-established "coastal excess" of poor health outcomes through action on the social determinants of health, initially focusing on employment, skills, income and pathways into work.

The paper highlights opportunities for the principles and objectives of the Marmot Coastal Region to inform the development of the emerging Kent and Medway Neighbourhood Health Plans and wider system transformation programmes.

The Board's discussion will be used to inform the continuing development of the Kent Marmot Coastal Region and engagement with the development of Kent and

Medway Neighbourhood Health Plans. Key themes arising will be captured in the minutes and shared with the Marmot Coastal Region Advisory Board and Steering Group and relevant system leads. A regular update will be provided to the Health and Wellbeing Board, including how Board feedback has been reflected in subsequent programme development.

Recommendation(s)

The Health and Wellbeing Board is asked to:

NOTE the progress made since the launch of the Kent Marmot Coastal Region.

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1. Background

1.1 The Kent Marmot Coastal Region was launched in March 2026 as a long-term initiative to reduce health inequalities across coastal communities in Kent. It focuses initially on three Marmot principles related to work and pathways into work.

1.2 The initiative covers the coastal districts of Swale, Canterbury, Thanet, Dover and Folkestone & Hythe, together with Ashford, recognising the strong economic and population links between these areas.

1.3 The programme brings together local government, the NHS, education, academia, the voluntary, community and social enterprise sector, and private sector businesses around a shared commitment to improving the social determinants of health.

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2. Current position

2.1 Governance and Strategic Development

The UCL Institute of Health Equity (IHE) continues to support the development of the Marmot Coastal Region until the end of 2026, including having developed a range of resources IHE Resources for Kent, making recommendations for long-term system change, developing a coastal indicator framework and an evaluation approach to track progress and impact over time.

A multi-agency Steering Group is overseeing delivery of the programme, supported by an Advisory Board chaired by Sir Michael Marmot.

2.2 System Alignment

Alignment of the Marmot Coastal Region with programmes is ongoing including with the Get Kent and Medway Working Plan, the Kent and Medway Work and Health Strategy, Connect to Work, Skills Bootcamps, and wider economic development initiatives to improve coordination and maximise collective impact on the coast.

2.3 Marmot Accelerator Programme

Delivery has commenced on the Marmot Accelerator Programme, which tests practical approaches to improving employment, skills and opportunities amongst communities experiencing the greatest disadvantage and aims at developing an evidence base of what works.

At the Launch of the Marmot Coastal Region, the Leader of Kent County Council made three pledges, which are going to be delivered as part of the Accelerator Programme over the next 18 months:

- Support at least 200 young people who would otherwise be Not in Education, Employment or Training (NEET) into education and employment.
- Get 150 people on probation living in the Kent coastal area into education and employment.
- Support 100 people facing additional disadvantages into work, including groups such as care leavers, unpaid carers, people with mental ill health.

The first Accelerator project, the Sheppey Career Readiness Initiative, is now underway and aims to support young people at risk of becoming ‘not in education, employment or training’ (NEET).

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3. Issues for Discussion

3.1 Embedding Marmot Principles in Neighbourhood Health Plans

The Marmot approach aligns closely with the prevention ambitions of neighbourhood health models by focusing on the root causes of poor health rather than solely on treatment and care.

Consideration should be given to how neighbourhood plans can explicitly address the wider determinants of health, including employment, skills, housing, transport, environment, community resilience and access to opportunities.

Neighbourhood plans should incorporate a health equity lens, ensuring that actions aim at reducing differences in outcomes experienced by communities with greatest disadvantage and poorest outcomes and other communities in Kent.

There is an opportunity for neighbourhoods within coastal communities to act as demonstration sites for Marmot-informed approaches, generating learning that can be shared across Kent and Medway.

3.2 Alignment with other HWBB activities

Alignment between the Marmot Coastal Region with the three groups reporting into the Board (Prevention Group, Inequalities Group and Strategic Partnership of Health and Economy) is in place and can be strengthened further.

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4. Next Steps

Further delivery of the Marmot Accelerator Programme and the KCC pledges.

Development of a coastal indicator set and evaluation framework to measure progress over time.

Future progress updates to the Health and Wellbeing Board.

Recommendation(s)

The Health and Wellbeing Board is asked to:

NOTE progress made since the launch of the Kent Marmot Coastal Region.

Contact Details

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From: Jamie Henderson, Cabinet Member for Coastal Regeneration and Public Health

Dr Anjan Ghosh, Director of Public Health

To: **Kent Health and Wellbeing Board** - 30 September 2026

Subject: Whole System Mental Health and Wellbeing : A prevention approach

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Summary

This paper provides the Health and Wellbeing Board with an overview of the current mental health and wellbeing context in Kent, the developing system response, and the key areas where collective Board leadership can accelerate progress.

It seeks the Board's endorsement of mental health as a shared, place-based prevention and health-inequalities priority; recognition of the importance of collective action across partner organisations and notes that further work will be undertaken to develop proposals for a whole-system menta health delivery framework for future consideration by the Board.

1. **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.
2. **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.
3. **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.

4. **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.
5. **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.

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1. Introduction

Kent is experiencing increasing and more complex mental health needs. This is seen in the demand experienced by health, care, education, housing, employment, voluntary-sector and community services, and in the growing overlap between poor mental health and wider social disadvantage.

The challenge cannot be met through specialist mental health services alone. While access to effective clinical support, crisis care and recovery services remains essential, a sustainable response requires prevention, earlier help, stronger community support and coordinated action on the social, economic and environmental conditions that shape mental wellbeing.

Kent has a substantial foundation on which to build. This includes:

- The developing mental health needs assessment, which will support a clearer understanding of prevalence, inequalities, priority populations, place-based variation, existing assets and gaps in provision.
- The development of neighbourhood health models alongside **Health Alliances**, working with primary care, communities and wider partners to support earlier identification of need, prevention, social prescribing and joined-up care.
- The start of a 6 Ways to Well Being public health campaign
- ***Live Well Kent***, which provides community-based wellbeing support for adults, including help with everyday living, keeping active and healthy, meeting people and connecting with local support.
- ***The Kent and Medway Suicide and Self-Harm Prevention Strategy*** 2026–2030, approved in early 2026, which sets a vision for the Kent and Medway suicide rate to fall below the national average 2030.
- ***The Localised Suicide Prevention and Well Being Plans: Starting with Dover and Thanet.***
- Ongoing work with children and young people's mental health partners, recognising the importance of prevention, early help and smoother transitions across the life course.
- **Trauma Informed Care** and Healing Centred Approaches (Kent SPACE Matters) enables front line workforce to be resilient and tackle stigma.
- Targeted work for ***people facing multiple disadvantage***, including people experiencing homelessness or rough sleeping, people with alcohol-related

brain damage, and people with multiple and co-occurring physical, mental health, substance use and social-care needs.
- A coherent **Drug and Alcohol strategy** linked to mental health and criminal justice partners.
- The ***Marmot Coastal Region*** and wider work on health and economy, which provide an opportunity to tackle the underlying drivers of mental ill health through action on employment, skills, housing, transport, regeneration, natural assets, culture and community connection.

The Board is well placed to provide visible system leadership. Its terms of reference include responsibility for commissioning and endorsing the JSNA and Joint Health and Wellbeing Strategy. The central proposition is that mental health should be treated as a shared public-health and system priority: locally informed, prevention-led, rooted in communities and neighbourhoods, and supported by coordinated specialist provision for people who need it.

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2. Background

2.1 Rising and complex need

Mental health and wellbeing are shaped by far more than access to treatment. They are influenced by people's financial security, employment, education, housing, relationships, physical health, safety, community connection, access to green space and opportunities to participate in society.

For many residents, mental distress is compounded by wider pressures. These can include poverty, debt, insecure work, poor-quality housing, loneliness, caring responsibilities, discrimination, domestic abuse, trauma, drug and alcohol use, homelessness and long-term physical health conditions. These factors can both contribute to poor mental health and make it more difficult for people to access, sustain or benefit from support.

The impact is not evenly distributed. There are significant differences between communities, with particular challenges in areas affected by deprivation, exclusion, poorer health outcomes, limited access to services or infrastructure, and reduced opportunities for education, employment and social participation.

2. 2 The public mental health response must therefore address:

- Prevention of mental ill health and promotion of mental wellbeing.
- Early identification and support before problems escalate.
- Timely, accessible and effective mental health treatment and crisis care.
- Coordinated support for people with multiple and overlapping needs.
- Partnership Action to reduce social and economic inequalities and poor social cohesion that contribute to poor mental health.
- Action across the life course, including childhood, adolescence, working age, later life and key transition points.

2.3 A whole-system opportunity

Kent's refreshed Health and Wellbeing Board will provide an opportunity to bring these strands together. The Board's role is not to duplicate the responsibility of individual commissioners or providers. It is to provide strategic leadership across organisations and sectors, identify shared priorities, support alignment of plans and resources, and maintain focus on outcomes for residents.

Mental health is closely connected to each of the Board's major areas of work:

- **Neighbourhood health and Health Alliances:** bringing earlier support, prevention, local assets and coordinated care closer to communities and primary care.
- **Prevention and health inequalities:** reducing avoidable mental ill health and narrowing unequal outcomes between communities and groups.
- **Marmot Coastal:** addressing the social determinants of health and wellbeing in coastal communities experiencing persistent and interconnected inequalities.
- **Economy (including creative arts & leisure):** supporting good work, skills, inclusion, regeneration, culture, connectivity and thriving communities as foundations for wellbeing.
- **Children and young people:** preventing escalation of need and improving outcomes across education, family, community and health systems.
- **Housing and homelessness:** reducing the harms associated with insecure accommodation, rough sleeping, social exclusion and repeated crisis.
- **Suicide and self-harm prevention:** strengthening collective action to reduce risk, offer hope and provide timely support.

Kent's Marmot Coastal Region is particularly relevant. Kent has established the UK's first Marmot Coastal Region, working with the Institute of Health Equity and partners to address the deep-rooted causes of health inequality in coastal communities. Improving mental wellbeing should be a core outcome of this work, alongside improvements in income, employment, educational opportunity, housing, health social connection and healthy environments.

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3. Current Position

3.1 Build on the Mental health needs assessment (see Appendix A)

Public Health is progressing mental health needs assessment work to build a more detailed and shared picture of:

- The prevalence and distribution of mental health need across Kent.
- Variation by geography, deprivation, age, ethnicity and other relevant characteristics.
- The relationship between mental health, long-term physical conditions, substance use, housing insecurity, unemployment, domestic abuse, trauma and homelessness.

- The experiences and needs of people who face barriers to accessing support.
- Existing assets and sources of resilience within communities.
- Current provision, pathways, service gaps and opportunities for better coordination.

The needs assessment will support the Board, commissioners and delivery partners to focus on the populations and localities experiencing the greatest inequalities, rather than applying a uniform response to very different levels and types of need.

Adult Social Care and Health (KCC) is undertaking a comprehensive mental health diagnostic assessment to understand current and future demand, review service capacity, spending and pathways, and identify barriers such as delayed discharges, readmissions and waiting lists. The work combines data analysis, benchmarking, research, stakeholder interviews and lived-experience stories to establish the current position, define an ideal pathway and produce a prioritised improvement plan with clear milestones and accountability.

The recent decision of the Integrated Care Partnership and Integrated Care Board was to take on further assessment and analysis to move to a truly preventative and coherent mental health system for Kent. This work is being planned for April 2027 and will build on current improvements to specialist, emergency and neighbourhood care.

3.2 Neighbourhood health and primary care

Neighbourhood health provides a practical route for making prevention and early help a routine part of local health and care delivery. It offers an opportunity to build stronger relationships between primary care, community health services, mental health services, social care, public health, housing, voluntary and community organisations, local communities and people with lived experience.

A mental-health-informed neighbourhood model can include:

- **Earlier identification of distress**, self-harm risk, loneliness, trauma and emerging mental health needs.
- **Support for people whose physical and mental health** needs interact.
- **Effective social prescribing** and connection to practical, community-based support.
- **Clear pathways** between general practice, community support, Live Well Kent, mental health services, adult social care, children’s services, housing and voluntary-sector provision.
- **Proactive support** for people at risk of repeat crisis, disengagement from care or deterioration in wellbeing.
- **Appropriate referral,** escalation and safeguarding arrangements for people with higher levels of risk or need.

This does not replace specialist care. Rather, it helps ensure that specialist mental health support is better connected to the wider network of prevention, social support and practical assistance that people need to recover and remain well.

3.3 Live Well Kent, community wellbeing & peer support networks

Live Well Kent forms an important part of Kent's community wellbeing offer. It is a community mental health support service that helps people with everyday living, staying active and healthy, meeting people and connecting with support. It is a free service for adults aged over 17 and can support people to make changes, access support and improve both mental and physical wellbeing.

The opportunity now is to ensure that Live Well Kent and comparable community-based provision are fully connected to neighbourhood health arrangements, primary care, social prescribing, housing, employment and skills support, specialist mental health services and the voluntary and community sector. This will help create a more coherent prevention offer for residents, with clear routes into help before needs reach crisis point. This model must also support the current peer networks and the contribution of the wider voluntary sector in order to sustain ease of access to support.

3.4 Suicide and self-harm prevention

The Kent and Medway Suicide and Self-Harm Prevention Strategy 2026–2030 provides a significant foundation for shared partnership action. It continues work undertaken through the previous 2021–2025 strategy and sets a vision that the suicide rate in Kent and Medway will fall below the national average by 2030.

The strategy has a clear prevention focus. Its priorities include making suicide everybody's business (strategic); tackling common risk factors at population level - by increasing surveillance alongside Police in order to understand and prevent deaths; providing tailored support for groups at higher risk; ensuring effective cross-sector crisis support; improving data and evidence; reducing access to means where appropriate; and promoting online safety and responsible media practice. There are co-ordinated networks of support for all organisations (Better Mental Health Network), a community fund to enable support to organisations and engagement. Training is critical and is commissioned via this programme.

Partners Include:

- Mental health and primary care services.
- Children and young people's services, schools, colleges and universities.
- Adult social care, safeguarding and domestic-abuse services.
- Housing, homelessness, rough-sleeping and supported-accommodation services.
- Substance use services and support for people with co-occurring conditions.
- Employers, jobcentres, community organisations and faith groups.
- Police, probation, prisons and other criminal-justice partners.
- Transport, environmental and place-based partners where safer-environment approaches may be relevant.
- Communications, media and digital partners.

Kent is also progressing work to procure suicide-prevention services for commencement from April 2027. This provides an opportunity to ensure that future

commissioned provision is closely aligned with the prevention strategy, local intelligence, the needs assessment and neighbourhood models.

3.5 Children, young people and families

Good mental health in childhood and adolescence is fundamental to educational achievement, healthy relationships, participation, employment prospects and long-term health. Kent's future public mental health approach should therefore be firmly life-course based. It should complement the children and young people's mental health system by strengthening:

- Promotion of emotional wellbeing and resilience in schools, colleges, family settings and communities.
- Early help for children, young people and families experiencing adversity or emerging need. Link with Family Hubs and Maternal Mental Health.
- Prevention and early intervention for self-harm, anxiety, low mood, trauma and other forms of emotional distress.
- Support for parents and carers, including where parental mental ill health, substance use, domestic abuse, poverty or insecure housing affect family wellbeing.
- Smoother transition from children's to adult services.
- Stronger support for young people at particular risk of exclusion, including care-experienced young people, young carers, young people not in education, employment or training, and those affected by safeguarding concerns.

3.6 Multiple disadvantage and inclusion health and Stigma Reduction

Some residents experience severe and persistent disadvantage across several areas of life. They may have mental ill health alongside physical health problems, drug or alcohol use, cognitive impairment, trauma, homelessness, insecure immigration status, contact with the criminal justice system, domestic abuse, exploitation or repeated safeguarding concerns. These residents are often least well served by fragmented systems. They may repeatedly present to emergency departments, crisis services, homelessness services, police or temporary accommodation without receiving the coordinated, sustained and trauma-informed support required to improve outcomes. Key partners here are district councils, social care, acute hospitals, substance misuse services, ICB, criminal justice and Housing Providers.

Current and developing work includes focused attention to:

- People experiencing homelessness and rough sleeping.
- People with alcohol-related brain damage.
- People with co-occurring mental health and substance use needs.
- People with multiple physical and mental health needs.
- People who experience repeated crisis, disengagement from services or high levels of social exclusion.
- People with physical health needs and mental health needs.
- Workforce and Carers.

The Board can add value by supporting a shared approach across public health, adult social care, housing, primary care, mental health services, substance use services, children's services, safeguarding partners, the voluntary sector, police and probation.

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4. Key issues for discussion: What more can we do?

4.1 Mental health must be a shared priority

The Board is invited to consider whether the current system response is sufficiently connected across prevention, community support, primary care, specialist provision, housing, education, employment and wider place-based activity. Mental health cannot be delegated entirely to one organisation or programme. It must be reflected in how the system designs neighbourhood services, commissions support, develops communities, plans housing, supports residents into good work, uses public spaces and responds to crisis. A paper with a clear governance for mental health and prevention will be brought back to the Health and Well Being Board alongside results of the whole system review.

4.2 Prevention should be visible and measurable

A whole-system approach needs an explicit prevention focus (the left shift). This means investing not only in treatment and crisis response, but also in the factors that help people remain mentally well and recover following distress.

The Board may wish to consider how its partners can collectively strengthen:

- ***Social connection***, belonging and participation and community cohesion.
- Access to ***good-quality work, skills***, volunteering and meaningful activity.
- Safe, secure and suitable ***housing***.
- Community infrastructure, including ***culture, creativity, sport, green space and nature.***
- Support for people facing ***financial hardship***, debt, caring responsibilities or social isolation.
- **Trauma-informed practice** across public services and community settings.
- Earlier access to practical and emotional support.
- **Reducing Stigma** – both in population and in front line workers.
- Understanding and preventing **Self Harm**.

Key Indicators on each of these actions may enable a 'score card' to show up system challenges as well as good practice.

4.3 Equity: The system should focus on priority groups and places

The needs assessment should be used to identify priority communities, populations and pathways where action can have the greatest impact.

This should include attention to coastal and deprived communities, people with multiple disadvantage, children and young people facing adversity, people experiencing homelessness, people with co-occurring conditions, unpaid carers, people with long-term physical conditions, and others identified through the evidence and engagement process. A place-based approach should also recognise local assets and sources of resilience, rather than focusing only on problems or service deficits.

Recommended Equity Audit – as part of score card.

4.4 Suicide and self-harm require sustained leadership

The Board has an important role in ensuring that the new Suicide and Self-Harm Prevention Strategy becomes an active system commitment, rather than a strategy held by a single partnership programme.

This requires leaders across sectors to consider what their organisations can do to:

- Reduce known drivers of distress and suicide risk.
- Improve timely access to support.
- Ensure staff have the confidence and tools to respond appropriately.
- Identify and support people who may be at increased risk.
- Strengthen postvention support for people, families, workplaces and communities affected by suicide.
- Use data, intelligence and learning to identify emerging risks and improve action.

Recommended : Clarity of Governance for the Suicide Prevention Programme as key public health infrastructure and ensure sustainability and coherent approach to self-harm.

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5. Proposed next steps

Subject to the Board’s agreement, the following next steps are proposed:

Following the Boards discussion and endorsement of the direction of travel, further work will be undertaken with partners to explore and develop a whole-system approach to mental health and wellbeing. This work will seek to:

- **Develop a proportionate delivery framework** through the Prevention and Health Inequalities workstream, aligned to neighbourhood-health development and relevant health-and-economy arrangements.
- **Use the mental health needs assessment** and ICB mental health service review: to identify priority populations, places, inequalities, community assets, service gaps and opportunities for targeted action for prevention (including strengthen Live Well approach and suicide and self-harm prevention).

- **Identify opportunities for local action via existing Voluntary and Community activity** via Health Alliances: across public health, the ICB, NHS providers, primary care, children's services, adult social care, housing, district councils, the voluntary and community sector, employers and other relevant partners.
- **Develop proposals fora small number of jointly owned priorities**, avoiding duplication of existing strategies while identifying areas where collective action is needed.
- **Develop proposals for a focused performance and outcomes framework/ scorecard**, drawing on available data on wellbeing, self-harm, suicide, access, crisis, inequality and wider determinants to track progress.
- **Bring a further report to the Health and Wellbeing Board setting out the progress** setting out proposed priorities, governance, lead partners, delivery milestones and the approach to oversight.

5.1 Proposed Initial outcome framework (for discussion only)

The following domains could form the basis of a future Board dashboard. Measures would be refined following completion of the needs assessment and engagement with partners. Below is illustrative and not definitive. A working group can improve this with the Board's direction.

Domain	Illustrative measures
Population wellbeing	Measures of mental wellbeing and social connection; variation by deprivation, age, geography and other relevant characteristics
Prevention and early help	Uptake of community wellbeing and social-prescribing support; access to early-help pathways; reach into priority communities
Suicide and self-harm	Suicide mortality, interpreted cautiously due to small numbers and registration delays; self-harm presentations and admissions; local intelligence on emerging risks
Access and experience	Timeliness and equity of access to relevant support; experience of people using services, including people with multiple disadvantage
Crisis and escalation	Crisis presentations, repeat attendance, avoidable escalation and pathways into sustained support
Children and young people	Emotional wellbeing, school attendance, exclusions, early-help access and transition-related indicators
Inclusion and multiple disadvantage	Housing stability, homelessness prevention, engagement with support and coordinated-care outcomes for people with overlapping needs
Wider determinants	Indicators relating to employment, income, housing, transport access, community connection and healthy environments in priority communities

6. Recommendation(s)

The Health and Wellbeing Board is asked to:

1. **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.
2. **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.
3. **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.
4. **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.
5. **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.

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7. Appendices

- Appendix A: Mental health and wellbeing in Kent — headline data and inequalities

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Appendix A: Mental health and wellbeing in Kent — headline data and inequalities

Overall picture

Mental health need in Kent is substantial, increasingly visible in primary care and is closely associated with deprivation, poor physical health, insecure housing, domestic abuse, substance use, loneliness and social exclusion. The available evidence points to a need for a life-course, place-based and prevention-led response alongside accessible, timely specialist support.

Indicator	Latest available Kent intelligence	Implication
GP-recorded depression	**17.4%** of adults in Kent had GP-recorded depression in the 2025 JSNA; this had increased by more than one percentage point.	Depression is a major and growing population-health issue, with implications for primary care, employment, physical health and demand for wider support.
People recorded with depression	**194,698** people in Kent were recorded as having depression as at December 2022; almost **30,000** were living in the most deprived areas.	Mental-health need is socially patterned. Prevention and early-help provision should be proportionately focused on deprived communities.
Common mental illness	Modelled estimates suggest that around **16%** of people aged 16 and over in Kent and Medway experience depression, anxiety or another common mental illness; the equivalent estimate for people aged over 65 is **9%**.	Kent requires both a working-age prevention response and an ageing-well approach that addresses isolation, caring, bereavement, long-term conditions and social connection.
Area variation	Seven Kent districts had higher and increasing prevalence of common mental illness; the highest modelled prevalence was reported in **Thanet (18.2%)**, with Dover, Folkestone and Hythe, and Swale also identified as high-prevalence areas.	Place-based action is essential. The needs assessment should identify priority neighbourhoods and ensure resources reflect inequality, not simply population size.
Severe mental illness	Earlier analysis identified particularly high prevalence of severe mental illness in Thanet and Folkestone and Hythe, at around **32–33 per 1,000** working-age population, compared with **27.3 per 1,000** nationally in the cited data.	Recovery, inclusion, supported housing, physical-health care and employment support are particularly important in areas experiencing higher levels of severe and enduring mental ill health.
Self-harm among young people	Hospital admissions for self-harm among people aged **10–24** had reduced in the 2025 JSNA, although self-harm remains a major concern requiring sustained preventative action.	A reduction in admissions is positive, but does not remove the need for accessible early help, school and college support, crisis alternatives and effective follow-up after self-harm.
Young-adult self-harm	The 2019/20 Kent hospital admission rate for self-harm among people aged **20–24** was **671.6 per 100,000**, above the England rate of **433.7 per 100,000**.	Young adulthood is a critical transition point. The system should prioritise continuity between children's and adult services, education, employment, housing and primary care.

Indicator	Latest available Kent intelligence	Implication
Suicide	The Kent age-standardised suicide rate has remained broadly static since 2018 at approximately **12.5 deaths per 100,000** population with high degree of district variation.	Progress has not yet been sufficient. Sustained cross-system action is required through implementation of the Suicide and Self-Harm Prevention Strategy 2026–2030.
Suicide and domestic abuse	Analysis covering the previous three years found that **30%** of suicides in Kent were associated with domestic abuse.	Suicide prevention must be integrated with domestic-abuse prevention, safeguarding, trauma-informed support, housing, substance use and mental-health services.

Strategic interpretation

The data indicate three important messages for the Health and Wellbeing Board:

1. **Mental health is a population-health and inequalities issue.** The high and rising prevalence of depression, together with marked variation between Kent places, means that the system should focus on prevention, early help and action on the social determinants of mental wellbeing—not only clinical treatment. This is particularly important for people who are under the threshold for requiring specialist mental health support (e.g. PNG 5-9).
2. **Suicide and self-harm prevention requires collective action.** Suicide rates have not shown the sustained reduction required, and self-harm remains an important marker of distress, particularly among young people and young adults. The Kent and Medway Suicide and Self-Harm Prevention Strategy 2026–2030 provides the framework for coordinated work across health, local government, education, housing, employers, communities and the voluntary sector]
3. **Priority communities and groups need a system coordinated response.** The emerging Kent mental health needs assessment should inform targeted action in high-prevalence areas and with people experiencing multiple disadvantage, including people who are homeless or sleeping rough; people with alcohol-related brain damage; people with co-occurring mental health, substance-use and physical-health needs; and people affected by domestic abuse, trauma, poverty or social isolation.

From: Jamie Henderson, Cabinet Member for Coastal Regeneration and Public Health

Dr Anjan Ghosh, Director of Public Health

To: **Kent Health and Wellbeing Board -** 30 September 2026

Subject: Kent and Medway Health Inequalities Group

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Summary

This report provides an update on the establishment of the **Kent and Medway Health Inequalities Group**, formerly known as the Integrated Care Partnership (ICP) Inequalities Sub-Committee. The report sets out the rationale for the revised governance arrangements following changes to the Integrated Care Partnership structure and outlines the role, purpose and membership of the Group.

The Health Inequalities Group provides system leadership for reducing health inequalities and improving health equity across Kent and Medway. It brings together partners from local government, the NHS, voluntary and community organisations, housing, and wider system partners to support coordinated action on the wider determinants of health and healthcare inequalities.

The Group will champion a shared ambition that everyone in Kent and Medway has a fair opportunity to live a healthy life, support the dissemination of Marmot principles and learning, and provide strategic oversight of programmes that seek to reduce avoidable differences in health outcomes.

The Group will strengthen collaboration across organisations, provide oversight of the Kent and Medway Core20PLUS5 approach, and make recommendations to the Kent and Medway Health and Wellbeing Boards and the NHS Kent and Medway

Integrated Care Board (ICB) Inequalities, Prevention and Population Health Committee.

Recommendation(s)

The Health and Wellbeing Board is asked to:

NOTE the establishment of the Kent and Medway Health Inequalities Group and its governance arrangements.

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.

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

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1. Introduction

1.1 Health inequalities remain one of the most significant challenges facing Kent and Medway. While overall life expectancy has improved over recent decades, substantial differences in health outcomes persist between communities, places and population groups.

1.2 People living in the most deprived communities experience poorer physical and mental health, shorter healthy life expectancy and greater exposure to the wider determinants of ill health, including poverty, poor housing, unemployment, environmental pressures, social isolation and adverse childhood experiences.

1.3 Reducing health inequalities requires action that extends beyond healthcare services. The greatest opportunities for improvement lie in influencing the conditions in which people are born, grow, live, work and age, often referred to as the wider determinants or building blocks of health.

1.4 Kent and Medway partners have a long history of collaboration on prevention, population health and health inequalities. The Health Inequalities Group provides a mechanism for strengthening this collaboration and ensuring a coordinated, system-wide approach to improving health equity.

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2. Background

2.1 The Health Inequalities Group was originally established in April 2023 as the ICP Inequalities Sub-Committee, reporting through the governance arrangements of the Kent and Medway Integrated Care Partnership.

2.2 The Group formed one of three key strategic partnerships focused on prevention and population health, alongside the Prevention Sub-Committee and the Strategic Partnership for Health and Economy.

2.3 Changes to Integrated Care Partnership governance arrangements have created the opportunity to simplify reporting structures while maintaining strong place-based leadership on health inequalities.

2.4 To reflect these changes, the ICP Inequalities Sub-Committee has been renamed the **Kent and Medway Health Inequalities Group**.

2.5 The revised arrangements position the Group as a collaborative partnership forum that provides advice, challenge, oversight and recommendations to:

- Kent Health and Wellbeing Board
- Medway Health and Wellbeing Board

2.6 The Group does not hold delegated decision-making powers. Its function is to provide leadership, and system intelligence as well as make recommendations to support action on health inequalities.

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3. Purpose of the Health Inequalities Group

3.1 The purpose of the Group is to provide system leadership for reducing health inequalities and advancing health equity across Kent and Medway.

3.2 The Group brings together partners to:

- Develop a shared understanding of health inequalities across Kent and Medway.
- Identify opportunities for coordinated action.
- Build and share evidence of effective practice.
- Influence policy and decision-making across organisations.
- Promote action on the wider determinants of health.
- Support the implementation of evidence-based approaches to reducing inequalities.

3.3 The Group champions the principle that everyone in Kent and Medway should have a fair opportunity to live a healthy life, regardless of where they live or their personal circumstances.

3.4 The Group also supports the dissemination of Marmot principles and learning from emerging Marmot Place initiatives across Kent and Medway.

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4. Key Areas of Focus

4.1 Wider determinants of health

The Group work collaboratively across partner organisations to influence action on the wider determinants of health.

This includes supporting improvements in areas such as:

- Housing
- Employment and good work
- Education and skills
- Transport
- Financial hardship and poverty
- Environment, climate and sustainability
- Access to community assets
- Mental wellbeing
- Social connectedness

The Group seeks to strengthen alignment across programmes and partnerships working on these issues and identify opportunities to maximise population benefit.

4.2 Core20PLUS5

The Group provides strategic oversight of the Kent and Medway Core20PLUS5 approach to reducing healthcare inequalities.Core20Plus5 is the main inequalities framework of the NHS.

This includes reviewing progress and identifying opportunities to improve outcomes for:

- The most deprived 20% of the population.
- Locally identified PLUS groups.
- Health inclusion populations experiencing multiple disadvantage.

The Group maintains oversight of national clinical priority areas for adults and children and young people and support system-wide efforts to reduce inequitable outcomes.

4.3 Health Equity and Marmot Approaches

The Group will support the adoption of evidence-based approaches to reducing inequalities, including:

- Proportionate universalism.
- Prevention-focused approaches.
- Trauma-informed and healing-centred approaches.
- Community-centred public health.
- Anchor institution approaches.
- Marmot principles and social determinants of health frameworks.

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5. Governance and Reporting

5.1 The Health Inequalities Group is accountable through its reporting arrangements to:

- Kent Health and Wellbeing Board
- Medway Health and Wellbeing Board

5.2 The Group will provide regular updates, recommendations and assurance reports to these bodies.

5.3 Where barriers, risks or opportunities requiring wider system action are identified, the Group will escalate these through its reporting arrangements.

5.4 The Group will seek to maintain a system-wide overview of health inequalities activity across Kent and Medway and support alignment between major programmes where this adds value.

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6. Membership

6.1 Membership will comprise senior representatives from NHS organisations, local authorities, Health and Care Partnerships, voluntary and community sector organisations, housing, population health and wider system partners.

6.2 Membership includes:

- Director of Public Health, Medway Council (Chair)
- Deputy Director of Public Health, Kent County Council (Co-Chair)
- VCSE Co-Chair (Co-Chair)
- ICB Strategy and Population Health representative
- NHS Provider Alliance representative

- Public Health consultant and specialist representatives from Kent County Council and Medway Council, with attendance aligned to meeting agenda items and professional portfolios
- Kent Housing Group
- Kent County Council Financial Hardship Programme

6.3 Members may nominate appropriately briefed deputies where necessary.

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7. Meetings

7.1 The Group meets monthly.

7.2 Meetings provide a forum for:

- System intelligence sharing.
- Strategic discussion.
- Review of health inequalities data and evidence.
- Identifying opportunities for collaboration.
- Development of recommendations for partner organisations and reporting bodies.

7.3 The Group may establish task and finish groups or other sub-groups to support delivery of specific priorities.

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8. Opportunities and Future Direction

8.1 The establishment of the Health Inequalities Group creates an opportunity to strengthen collaboration across Kent and Medway and ensure a consistent focus on reducing avoidable differences in health outcomes.

8.2 The Group supports greater alignment between work on healthcare inequalities and action to address the wider determinants of health.

8.3 The revised governance arrangements will create a direct relationship with both Health and Wellbeing Boards, strengthening democratic oversight and place-based leadership for health equity.

8.4 The Group will continue to support major strategic programmes including Marmot Place development, Core20PLUS5 implementation, prevention initiatives and broader work to improve the social and economic conditions that shape health outcomes.

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9. Recommendation(s)

9.1 The Health and Wellbeing Board is asked to:

- **NOTE** the establishment of the Kent and Medway Health Inequalities Group and its revised governance arrangements.

- **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.

- **NOTE** that periodic updates and recommendations will be brought to the Health and Wellbeing Board by the Kent and Medway Health Inequalities Group.

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10. Contact details

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From: Jamie Henderson, Cabinet Member for Coastal Regeneration and Public Health

Dr Anjan Ghosh, Director of Public Health

To: **Kent Health and Wellbeing Board** - 30 September 2026

Subject: Kent and Medway Prevention Group Review

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Summary

This report presents the findings of the Kent and Medway Prevention Group review undertaken during summer 2026. The review considered the future role, purpose, priorities, governance arrangements and membership of the Prevention Group in the context of wider system changes, Neighbourhood Health development, changes to Integrated Care Board arrangements, and the evolving role of the Health and Wellbeing Boards. The review identified broad support for retaining a dedicated prevention-focused forum within Kent and Medway, recognising its value in bringing partners together to provide strategic leadership, collaboration and oversight of prevention activity across the system, whilst highlighting the need to clarify future priorities, purpose and governance arrangements. The report summarises feedback received from members and stakeholders and outlines the next steps arising from the mapping exercise.

Recommendation(s)

The Health and Wellbeing Board is asked to:

1. **NOTE** the findings of the Prevention Group review.
2. **ENDORSE** in principle the continuation of a dedicated multi-agency Prevention Group for Kent and Medway, subject to further work on its future purpose, priorities, governance arrangements and membership.
3. **NOTE that** a further update will be provided following completion of the mapping exercise and subsequent Prevention Group discussions.

1. Introduction

1.1 Prevention remains central to improving population health outcomes, reducing health inequalities and supporting the sustainability of health and care services across Kent and Medway.

1.2 The Prevention Group has historically provided a multi-agency forum bringing together local government, NHS organisations, Adult Social Care, voluntary and community sector partners and wider determinants stakeholders to support collaboration on prevention priorities.

1.3 Given significant changes across the health and care system development of the Neighbourhood Health model, evolving Integrated Care Board arrangements and changing governance structures, members agreed it was timely to review the future role and purpose of the Prevention Group.

2. Background

2.1 At its July 2026 meeting, the Prevention Group participated in a facilitated discussion to consider its future purpose, priorities, governance arrangements and meeting structure.

2.2 A review template was subsequently circulated to members and stakeholders to validate and expand upon the discussion. Responses received, alongside feedback from the workshop discussion, have informed the findings presented within this report. The detailed findings from the review are provided in Appendix 1.

3. Key Findings

3.1 Support for a Prevention Function

Feedback demonstrated strong support for retaining a dedicated prevention-focused forum within Kent and Medway. Members considered prevention to be a critical component of improving population health and reducing future demand on services.

3.2 Need for Greater Clarity of Purpose

Members identified the need to clearly define whether the future role of the group should focus on strategic leadership, influencing, advisory functions, delivery oversight, implementation support or a combination of these functions.

3.3 Attendance and Added Value

While attendance has reduced over time, largely reflecting the number of prevention-related meetings operating across the system, members continued to value the unique multi-agency nature of the forum.

3.4 Relationship with Health Inequalities

Members recognised the close relationship between prevention and health inequalities and identified opportunities for greater alignment between the two agendas.

3.5 Priority Setting

Members suggested that future arrangements should focus on a smaller number of strategic priorities where the group can add the greatest value and influence. Potential areas identified included health inequalities, wider determinants of health, rising risk populations, cardiovascular disease prevention, healthy ageing and neighbourhood health.

3.6 Action-Focused Meetings

There was strong support for future meetings to focus more clearly on delivery, outcomes and accountability, supported by clear actions and measurable objectives.

3.7 Mapping Exercise

Members supported a mapping exercise to understand the wider prevention and population health governance landscape, identify duplication and explore opportunities for alignment and simplification.

3.8 Why a Dedicated Prevention Group Remains Important

The review identified strong support from members and stakeholders for maintaining a dedicated prevention-focused forum within Kent and Medway. Participants highlighted that the Prevention Group remains one of the few system-wide forums bringing together partners from local government, the NHS, Adult Social Care, VCSE organisations and wider determinants sectors to collectively consider prevention priorities.

Members identified several benefits associated with the current arrangements, including cross-system collaboration and partnership working, alignment of prevention programmes across organisations, shared learning and dissemination of good practice, maintaining a strategic focus on prevention and population health, and supporting coordination between prevention, health inequalities and wider determinants of health activity.

The review also highlighted the value of maintaining a multi-agency approach, recognising the importance of participation from Public Health, NHS organisations, local authorities, Adult Social Care, VCSE organisations and

wider determinants partners in influencing system priorities and improving population health outcomes.

While members recognised the need to clarify purpose, improve attendance and review governance arrangements, there was little support for discontinuing prevention-focused partnership working. Instead, feedback consistently suggested that the response should be to evolve and strengthen the Prevention Group, rather than remove the prevention function from the system.

Collectively, the feedback suggests that prevention continues to require visible system leadership and that a dedicated Prevention Group remains an important mechanism for coordinating action across organisations and sectors.

Members also recognised the importance of demonstrating the impact of the Group more clearly in future. This includes developing a stronger focus on outcomes, identifying measurable priorities and ensuring appropriate reporting arrangements are in place to demonstrate how the Group contributes to improving population health and reducing health inequalities across Kent and Medway.

4. Emerging Considerations

The review identified several areas requiring further discussion:

- Future purpose and function of the Prevention Group.
- Strategic priorities for the next 12 months.
- Future governance and reporting arrangements.
- Membership and representation requirements.
- Opportunities to streamline existing structures.
- How should prevention priorities, delivery and outcomes be monitored and reported across the system?

5. Proposed Next Steps

5.1 A mapping exercise will be undertaken to identify key prevention, population health and health inequalities groups operating across Kent and Medway and clarify reporting arrangements and responsibilities.

5.2 The findings from the review and mapping exercise will inform future discussions regarding the purpose, priorities, governance arrangements and membership of the Prevention Group.

5.3 The findings of the review and mapping exercise will inform future proposals, which will be reported back through the appropriate governance arrangements, including the Health and Wellbeing Board. This work will also consider how prevention priorities, actions and outcomes are monitored and reported across the system to support greater accountability and evidence of impact.

6. Opportunities and Future Direction

6.1 The review demonstrates that prevention continues to be a strategic priority across Kent and Medway and that partners value the role of a dedicated multi-agency forum to support leadership, collaboration and shared action.

6.2 Maintaining a dedicated prevention focused partnership approach provides an opportunity to strengthen coordination across organisations, align prevention activity with emerging system priorities and the strategic ambitions of NHS, local authority and wider partner organisations, and maintain a focus on improving population health, reducing health inequalities and addressing the wider determinants of health.

6.3 The planned mapping exercise and subsequent Prevention Group discussions will inform future proposals, ensuring that future arrangements are effective, streamlined and aligned with the evolving health and care system.

6.4 Future arrangements should build on the strengths of the current Prevention Group, retaining its unique multi-agency partnership approach while increasing focus on action, delivery and measurable outcomes.

7. Recommendation(s)

The Health and Wellbeing Board is asked to:

1. **NOTE** the findings of the Prevention Group review.
2. **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.
3. **NOTE that** a further update will be provided following completion of the mapping exercise and subsequent Prevention Group discussions.

8. Appendices

- Appendix 1 - Kent and Medway Prevention Group Review

9. Contact details

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Prevention Group Review

Findings and Discussion Paper
Date: September 2026

Purpose: To support discussion and decision-making regarding the future role, priorities and structure of the Prevention Group.

Background:

At the July 2026 Prevention Group meeting, members participated in a facilitated discussion regarding the future purpose, priorities, governance arrangements and meeting structure of the Prevention Group.

The discussion took place within a rapidly changing system context, including:

- Development of the Neighbourhood Health model.
- Changes to Integrated Care Board (ICB) structures and governance.
- The evolving role of the Kent and Medway Health and Wellbeing Boards.
- Existing prevention, health inequalities and population health programmes across the system.

The purpose of the discussion was to consider whether the current operating model remains fit for purpose and how prevention should be positioned within future system arrangements.

Following the meeting, a review template was circulated to attendees and key stakeholders to validate and expand upon the themes identified during the discussion. Four responses were received and have informed this paper alongside the views expressed at the July meeting.

Key Themes

1. Strong Support for Retaining a Prevention Function

There was broad agreement that prevention should continue to have a visible and identifiable place within Kent and Medway's governance arrangements.

Members recognised the value of having a dedicated forum that brings together partners from Public Health, NHS organisations, Adult Social Care, local authorities, VCSE organisations and wider determinants partners.

Although there was discussion regarding the future structure of the group, there was limited support for disbanding prevention activity altogether. Members felt there remains a need for a forum that can champion prevention, influence strategic priorities and maintain a focus on improving population health and reducing demand on services.

2. Clarification of Purpose is Required

A significant theme throughout the discussion was the need to clearly define the purpose of the group.

Questions raised included whether the future group should primarily:

- Provide strategic leadership.
- Influence policy and system priorities.
- Act as an advisory or reference group.
- Oversee delivery against agreed priorities.
- Support action and implementation across partner organisations.

Members felt greater clarity around purpose would be required before agreeing future priorities, membership and governance arrangements.

3. Attendance, Value and Future Alignment

Members recognised that attendance has reduced over time, reflecting the number of prevention-related meetings and governance forums across the system. There was support for undertaking a mapping exercise to identify overlaps, improve alignment and make best use of partner capacity.

Despite this, members agreed the Prevention Group continues to add value as one of the few forums bringing together partners from health, local government, Adult Social Care, VCSE organisations and wider determinants sectors. Key benefits identified included cross-system collaboration, shared learning, programme alignment and maintaining prevention as a visible strategic priority.

While some members supported streamlining future arrangements, there was little appetite for removing a dedicated prevention forum. Instead, discussion focused on how the group could evolve to improve attendance, increase value and become more action oriented.

4. Prevention and Health Inequalities are Closely Linked

There was considerable support for exploring closer alignment between prevention and health inequalities.

Several members noted that prevention is a key mechanism for reducing health inequalities and improving outcomes, and that both agendas share common objectives and stakeholders.

Suggestions included exploring closer alignment between prevention and health inequalities arrangements, recognising the overlap in objectives, stakeholders and areas of focus

5. Need for a Smaller Number of Priorities

Members felt that the current programme spans a wide range of topics and that greater impact may be achieved through a more focused approach.

Discussion suggested that the future group should concentrate on a limited number of priorities where it can add value and influence change.

Areas highlighted during discussions included:

- Health inequalities and equity.
- Rising Risk populations.
- Cardiovascular disease prevention.
- Wider determinants of health.
- Neighbourhood Health.
- Healthy ageing and population wellbeing.
- There was support for identifying one to three priorities that could form the core focus of the group's work programme.

6. Meetings Should Be More Action-Focused

A consistent message from both the discussion and written feedback was that meetings should focus more strongly on action, outcomes and impact.

Members suggested:

- Clear objectives for each agenda item.
- Specific actions and asks of members.
- Greater accountability for delivery.
- Reduced emphasis on information-sharing updates.
- Clear measures of success linked to priorities.

Several members felt this would improve engagement and attendance and create a stronger sense of purpose.

7. Mapping Existing Groups and Governance Arrangements

Members highlighted the complexity of current governance arrangements and the number of groups operating across the prevention, inequalities and population health landscape.

Several participants indicated that duplication may exist and that responsibilities are not always clear.

There was strong support for undertaking a mapping exercise to:

- Identify existing groups.
- Clarify remits and reporting arrangements.
- Highlight areas of overlap.
- Explore opportunities for alignment or merger.
- Improve efficiency and reduce duplication.

8. Value of Multi-Agency Collaboration

Members consistently highlighted the value of bringing together different sectors and perspectives.

The Prevention Group was recognised as one of the few forums where Public Health, NHS partners, local authorities, Adult Social Care, VCSE organisations and wider determinants partners can consider prevention collectively.

There was support for maintaining this multi-agency approach regardless of the future structure adopted.

Review responses also highlighted the importance of maintaining representation from the VCSE sector and wider determinants partners, recognising that many of the factors that influence health outcomes sit outside traditional health and care services. The Prevention Group was viewed as an important mechanism for bringing these perspectives together and influencing wider system priorities

Emerging Considerations

Based on the discussion and feedback received, the following areas merit further consideration:

Purpose

- What should the primary purpose of the group be?
- Should it be strategic, advisory, influencing, delivery-focused or a combination of these functions?

Priorities

- What are the two to three areas where the group can have the greatest impact over the next 12 months?

Alignment

- Should prevention and health inequalities functions be more closely aligned?
- Are there opportunities to align or merge with existing prevention-related groups?

Governance

- How should the group sit within emerging Health and Wellbeing Board arrangements?
- What reporting and accountability mechanisms are required?

Membership

- Does current membership reflect the partners required to achieve the group's objectives?
- Are there gaps in representation that need to be addressed?

Initial Recommendations

The following recommendations are proposed for discussion:

1. Retain a dedicated prevention-focused forum within Kent and Medway.
2. Review membership, attendance expectations and reporting arrangements to ensure the group adds value, remains representative and makes the best use of partner capacity.
3. Clarify the group's future purpose and function.
4. Focus on a small number of agreed strategic priorities.
5. Explore opportunities to align prevention and health inequalities activity.
6. Undertake a mapping exercise of key prevention-related groups and governance arrangements.
7. Redesign meetings to be more action-focused and outcome-driven.

Next Steps

The September meeting has been cancelled to allow time for members to review the findings set out in this paper and provide any further comments.

The feedback received, alongside the findings of the planned mapping exercise, will be used to inform discussion at the October meeting, where members will be asked to agree:

- The future purpose of the Prevention Group.
- Future priorities.
- Governance arrangements.
- Membership and representation.
- Options for alignment with related groups and programmes.

This paper is intended to support discussion and does not represent a final proposal. Further feedback and discussion will inform future recommendations.

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From:	Jamie Henderson, Cabinet Member for Public Health Dr Anjan Ghosh, Director of Public Health
To:	**Kent Health and Wellbeing Board** – 30 September 2026
Subject:	Early Draft of the Kent Neighbourhood Health Plan
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	None
Electoral Division:	All

Summary:

1. The purpose of this paper is to share progress around the development of the Kent Neighbourhood Health Plan (NHP) including access to the current early draft to allow the Plan to benefit from the input of the Kent Health and Wellbeing Board (HWB) in its development.

2. The DHSC Neighbourhood Health Framework details actions required to deliver neighbourhood health from now until 2029. A key element within this is the role of the Health and Wellbeing Board in leading the development of the Neighbourhood Health Plan (NHP). This is to be implemented from April 2027 so will need to be developed over the coming year.

3. Neighbourhood Health is the proposed new system approach to both improving health and preventing the need for hospital admissions. It is based around the NHS Plan ambitions to increase prevention, community based care and digital services. While it initially focussed on helping keep people out of hospital, it has expanded to include access to primary care and reducing waiting times.

4. Importantly, it has also expanded to embrace locally defined, wider health and wellbeing priorities within the local system including addressing inequalities. These will be delivered through the NHP with the Board having a critical role in the plan's development and delivery.

5 The Kent NHP should include both County wide priorities as well as mechanisms to ensure that local district level priorities are recognised and can be actioned. The complexity of upcoming Local Government Reform (LGR) is recognised, however the need for the NHP to commence in April 2027 means action needs to progress within prevailing systems.

Recommendation(s):

The Health and Wellbeing Board is asked to **NOTE** the progress in developing the Neighbourhood Health Plan and **COMMENT** on the attached developing draft at this early stage.

1 Introduction

1.1 The Kent Health and Wellbeing Board (HWB) has a role in leading the development of the required Neighbourhood Health Plan (NHP) for implementation from April 2027. This was discussed in detail at the last meeting.

1.2 The nationally published Neighbourhood Health Framework (NHF) requires local systems to develop a Neighbourhood Health Plan (NHP) that will be overseen by the Health and Wellbeing Board. This represents an opportunity to ensure that all partners can both contribute to, and have their ambitions furthered by, Neighbourhood health to improve local health and wellbeing as well as achieve key partner and system priorities.

1.3 The current Kent Joint Local Health and Wellbeing Strategy (JHWS) is the local iteration of the Kent and Medway Integrated Care Strategy (ICS) which has a strong focus on tackling the full range of health determinants using the Robert Wood Johnson model as well as addressing inequalities and focusing on prevention. This strategy, which runs to 2029 remains highly relevant and appropriate to addressing local health challenges although it is recognised that some challenges e.g. around the cost of living, have been exacerbated in recent years.

1.4 Development and delivery in Kent and Medway will require actions that are led at both a system wide and at a very local level. The development of the NHP must reflect this, with a balance of top down centrally defined and locally agreed priorities and actions.

1.5 The Kent HWB will formally approve the Kent NHP while Medway HWB will approve the Medway NHP. It is planned that these documents closely align where possible to allow a Kent and Medway NHP to be agreed at the ICB.

2 Background to Health in Kent

2.1 This was rehearsed at the last Board meeting. There remain many challenges to improving the health and wellbeing of the people of Kent which are well

outlined within the local Joint Health Needs Assessments. The key challenges include avoidable early deaths from cardiovascular diseases and cancer as well as mental health challenges, an ageing population and ensuring people reach their potential with a best start in life.

2.2 There is a recognition amongst local partners that to address these challenges our actions must tackle the full range of health determinants including socioeconomic, lifestyle, health and care service and environmental elements. These are captured in the Robert Wood Johnson model embraced locally and shown below. The cost of living crisis is currently central to these issues. Addressing all these elements will require input and collaboration between the full range of local stakeholders, statutory, non-statutory, communities and people themselves.

SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

2.3 Further key elements of the JHWS include a focus on prevention and a focus on tackling inequalities. It is important that these elements are included within the developed NHP.

3 Background to Neighbourhood Health

3.1 The initial priority for the NHS in NH is to identify frail people who may be at risk of admission and offer them a range of proactive support services and interventions to help them remain independent. There is also a drive to develop reactive community services able to offer rapid, intense, community based care that would avoid hospital admission in those who might otherwise require it.

3.2 The thinking was widened considerably within the Neighbourhood Health Framework (NHF) document which expanded the focus to include access to primary care and routine hospital waits as well as the wider role of partners in delivering prevention with the HWB being made responsible for developing the NHP.

3.3 While the NHF does discuss the need to address mental health challenges and the needs of children, young people and families, it is fair to say that these areas do not receive the initial focus and emphasis that is afforded to prevention of hospital admission in frail older people. While the model is largely a medical one, there is the recognition of the role of partners in wider elements of prevention.

3.4 The NHP will need to include priorities at a Kent level and how these will be addressed as well as clarifying mechanisms to enable local partnerships to best deliver on very local priorities and challenges

4 The Neighbourhood Health Plan

4.1 The NHF states that the Plan will need to:-

- Provide an overview of how NHS objectives will be delivered through the three NHS Reform Agendas (improved routine services, proactive care and alternatives to hospital).
- Describe how Neighbourhood Health (NH) will support local goals around inequalities and health outcomes.
- Link local objectives to the Joint Strategic Needs Assessment (JSNA).
- Confirm geographies for Neighbourhood Health.
- Confirm organisational responsibilities.
- Define governance and operational partnerships to deliver the Plan.
- Describe how other local initiatives align with Neighbourhood Health e.g. Family hubs, housing, VCSE, employment support.

4.2 The agreed Neighbourhood Health Plan will be part of the Integrated Care Board's 5 year commissioning plan. This is a nationally required ICB level document that the ICB will develop and approve.

4.3 There is an expectation that the Health and Wellbeing Board will agree and formally approve local targets in the Neighbourhood Health Plan to begin delivery in 2027/8 with local outcome measures covering the whole life course including both health and social needs.

4.4 It is suggested by the DHSC, that the Health and Wellbeing Board might use the Local Outcomes Framework in defining local objectives and metrics. It is proposed that the Health and Wellbeing Board look at how neighbourhood health can help deliver objectives around numbers of people in care homes by age, and user and carer satisfaction, as well as objectives around Best Start in Life and Family Hubs.

4.5 There is further an expressed desire from the centre to link the Neighbourhood Health Plan to wider local public service reform including around access to work, to housing and to community initiatives.

5. Developing the draft Plan in Kent

5.1 There are key deliverables that must be included in the NHP that will be defined by partners including the NHS, County, and potentially Districts. Partner organisations will need to agree how we best work together to deliver win-wins for the system and the people we serve.

5.2 A small group of officers from Kent, Medway and the NHS are meeting to collate and coordinate an initial draft of the plan. The draft as it stand is attached (Appendix A) and will benefit from member comment and input.

5.3 The Plan includes current NHS plans around neighbourhood health as well as local structures. NHS priorities and metrices are largely centrally dictated.

5.4 It also includes draft Kent County level priorities with a focus on Adult Social Care. These follow a KCC workshop looking at adult social care and neighbourhood health. It will also include priorities around children services and mental health.

5.5 Meetings around the Plan and Neighbourhood Health have taken place with officers from all city, districts and boroughs with the opportunity to have a subsequent local partnership/alliance focussed workshop. This has allowed the draft to benefit from both current local partnership priorities as well as key potential asks of the partnerships of the wider system in improving health and wellbeing locally.

5.6 A meeting has taken place with Healthwatch to consider how qualitative information they have collated on local resident needs and challenges can best inform the developing work.

5.7 There are additional wider system groups who have a role to play and are being engaged in the NHP. These include the Kent Housing Group and the VCSE Health Alliances.

5.8 While the NHF has more of a focus on Mental Health and Children and Families than the earlier NH publications, there is still a sense that a higher

profile is required. It is important that these areas are included specifically in the NHP and agreed actions.

5.9 There are a number of key initiatives underway focussing on the wider determinants of health including Marmot Initiatives. It is important that this work is linked in with NHP development and action.

5.10 It is proposed the plan is for three years with more detail around year one and high level actions for years two and three to be further developed.

5.11 It is proposed the NHP be a high level document referencing other more focussed local and system level action plans for more detail.

5.12 The need to develop a plan that remains relevant following LGR is important given the three year timeframe. The plan will therefore be developed at Kent and Medway level with overlapping but distinct outputs for Kent and Medway.

6. The Draft Neighbourhood Health Plan for Kent

6.1 Work on the plan, due for launch in April is at a fairly early stage but it is important that there is every opportunity for it to benefit from input from, and to secure full ownership of, the Board.

6.2 The plan starts with an overview of Neighbourhood Health, followed by the Strategic context driven by the Integrated Care Strategy and the NHS asks within the Neighbourhood Health Framework.

6.3 It then considers key outcomes with Kent wide priorities, city, district and borough priorities and NHS priorities.

6.4 It then describes the local proposed NHS model and proposed actions at a local and system level. It is proposed that the Plan discusses key actions across the system at a local level that will enhance and enable local system objectives as well as key actions to deliver objectives at a Kent level.

6.5 Learning from the pilots will be discussed and will inform the plans.

6.6 Key metrices will be agreed at a system level. The number will be deliberately small but will represent progress in key areas.

6.7 Enablers and Governance will be discussed.

7. Conclusions

7.1 The NHP offers a local opportunity to improve health through agreeing local priorities and actions, both at county level and at a local level, as well as

catalysing stronger partnership working at both a strategic and an operational level.

7.2 Work is at an early stage and aims to balance system level asks including around independence and reduced reliance on residential care with local priorities addressing the wider determinants of health and inequalities locally.

7.3 The input of the Board is sought at this early stage in refining content and agreeing next steps and how we can best ensure appropriate ongoing involvement of Members.

8. Recommendation(s):

8.1 The Kent Health and Wellbeing Board is asked to **NOTE** the progress in developing the Neighbourhood Health Plan and **COMMENT** on the attached developing draft at this early stage.

9. Appendices

- Appendix A - Draft Neighbourhood Health Plan

10. Contact details

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Kent and Medway Neighbourhood Health Plan

(Draft version 2)

18.08.26

Improving health and wellbeing through integrated neighbourhood working across Kent and Medway.

Balancing local and system-wide needs

- A core concept of neighbourhood health is that it responds to local needs and involves local stakeholders. However, neighbourhood health also needs to be coordinated across the Kent and Medway system to avoid fragmentation and confusion for patients, residents and those delivering services
- There is, therefore, a Kent and Medway Neighbourhood Health Plan and separate plans (or sections, depending on how things evolve) for Kent and for Medway. The Kent and Medway plan contains all of the shared content, while the separate plans for Kent and for Medway contain locally-specific content.

Contents

- Introduction
- Strategic Context
- Outcomes
- System and Partner Priorities
- Neighbourhood Health Model
- Alliances and System Working
- Mental Health
- Neighbourhood Health Pilots *(needs to be earlier)*
- What Will Be Delivered and By Whom
- Enablers
- Programme Management and Oversight

Introduction

- The Neighbourhood Health Framework (NHF) requires systems develop a Neighbourhood Health Plan (NHP) overseen by the Health and Wellbeing Board.
- Health Strategy in Kent and Medway in recent years has been underlined by the Integrated Care Strategy (ICS). This is driven by the Robert Wood Johnson model of impacts on health and has led to better consideration of socio-economic, lifestyle and environmental as well as health and care service impacts
- Following this, and in line with the Ten-Year Plan, the system, including the NHS, has looked to better address prevention, health inequalities and the wider determinants of health (WDH). The NHP is an opportunity to accelerate work in these areas.
- The NHP is an opportunity to ensure all partners can contribute to, and have their ambitions furthered by, Neighbourhood health to improve local health and wellbeing through action to tackle local inequalities and the WDH and achieve key partner and system priorities.
- Development and delivery in Kent and Medway will require actions that are led at both a system wide and at a very local level. The development of the NHP reflects this, with a balance of top down centrally defined and locally agreed priorities and actions.

Purpose and rationale

The Kent & Medway Neighbourhood Health Plan will translate national neighbourhood health expectations and local population priorities into a shared framework for action.

WHAT IS THE PLAN?

- Brings together NHS objectives, local health and wellbeing priorities and population health evidence.
- Agrees a small number of shared outcomes, priorities and measures for neighbourhood health.
- Clarifies responsibilities, governance and operational partnerships across the NHS, councils, providers and wider partners.
- Connects system-wide ambition with neighbourhood and hyper-local action.

WHY IS IT NEEDED?

- The national Neighbourhood Health Framework requires systems to develop a locally owned plan overseen by Health and Wellbeing Boards.
- Kent and Medway needs a shared route for accelerating prevention, reducing inequalities and addressing wider determinants of health.
- The Plan creates a balance between centrally defined NHS expectations and priorities agreed locally with partners.
- It provides the partnership framework for action to reduce avoidable hospital and residential care admissions and support independence.

TIMING AND ALIGNMENT

2026/27

Co-develop the Plan, agree priorities, governance, measures and delivery arrangements.

By April 2027

Complete the development tasks and prepare for implementation.

From 2027/28

Implement the locally owned Neighbourhood Health Plan.

Developing and delivering the Plan

The Plan will combine system-wide direction with locally led action, informed by evidence, engagement and learning.

THE PLAN WILL INCLUDE:

- How NHS objectives will be delivered
- How Delivery of local goals around inequalities and health outcomes are supported
- Linked to JSNA
- Confirm geographies, organisational responsibilities, governance and operational partnerships

MAKING THE PLAN WORK:

- Drive key actions at a system and local level that will reduce acute and residential admissions.
- Define how the wider system will support local partnership priorities in their local action plans.
- Agree a small number of key system partner priority measures alongside the national NHS measures

SYSTEM OPPORTUNITY:

- Develop systems and structures at a local and higher level to deliver key evidence-based interventions Local clinical leadership is key.
- Deliver the key priorities of ALL partners, including the NHS, County, Unitary and District with win-wins.
- The plan must deliver on both sustainability challenges around reducing emergency hospital and care home admissions and address inequalities and wider determinants.
- The plan needs to support local partnerships at district and community level through system level approaches.
- Include opportunities Mental Health and Children and Families

DEVELOPING THE PLAN:

- The Integrated Care Strategy (ICS) remains the appropriate System Strategy
- System Clinical Leaders will define key evidence-based interventions that prevent hospital and residential care admissions
- Districts are engaged in discussions on how local partner priorities and actions can be supported
- Engagement has taken place with partners including Kent Housing Group to agree roles in NH.
- Leads for Mental Health and on Children and Young People are engaged
- The System will learn from the local NH pilots
- The NHP is informed by Healthwatch/EK360 insights into population needs

Health and Wellbeing Board priorities to delivery

The Kent and Medway Neighbourhood Health Plan provides a shared framework for turning Board priorities into coordinated action. It brings together national expectations, local priorities and population insight to agree shared outcomes and focus collective delivery.

Strategic Context: The Integrated Care Strategy

Kent and Medway is an attractive place for so many who choose to make their lives here. With close proximity to London and mainland Europe, and a plethora of green spaces known as the 'garden of England', it is home to some of the most affluent areas of England. Nevertheless, it is also home to some of the most (bottom 10%) socially deprived areas in England. This correlates with the health outcomes achieved. With the current cost of living crisis, these disparities will persist or worsen without our concerted, collective effort.

Kent and Medway Integrated Care Partnership was formed in 2022 and led the development of the Integrated Care Strategy (ICS) following consultation with local people, organisations and partnerships. It is underpinned by our Joint Strategic Needs Assessments, individual subject-specific strategies and the Medway Joint Local Health and Wellbeing Strategy. It was adopted as the Kent Joint Local Health and Wellbeing Strategy.

Our population is growing faster than the national average - over 20% growth is predicted between 2011-2031.

In Medway and Swale, local survival rates for cancer, in particular lung cancer, are among the lowest in the country.

Life expectancy is no longer increasing in Kent and Medway. In all areas, apart from Thanet, the gap in life expectancy is wider for men than women. Life expectancy at birth in Medway, Swale and Thanet is below the England average for both men and women.

More people are experiencing depression or severe mental illness

Over two thirds of adults are now overweight or obese and physical activity levels for children and young people are not increasing

Incidents of domestic abuse are increasing

Kent and Medway lags behind the UK and South East in some indicators of economic success, including productivity and skill levels

The covid-19 pandemic has brought inequalities into focus. Fewer children are school ready and there has been a drop in expected levels in phonics screening for Year 1.

Across Kent and Medway around 170,000 adults aged 16+ provide hours of unpaid care each week

Although women's life expectancy is higher, women spend more years, and a greater proportion of their lives, in poor health than men (23% vs 19-22%). The number of years spent in poor health has either increased or remained relatively unchanged across Kent and Medway.

12% of people in West Kent smoke, compared to over a fifth (21%) in Swale.

England's Chief Medical Officer Annual Report 2021 highlighted that coastal communities have some of the worst health outcomes in England, with low life expectancy and high rates of many major diseases. Running through the report is the fact that coastal communities, of which there are many in Kent and Medway, have multiple, overlapping but addressable health problems.

Delivering together

Kent and Medway is a large and diverse area, and the Integrated Care Strategy recognises that delivery of the shared outcomes will need to be tailored to local places and specific needs. This plan sets out only the main system-level strategies and activities that will drive work to deliver the outcomes.

Our Integrated Care System is made up of many other partners who also lead strategies and activities that will play an important role in improving the health and wellbeing of the Kent and Medway population. It would be impossible to capture all of these, and it is important that local areas and partners have the flexibility they need to meet the needs of the people they support. However, this activity is a vital part of the success of our system and the ICP will continue to develop its connections with partners across places and sectors.

The voluntary, community and social enterprise sector is an integral part of our system at every level and helps shape strategy and activity as well as providing vital support in our communities.

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1.9 million people	**2** Healthwatch organisations	Approx **4,000** registered charities	**90,000** staff working across health and care
13 housing authorities	Over **74,000** businesses and enterprises	**14** councils 1 county, 1 unitary, 12 districts	**184** GP practices in **41** Primary Care Networks
694 schools and **1,713** nurseries/early years settings	**4** Health and Care Partnerships	**325** pharmacies	**1** medical school and **3** universities
7 NHS provider trusts and **1** Integrated Care Board	**642** care homes	**321** parish and town councils	**1** Police Force and **1** Fire and Rescue Service

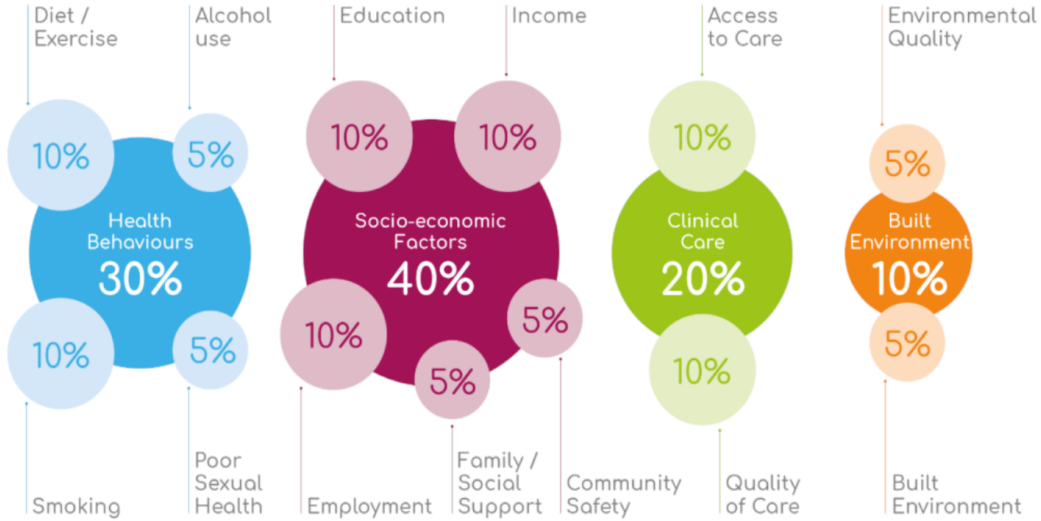
Role of Health and Care Partnerships and District & Borough Councils

Health and Care Partnerships and District & Borough Councils have a key role in improving health and wellbeing through local action involving key local partners including the local VCSE to deliver the priorities for their place supported by appropriate programmes of work and action plans. Together, these place-based plans will have significant impact on the overall delivery of our shared strategy. Place-based priorities and plans have been reflected in this shared delivery plan.

The Integrated Care Strategy remains relevant now:

- ✓ Key measures of health and wellbeing are getting worse, or not improving as fast as the national average. We must take a **different approach and all tackle the wider determinants of health** (see figure of Robert Wood Johnson model).
- ✓ We must seize the **enormous opportunity** that working as an integrated system presents to bring real improvements to the health and wellbeing of our population and put our services on a sustainable footing, within the context of the resource and demand pressures and constraints we all face.

- ✓ This strategy uses a consensus to agree and focus on the **priorities we must deliver together as a system**, so all partners can target our limited resources and assets where we can make the biggest improvements and deliver value for money together.
- ✓ This strategy should not provide the 'how'. We recognise that **local partners** are best placed to **understand local needs** and the actions required to tackle them. The strategy will be supported by delivery plans which are organisation or subject matter specific.
- ✓ The strategy will enable a balance between universal preventative services and bespoke additional support for those with greatest needs, also known as **proportionate universalism.**
- ✓ There is recognition that we additionally need to ensure the **NHS plan** is delivered with its focus on **prevention, community-based care and digital** solutions, and the actions detailed in the **Neighbourhood Health Framework** are delivered



Based on: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, US County health rankings model 2014 https://www.countyhealthrankings.org/sites/default/files/media/document/CHRR_2014_Key_Findings.pdf

Overview of the Integrated Care Strategy

Our vision:
We will work together to make health and wellbeing better than any partner can do alone

Together we will…

Give children and young people the best start in life	Tackle the wider determinants to prevent ill health	Support happy and healthy living for all	Empower patients and carers	Improve health and care services	Support and grow our workforce

What we need to achieve

• Support families and communities so children thrive • Strive for children and young people to be physically and emotionally healthy • Help preschool and school-age children and young people achieve their potential	• Address the social, economic and environmental determinants that enable people to choose to live mentally and physically healthy lives • Address inequalities	• Support people to adopt positive mental and physical health • Deliver personalised care and support centred on individuals providing them with choice and control • Support people to live and age well, be resilient and independent	• Empower those with multiple or long-term conditions through multidisciplinary teams • Provide high quality primary care • Support carers	• Improve equity of access to services • Communicate better between our partners when changing care settings • Tackle mental health issues with the same priority as physical illness • Provide high-quality care to all	• Grow our skills and workforce • Build ‘one’ workforce • Look after our people • Champion inclusive teams

Enablers:
We will drive research, innovation and improvement across the system
We will provide system leadership and make the most of our collective resources including our estate
We will engage our communities on our strategy and in co-designing services

MEDWAY'S JOINT LOCAL HEALTH AND WELLBEING STRATEGY 2024-2028

GOAL: Improve the physical and mental health and wellbeing of Medway residents and reduce inequalities.

PURPOSE: To ensure everyone in Medway lives a long, healthy, and happy life, with people valuing self-care and helping others. Opportunities are available to all throughout life to help people grow and create a brighter future. Medway is a place where help is easily available, places are connected, and when people move between services, their journey is seamless.

People are proud to live in Medway and feel part of their community.

PRIORITY THEME 1

HEALTHIER & LONGER LIVES FOR EVERYONE

- Babies and children are healthy, happy, and safe. They develop well and are ready to start school.
- People in Medway are supported to live healthy, long and happy lives, and value self-care.
- Vulnerable adults lead fulfilling lives in a caring environment that ensures their wellbeing and safety.
- Older people live with dignity and stay independent for as long as possible.
- Good mental health is enjoyed by everyone. People can cope with life's challenges, sleep well, have positive relationships, and experience a sense of purpose and fulfilment.

PRIORITY THEME 2

REDUCE POVERTY AND INEQUALITY

- All children achieve a good level of education leading to secure employment in adulthood.
- Outcomes are improved for those in vulnerable and disadvantaged groups, such as children in care and care leavers.
- People and families can access healthy food, have steady jobs, and live in affordable, good quality homes.
- People in Medway are supported in managing the cost of living.

PRIORITY THEME 3

SAFE, CONNECTED AND SUSTAINABLE PLACES

- Services are close to where people live and accessible by active transport such as walking or cycling, or using public transport.
- People and organisations work together to create a sustainable, clean and green environment.
- Green spaces can be accessed and used by all.
- People feel safe in their neighbourhood.

PRIORITY THEME 4

CONNECTED COMMUNITIES AND COHESIVE SERVICES

- People feel connected with their community, have a sense of belonging and strong support networks.
- Everyone can find and access services and information easily, with support to ensure digital inclusion.
- Organisations work together so when people move between services, their journey is seamless.
- There is trust and respect between services, organisations and users, regardless of their differences; diversity is recognised and embraced.

Government guidance for Neighbourhoods

NAPC

Neighbourhood health will only work as a **joint endeavour** between the NHS and local authorities, alongside wider partners.

Three principles of public sector reform:
- Integrated services around people's lives
- Improve outcomes, by focusing on prevention rather than crisis management
- Devolve power to local areas, which understand local needs, with services with and for people.

Measuring success of neighbourhood health

National minimum goals and objectives, plus locally developed aims and outcomes defined through neighbourhood health plans under the leadership of Health and Wellbeing Boards.

National NHS goals, objectives and metrics

1 Improve health outcomes

Targets include:
- reducing non-elective admissions
- improving outcomes for long-term conditions
- improving quality and access to care for children
- better end of life care

2 Improve access to general practice

Objectives include:
- 90% of clinically urgent patients seen the same day by March 2027
- faster access to routine GP care
- improved patient satisfaction

3 Improve experience of planned care

This will include:
- reducing variation in outpatient referrals
- improving coordination of outpatient care & reducing secondary care follow-up appointments

4 Improve urgent and emergency care
- Improving co-ordination of care for high priority cohorts (frailty, care homes, end of life)
- reducing emergency department attendances
- improving ambulance response times
- improving hospital discharge processes

5 Improve patient and staff satisfaction
- introducing patient-reported experience and outcome measures
- ensuring 95% of people with complex needs have an agreed care plan
- introducing neighbourhood staff experience measures

6 Local goals
- Health and Wellbeing boards recommended to consider the local outcomes framework for health and wellbeing, adult social care, Best Start in Life and neighbourhood health and integration
- Enabling those who receive long term support to live in their home
- Adults whose needs are met by admission to residential and care homes
- Consider how neighbourhood plans align with wider public service reform

Aims

- Improve people's health and care outcomes
- Organise services around the person
- Reduce pressure on acute services
- Cut waste and duplication
- Help the NHS deliver against core targets

Delivering neighbourhood health

To deliver neighbourhood health, the NHS and local authorities must transform how they work together alongside wider partners including **voluntary, community and social enterprise organisations (VCSEs).** ICBs will ensure neighbourhood health becomes the default model of care

Reform agendas

1 Improve routine healthcare

The NHS will support GP access recovery by:
- through new GP access targets
- improving online access
- ensuring practices open during core hours, and reform out of hours
- providing faster access to care

GPs will be empowered to deliver better care through:
- proactive population health management
- reduced bureaucracy
- improved access to specialist advice

2 Improve proactive care
- Develop Integrated Neighbourhood teams to deliver better management of Long term conditions, frailty, children and young people and cancer
- Grow community services
- Reform outpatients, with closer working between GPs and specialists

3 Better alternatives to hospital care
- Expand urgent community response services
- Increase the capacity of virtual wards
- Increase intermediate care capacity
- Piloting 24/7 neighbourhood mental health centres

Read how NAPC helps partners implement neighbourhood health.

Contracting models

ICB → IHO → MNPs → SNPs

Single Neighbourhood Providers (SNPs): Deliver neighbourhood services through integrated teams within a defined area; allow primary care to offer services beyond core GP contracts.
Multi-Neighbourhood Providers (MNPs): Coordinate services across multiple neighbourhoods, supporting consistency, service design and shared risk for the registered population list.
Integrated Health Organisations (IHOs): Hold a whole-population budget, allocate resources across pathways, redesign services and invest in prevention. Initially likely led by high-performing NHS trusts, in partnership with primary and community providers.
All primary care contracts remain nationally contracted. PCNs might evolve into SNPs. More guidance to follow.

Changes for 2026/27

- Neighbourhood footprints considered in terms of local authority boundaries
- Reduce non-elective admissions
- GP access
- Establish integrated neighbourhood teams
- Improve outpatient pathways
- Confirm use of Better Care Funding (BCF)
- Improve primary secondary care interface
- Confirm organisational ownership of deliverables
- Improve data-sharing arrangements
- Plan for April 2027 to April 2029

Other headlines

- **Neighbourhood Health Centres (NHCs)**: 250 neighbourhood health centres by 2035, 120 by 2030
- **Workforce:** staff working differently rather than entirely new staff groups providing proactive, preventative personalised care, organisational boundaries
- **Finance:** ICBs prioritise funding for neighbourhood health services locally. National support will include: financial incentives encouraging the shifting care from hospital care to community, reforms to payment mechanisms, & support for outcome-based contracting

NAPC welcomes the continued focus on population health and prevention at a local level.
The national voice for primary and community care, NAPC is a not-for-profit membership organisation leading change, driving innovation and supporting partners across the health and care ecosystem.

Contact us: napc@napc.co.uk • www.napc.co.uk

Healthcare we need to plan for

Spending £250 million a year more than we have; we are £100 million 'overfunded'

Highest prevalence of frailty in over 50s in the south-east region

14.9% of children and young people in Kent and Medway have depression, the highest rate in the south east

Demand is greater than capacity and long waiting times impact outcomes. By 2030, we will need 1.7 million more GP appointments and acute demand will increase by 19 per cent for those aged over 65

£500 million (and growing) estate maintenance backlog. Large parts of estate and infrastructure not fit for 21st century effective healthcare

Circulatory diseases and cancer are the leading causes of poor quality of life and death in Kent and Medway

Digital innovation is challenging to embed and scale

Variability in staff experience and performance.

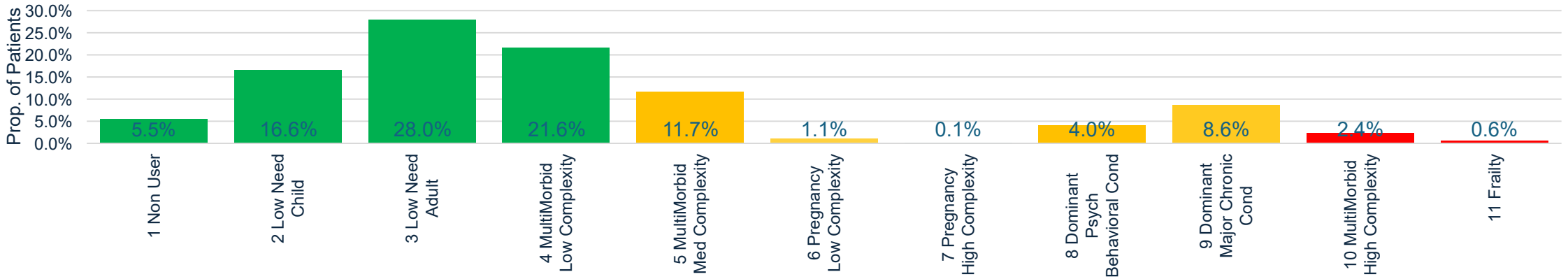
In five years, 70 older people will be presenting to emergency departments every day and 30 will be admitted to acute beds each day. The 85+ year age group is growing at the fastest rate

Patient experience is inconsistent and not always something we can be proud of

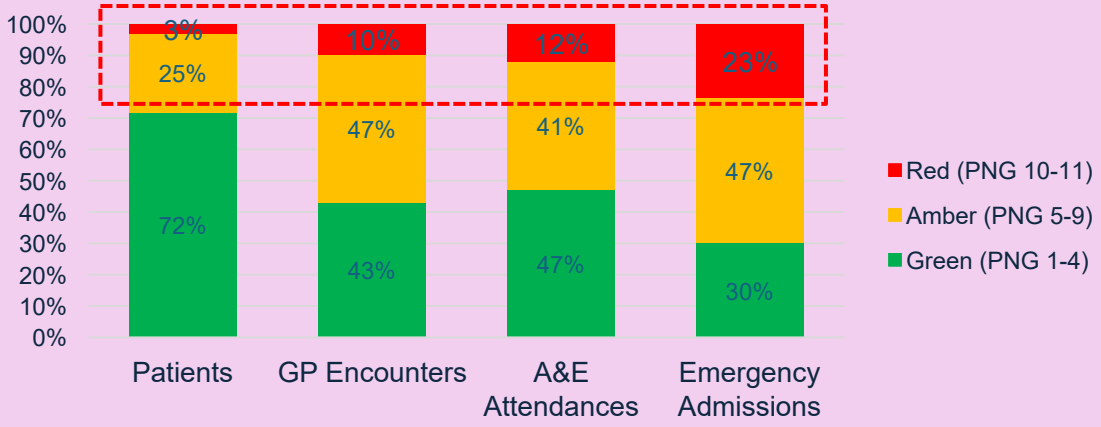
Significant health inequalities, particularly in coastal areas – 12-year lifespan gap

Population segmentation

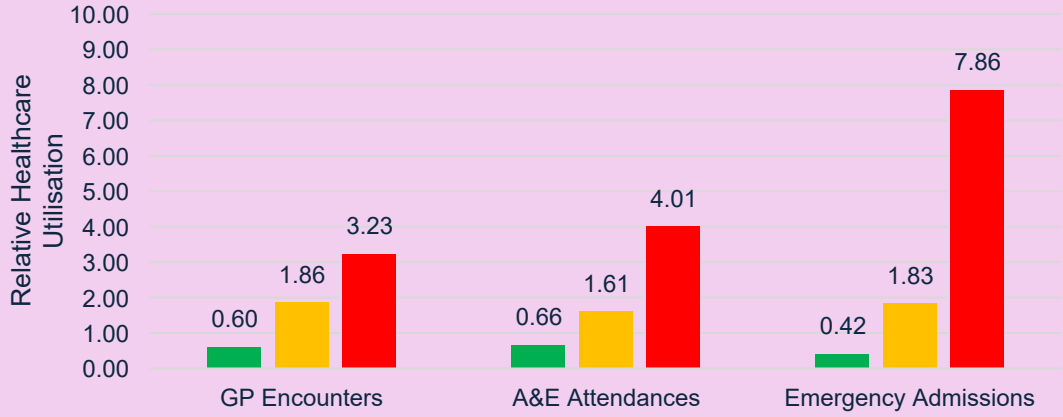
Patient Need Group (PNG) segmentation takes a multimorbidity approach to categorising patients across Kent and Medway.



PNG 10-11 (Red) account for 3% of the pop. but 10% of GP encounter and almost 25% of emergency admissions



PNG 10-11 have >3x more GP encounters, 4x more A&E attendances and 8x as many emergency admission compared to the average patient



Resident insight and shared priorities

How public engagement has informed the priorities, outcomes and measures for the Plan

Community Engagement Activity Undertaken

Engagement Activity Undertaken

Healthwatch and EK360 undertook community engagement activity across a few Kent and Medway , including:

Kent:

- Ashford
- Dover
- Folkestone & Hythe
- Tonbridge & Malling
- Swale

Medway:

Rochester
Gillingham

Further localities continue to be explored through ongoing engagement activity

Key Themes Raised by Residents:

The following themes consistently emerged through community conversations:

- Mental Health and Wellbeing
- Community support, social connectedness and belonging
- Community safety and anti-social behaviour
- Financial Hardship and cost of living pressures
- Access to services, transport and local amenities
- Health ageing and independence
- Children and young people
- Wider Determinants of Health
- Prevention and early intervention

What This Tells Us

Community engagement highlights the issues that matter most to residents and provides an important complement to strategic evidence and population health data. These insights have informed the development of Neighbourhood Health Plan priorities and delivery approaches.

What residents told us

EK360 and Healthwatch place-based engagement identified recurring themes across six local areas.

ENGAGEMENT COVERAGE

Six place-based views

- Ashford
- Rochester
- Gillingham
- Folkestone & Hythe
- Swale
- Tonbridge

Themes varied in prominence by place, but a consistent picture emerged.

COMMON THEMES ACROSS PLACES

Mental wellbeing

A recurring concern across all six areas.

Community connection

Belonging, social cohesion and local networks matter.

Prevention and early support

Residents want support before needs escalate.

Healthy ageing and independence

Remaining independent and supported close to home is important.

Community safety

Safety and the local environment affect wellbeing.

Inequalities and wider determinants

Cost of living, transport and access shape outcomes.

Residents describe health and wellbeing through everyday life, communities and access to local support, not through services alone.

Detailed place-by-place matrix included in the appendix.

From resident insight to shared priorities

Resident insight has informed and reinforced the emerging priorities, alongside strategic, population health and partner evidence.

WHAT RESIDENTS TOLD US

- People are concerned about mental wellbeing and access to support
- Strong communities and social connections matter to health and wellbeing
- Support should be available earlier, before problems become crises
- People want to remain independent and live well for longer
- Cost of living, transport and access to local services affect health
- Local community organisations provide important support

Resident voice

WHAT THIS TELLS US

- Health is shaped by more than health and care services
- Earlier support can prevent deterioration and escalation
- Community assets and VCSE organisations are central to delivery
- A neighbourhood approach is needed to connect support around people

Interpretation

HOW THIS SHAPES THE PLAN

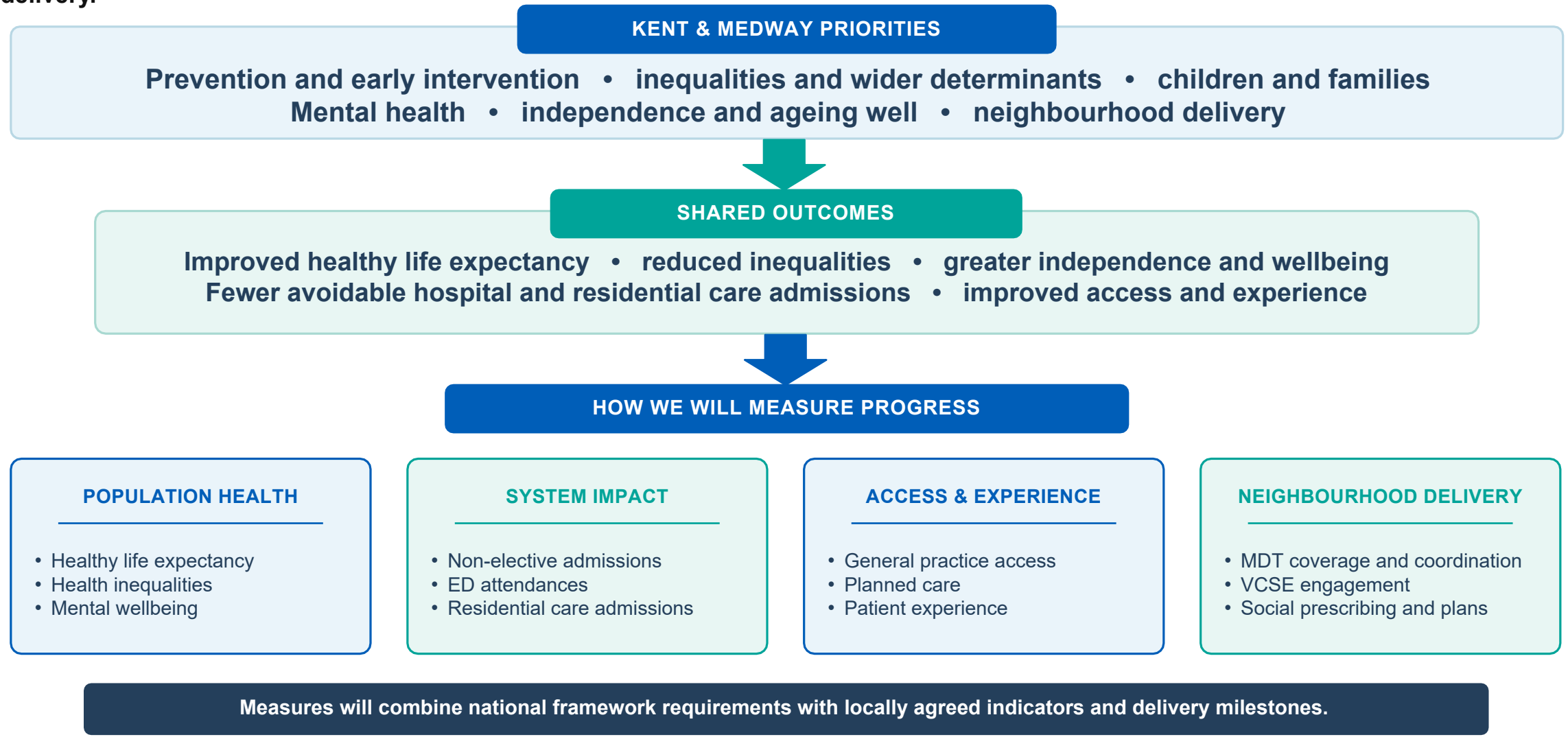
- Prevention and early intervention
- Mental health and wellbeing
- Independence and ageing well
- Inequalities and wider determinants
- Children and families
- Neighbourhood delivery and community capacity

Plan response

Resident insight has informed and reinforced the priorities alongside strategic, population health and partner evidence.

Shared priorities, outcomes and measures

The Plan will connect locally agreed priorities to a small set of shared outcomes and measures, creating a clear line from ambition to delivery.



Measures will combine national framework requirements with locally agreed indicators and delivery milestones.

Kent County Council Adult Social Care priorities:

1. **Delivering** major recommissioning programmes and strengthening market stability, quality and value for money
2. **Developing** our workforce, digital infrastructure and enablers that support safe, efficient and modern practice
3. **Strengthening** practice, safeguarding, decision-making and quality assurance, including delivery of the CQC Improvement Plan
4. **Managing** demand and affordability through better pathways, decision-making and commissioning rather than reliance on in-year savings alone
5. **Shifting** investment upstream through prevention, enablement, community support and technology enhanced lives
6. **Improving** discharge, intermediate care and joint working with health partners to reduce delays and system pressure

A range of key themes, detailed below, present an opportunity to embed Neighbourhood Health into existing activities within the Delivery & Transformation Plan.

Opportunities: Key Outputs from ASC Workshop

- **Prevention and Early Intervention** Focus will shift more to upstream action, with a greater focus on identifying people earlier, supporting rising-risk cohorts and preventing escalation into statutory services recognising a need to "invest to save" and protect prevention activity.
- Neighbourhood health provides an opportunity to strengthen ASC's preventative approach by supporting earlier intervention, targeted support and improved connection to community resources before people reach crisis point.
- **Demand Management, Pathways and Decision Making** There are challenges associated with increasing demand, limited capacity and the need to use resources more effectively. There are benefits in pathway mapping, reducing duplication, simplifying access routes and improving the consistency of decision-making. We should focus professional time on preventative activity by reducing unnecessary processes and improving how people move through health and social care systems.
- Neighbourhood health can support clearer pathways, improved decision-making and more effective management of demand by ensuring people receive the right support at the right time and in the least restrictive way possible.

- **Independence, Enablement and Discharge.** Action must help people remain independent reducing reliance on long-term care with a greater focus on enablement, rehabilitation and strengths-based practice, alongside recognition that hospital admission and discharge pathways represent a key opportunity to intervene earlier and improve outcomes. This includes admission avoidance, prevention at the point of admission, stronger hospital discharge arrangements and investment in community-based support as alternatives to long-term dependency.
- Neighbourhood health can support a seamless pathway that promotes independence before, during and after periods of ill health, ensuring enablement, discharge and community support operate as a single system focused on helping people recover and remain at home
- **Integrated Working and Workforce Culture** We need to break down organisational barriers and work more effectively across health, social care and community partners. Including improving relationships, communication and shared decision-making, with more joint visits, integrated roles and locality-based working. Co-location may enable stronger partnership working. There needs to be some cultural change, with professional trust and greater confidence in strengths-based practice.
- Neighbourhood health can promote integrated ways of working that bring services together around the individual, supported by shared ownership of outcomes, multidisciplinary working and a culture of collaboration.

- **Data, Digital and Population Health Intelligence** Data sharing and digital integration are key enablers of neighbourhood health. Partners need a better understanding of rising risk, unmet need and pathways into services. Partners need to explore integrated data, shared systems, waiting list visibility, AI-enabled solutions and the need for "one version of the truth" to support earlier intervention and coordinated care.
- Neighbourhood health can utilise data, digital technology and population health intelligence to identify people earlier, improve service coordination and support more proactive interventions.
- **Community Capacity, VCSE and Commissioning** Neighbourhood health cannot be delivered without community assets, voluntary organisations and local networks supporting wellbeing, preventing escalation and reducing demand on public services. Opportunities include strengthening VCSE infrastructure, expanding Community Wellbeing Services and using commissioning to create more preventative, community-based support.
- Neighbourhood health can strengthen community capacity by building stronger partnerships with VCSE organisations and commissioning services that support prevention, resilience and independence within local communities.

DRAFT children and young people priorities

1. **Delivering** major recommissioning programmes and strengthening market stability, quality and value for money
2. **Developing** the workforce across the system, digital infrastructure and enablers that support safe, efficient and modern practice
3. **Strengthening** practice, safeguarding, decision-making and quality assurance, including delivery of CYP and SEND reforms
4. **Managing** demand and affordability through better pathways, decision-making and commissioning rather than reliance on in-year savings alone
5. **Shifting** investment upstream through prevention, enablement, community support and technology enhanced lives
6. **Improving** discharge, intermediate care and joint working with health partners to reduce delays and system pressure

A range of key themes, detailed below, present an opportunity to embed Neighbourhood Health into existing activities within the Delivery & Transformation Plan.

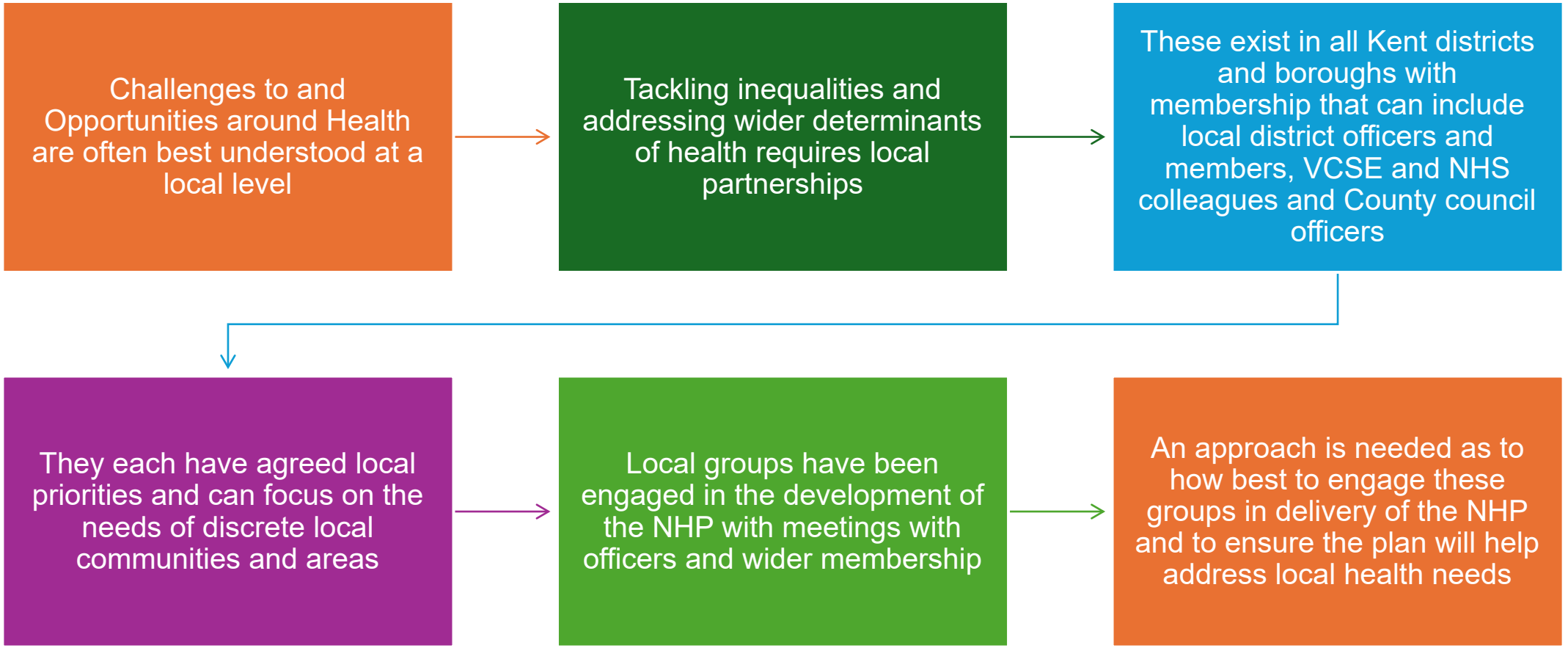
Opportunities

- **Prevention and Early Intervention** Focus will shift more to upstream action, with a greater focus on identifying people earlier, supporting rising-risk cohorts and preventing escalation into statutory services recognising a need to "invest to save" and protect prevention activity.
- Neighbourhood health provides an opportunity to strengthen preventative approach by supporting earlier intervention, targeted support and improved connection to community resources
- Support self management so that families and carers feel able to manage clinical conditions safely and appropriately at home
- **System Integration**
- Coordinate closely across education, social care, and voluntary (VCSE) partners using shared decision-making and streamlined "tell-us-once" navigation for families
- **Demand Management, Pathways and Decision Making**.
- For example, identifying support for children with behaviours that challenge before they go into crisis and end up in hospital and/or placements break down.

- **Timely Community Access:** GPs use integrated neighbourhood teams (INTs) to provide direct, local access to paediatric expertise alongside mental health and community services.
- For example taking an MDT approach to children's care within primary care setting bringing together paediatricians, GPs, social prescribers, social care, mental health services and VCSEF to reduce the number of appointments families are given and ensure a clear consistent care plan is in place and understood by all. **Integrated Working and Workforce Culture**.
- Align neighbourhood teams with community assets like Best Start Family Hubs to support babies and children aged 0 to 5.
- Align neighbourhood health teams with the children's and SEND reforms

- **Data, Digital and Population Health Intelligence** Data sharing and digital integration are key enablers of neighbourhood health. Partners need a better understanding of rising risk, unmet need and pathways into services. Partners need to explore integrated data, shared systems, waiting list visibility, AI-enabled solutions and the need for "one version of the truth" to support earlier intervention and coordinated care.
- Families are able to better navigate the system to access the right support and only need to tell their story once.
- Children with disabilities are clearly flagged within the system and reasonable adjustments are made to meet their need.
- **Community Capacity, VCSE and Commissioning** Neighbourhood health cannot be delivered without community assets, voluntary organisations and local networks supporting wellbeing, preventing escalation and reducing demand on public services. Opportunities include strengthening VCSE infrastructure, expanding Community Wellbeing Services and using commissioning to create more preventative, community-based support.
- Neighbourhood health can strengthen community capacity by building stronger partnerships with VCSE organisations and commissioning services that support prevention, resilience and independence within local communities.

Local Health Partnerships and Alliances



District Alliance Priorities

District	Title
Ashford	Ageing well, Housing, Young People
Canterbury	Health and wellbeing and self-care , Poverty, Homelessness and housing, teenage mental health
Dartford	Building Community Capacity, Dementia friendly community, Healthy Behaviours, Children and families, Older people and Ageing Well, WDH, Food Security, HiAP,
Dover	Healthy Minds, Healthy Weight and Lifestyle, Long Term Conditions
Folkestone and Hythe	Ageing Well, Building Community Capacity, Prevention
Gravesham	Embed a Health in All Policies (HiAP) , Young people, MECC, Longe Term Conditions
Maidstone	Empower communities , improve housing and environment, better partnership work
Sevenoaks	wider determinants of health, lever power of communities, promote healthy behaviour
Swale	Community, Economy, Environment, Health and Housing
Thanet	Employment, Mental Wellbeing, Frailty
Tonbridge and Malling	Improving children's health and healthy weight, Mental health, Age well
Tunbridge Wells	Addictions, Loneliness and isolation, Mental health, Obesity and Physical inactivity, Older people and people with disabilities

Key outputs from discussions with Alliances

- Local partners need consistent defined operational links at PCN level
- VCSE need to be engaged at Strategic level as well as locally
- Folkestone and Hythe holistic pilot approach and learning endorsed
- There is a need to balance clinical and WDH actions
- Mental health, children, housing, education, deprivation and transport issues cited
- Opportunities for coordinated social prescribing to help link PCNs to alliances
- Mapping of local services
- Sustainable funding for local initiatives

- Summary output by Districts engaged is available on link.....

NHS priorities for neighbourhood delivery

NHS services will shift from reactive, hospital-focused care towards proactive, integrated support closer to home.

1 Proactive neighbourhood care

Identify people at greatest risk earlier and coordinate support around frailty, complex needs, care-home residents, long-term conditions, mental health and children and young people.

2 Stronger primary care and urgent access

Improve general practice access, use community pharmacy more effectively and help people reach the right service first time.

3 Community care at greater scale

Bring together urgent response, virtual wards, hospital-at-home, rehabilitation, reablement and discharge support across nine footprints.

4 Planned care closer to home

Use Advice and Guidance, single points of access, straight-to-test pathways and community specialist services to reduce unnecessary hospital appointments.

5 Sustainable delivery

Use data, digital technology, workforce, contracts and funding differently to improve outcomes, productivity and financial sustainability.

SELECTED NATIONAL REFERENCE POINTS

- **10%** fewer admissions and bed days for specified high-priority cohorts by March 2029
- **90%** urgent GP patients seen the same day by March 2027
- **25%** outpatient diversion in ten high-volume specialties by March 2027
- **95%** people with complex needs to have an agreed care plan by 2027

National reference points are for context. Kent and Medway baselines and trajectories will be confirmed through the outcomes framework and annual planning process.

These priorities describe how NHS services will support delivery of the shared Plan, working with councils, providers, primary care, VCSE partners and communities.

From priorities to delivery over three years

Over the next three years, NHS services will move from establishing the model, to expanding it, to making neighbourhood working the normal way care is organised.

2026/27 ESTABLISH AND CONNECT

- Make Single Neighbourhood Health operational for complex and highest-risk populations
- Confirm responsibilities, pathways and escalation arrangements
- Begin urgent access and outpatient reform
- Put data-led commissioning and accountability foundations in place

2027/28 EXPAND AND SHIFT

- Extend proactive care to rising-risk populations, mental health and children and young people
- Implement consistent community and intermediate care
- Move selected planned care and diagnostics closer to home
- Align contracts, workforce and funding with neighbourhood delivery

2028/29 EMBED AND SUSTAIN

- Make neighbourhood care the normal operating model
- Reduce avoidable reliance on hospital-based care
- Provide simpler pathways with fewer hand-offs
- Sustain access, outcomes, productivity and financial balance

HOW SHARED PRIORITIES BECOME NHS DELIVERY

Neighbourhood Health Plan
Agreed priorities, outcomes and model

Three-year NHS plan
Phased pathway, workforce, activity and financial change

Annual commissioning intentions
Specific service and provider expectations

Contracts, investment and assurance
Funding, specifications, measures and oversight

The Kent and Medway Neighbourhood Model

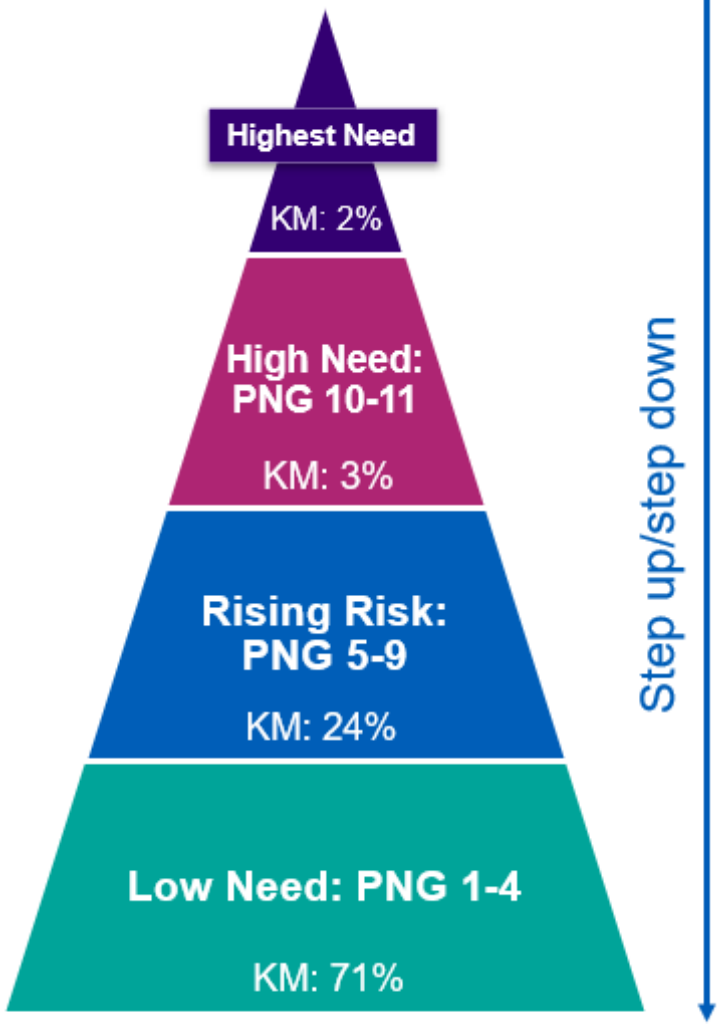
Health and care model, neighbourhood footprints and delivery arrangements

Neighbourhood Health and Care Model

Population Need Group	
	End of Life
	Highest complexity Care Home
11	Frailty
10	Multi Morbidity High Complexity
9	Dominant major chronic condition
8	Dominant psychiatric behavioural condition
7	Pregnancy – High complexity
6	Pregnancy – Low complexity
5	Multi-morbidity medium complexity
4	Multi-morbidity Low complexity
3	Low need adult
2	Low need child
1	Non-user

Patient needs

What are the levels of need in Kent and Medway?



Step up/step down

Care will be:

- Proactive identification and prevention
- Accessible and reliable ongoing care
- Rapid reactive care when needs arise
- The Integrated Neighbourhood Team working with one team ethos.
- Care matched to complexity, delivering the right intervention at the right time
- Improved outcomes, experience and continuity for all patient groups.

Where and by which teams:

- Predominantly out of hospital-general practice, neighbourhood, and people's homes/ care homes.
- GP teams, community health, mental health, social care, pharmacy, Hospice, Acute and voluntary sector partners working together
- Multi-neighbourhood teams provide higher-acuity, hospital-level care at home
- An integrated neighbourhood workforce wraps around patients across, predominantly, out of hospital setting.

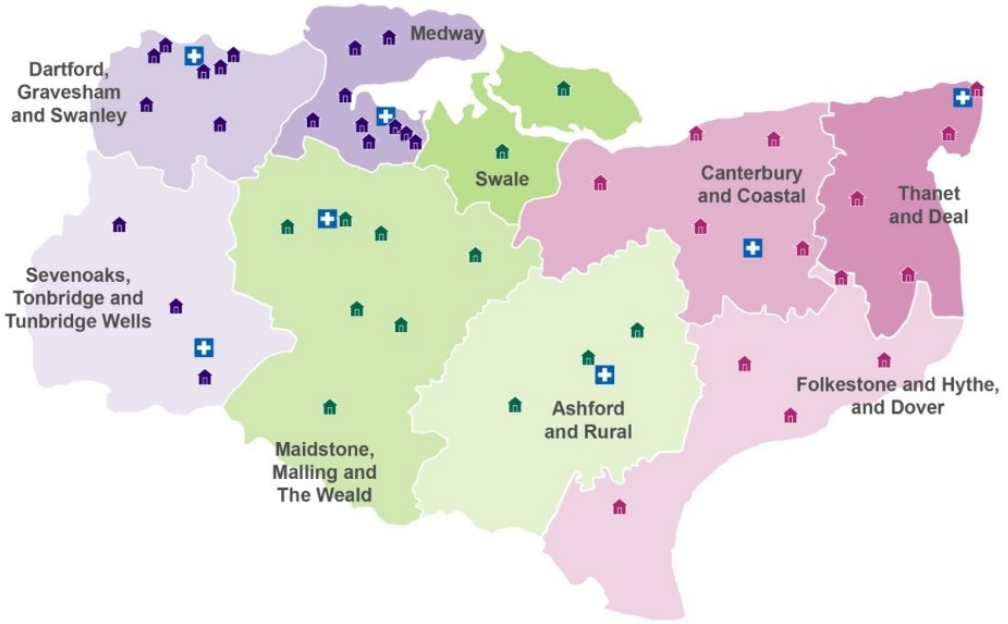
Key enablers

- Modern General Practice Access Model
- Population segmentation and risk stratification
- Digital transformation and interoperability
- Shared records
- Provider collaboratives

- Clinical governance/risk management
- Contracting mechanism / risk sharing
- Workforce
- Finance
- Clinically led
- Estates
- Communication and Engagement

Our neighbourhood footprints

A consistent framework for organising local delivery while reflecting communities, population need and existing partnerships.



	Multi-neighbourhood footprint	Registered patients
1	Dartford, Gravesham & Swanley	297,955
2	Medway	338,780
3	Swale	109,030
4	Canterbury and Coastal	221,200
5	Thanet and Deal	205,020
6	Dover, Folkestone & Hythe	180,890
7	Ashford and Rural	216,000
8	Maidstone, Malling and The Weald	297,990
9	Sevenoaks, Tonbridge & Tunbridge Wells	241,660

SINGLE NEIGHBOURHOODS

45 geographic footprints, each covering around 30,000–50,000 residents and broadly aligned to PCN footprints. They provide the local basis for relationship-based care and partnership working.

MULTI-NEIGHBOURHOODS

Nine wider footprints bring together several single neighbourhoods to coordinate services, workforce and capability that need greater scale.

How single and multi-neighbourhoods work together

The two neighbourhood levels connect proactive health and care services with community assets, prevention and wider support.

PRIMARY CARE › SINGLE NEIGHBOURHOOD › MULTI-NEIGHBOURHOOD › ACUTE HOSPITAL

Support increases as needs change, while maintaining a consistent emphasis on prevention, independence and care close to home.

SINGLE NEIGHBOURHOOD

Proactive and coordinated care for defined populations

- Identifies people who would benefit from earlier, proactive support
- Coordinates support around individuals, families and communities
- Connects primary care, community health, mental health, social care and VCSE partners
- Links clinical care with prevention, wellbeing, community assets and wider support

CONNECTED MODEL ⟷

MULTI-NEIGHBOURHOOD

Scaled services serving several single neighbourhoods

- Provides urgent, specialist and recovery services requiring greater scale
- Coordinates pathways, workforce and resources across neighbourhoods
- Supports diagnostics, rapid response, rehabilitation and hospital-at-home
- Connects local prevention and support with specialist and acute services when needed

Together, the two levels connect local prevention, wellbeing and community support with increasingly coordinated and specialist health and care services as people's needs change.

System Action to support Local Health Partners

Agree mechanism to allow local NHS engagement with local partnership through PCNs/SNTs

Define key lessons from local NHHIP pilots to deliver key system objectives including reduced hospital and residential care admissions, reduces GP attendances and improved, local joined up partnership working.

Develop a coordinated joined up approach to social prescribing

Develop systems with VCSE Alliances and leadership to enable local VCSE partners to play an optimally effective role in improving health

Produce local health profiles at community/PCN level to inform local action

Mental Health

Mental Health Challenges and Opportunities

- Mental health need is rising, increasingly complex and unevenly distributed, with high-risk cohorts, significant hidden need and stark geographic variation driving avoidable pressure across urgent and emergency care and can lead to early deaths.
- MH Conditions are concentrated in areas of deprivation exacerbated by multimorbidity and variation in access/ barriers to access.
- These inequalities make a clear case for shifting to proactive, equitable preventative neighbourhood models that intervene earlier, strengthen community and VCSE support, and reduce reliance on crisis pathways.
- This requires a coordinated whole-system response - spanning acute care, mental health services, primary care, local authorities, VCSE organisations, criminal justice partners, substance misuse, carers and people with lived experience and local residents- working together to build resilient, integrated community-based mental health support.
- There is a significant opportunity to use community assets, hyperlocal alliances, economic development and creative partnerships to strengthen the opportunities and lived experiences of people with mental health problems.

High Level Objectives

Focus is on high-impact objectives where local and national evidence shows the greatest opportunity to move activity away from crisis pathways:

- **Reducing avoidable Emergency Department presentations and inpatient bed occupancy** through enhanced neighbourhood and primary care mental health support, including Assist & Embrace and short-term step-down alternatives to prolonged KMMH admission.
- **Establishing a sustainable, well supervised Additional Roles and Reimbursement Scheme (ARRS) mental health practitioner workforce** in primary care, protecting and growing these roles and using new GP contract flexibilities to support future expansion.
- **Using best evidence and research to tackle suicide and self harm and deaths from despair**– strategically and locally – increasing opportunities to ensure people get help earlier, better mental health networks, peer support, training and community assets and enhancing the LIVE WELL model.
- Additionally, Linked to Long Term Conditions, **Reshaping the dementia pathway** by closing the post diagnostic support gap and rebalancing delivery between KMMH and VCSE partners, enabling specialist teams to focus on evidence based clinical interventions while community organisations provide personalised support closer to home.

Priority 1: ED presentations and step-down beds

- Develop short term step-down bed offer that enables clinically ready-for-discharge patients to move from acute wards into a transitional setting for assessment, stabilisation and discharge planning.
- Trust-wide extension of Assist & Embrace model alongside a new Start-Afresh CBT/ACT clinic to provide early stabilisation, psychological support and co-produced safety planning for people at risk of crisis escalation, reducing inappropriate ED presentations and supporting safer, more timely transitions back into community care.

Impact across the pathway:

- Improving flow and discharge- through short-term step-down capacity that release acute beds, reduce CRFD related pressure and prevent high-cost private placements.
- Crisis-prevention models –reducing inappropriate ED presentations and preventing avoidable discharge.
- Targeted upstream flow-improvement interventions – reducing OOA placements and LOS and improving system flow.

Priority 2: Dementia Pathway

Kent and Medway already have several initiatives underway that provide a strong foundation for a neighbourhood-based dementia model:

- 43 VCSE Dementia Care Coordinators (DCCs) across all 42 PCNs providing proactive case management, navigation, carer support and continuity from pre-diagnosis to end-of-life. Focus is on wider, non-clinical need, enabling specialist teams to focus on diagnosis, medication and complex presentations. There are also Hospital Dementia Coordinators including at Darent Valley Hospital
- Community Wellbeing Service: A county-wide VCSE wellbeing service offering early help, social connection, lifestyle support, benefits advice, housing guidance and carer support providing a ready-made infrastructure for neighbourhood dementia support, strengthening prevention and reducing isolation. The service is being redesigned for launch late 2027.

- NNHIP Dementia Transformation Programme testing how specialist mental health expertise can be embedded within neighbourhood teams:
  - Level 1: Dementia support in care homes
  - Level 2: Community diagnostic pilot delivering “diagnosis closer to home through neighbourhood teams” and MDT decision-making supported by secondary care
  - Level 3: Specialist oversight, advanced practitioners and consultant input integrated into neighbourhood MDTs

The NNHIP programme has shown that effective dementia pathways require “primary care, mental health, community, social care and VCSE partners to work as a single system.” This learning directly supports the shift towards neighbourhood-based post-diagnostic support.

Proposed Model for Dementia Pathway:

- Improve ascertainment of people with dementia increasing levels of diagnosis to the level of peers.
- The mental health trust to deliver assessment, diagnosis, medication and CST (cognitive stimulation therapy). Living Well with Dementia to be delivered by partners.
- The model protects evidence-based clinical interventions, makes efficient use of specialist capacity, and strengthens neighbourhood-based support. Delivery will require upfront investment and/or system-wide savings if elements of the model are delivered by partner organisations, ensuring the neighbourhood-based capacity needed to achieve the intended benefits is fully funded and sustainable.
- Ensure strong carer support learning from the recent Carers' Health Needs Assessment.

Priority 3: ARRS Mental Health Practitioners

- Standardisation of the ARRs roles (with room for local tailoring), specific links into MHT including formal supervision, and a single identified link person in each neighbourhood
- Mental Health Practitioners will receive formal, structured clinical supervision from KMMH, embedded as a core requirement agreed with GP partners to ensure consistency, safety and sustainability across neighbourhoods. This will provide clear clinical governance, strengthen links between primary and secondary care, and address the isolation and variability highlighted in previous reviews.
- Retire the “MH ARRS” label, which carries stigma and does not reflect the breadth or purpose of the role. A refreshed role identity will support clearer communication with patients and staff, improve professional recognition, and reinforce the practitioner’s function within integrated neighbourhood mental health teams.

Live Well (a wraparound easy to access Early Help approach to well being)

- Live Well Kent & Medway: A county-wide VCSE wellbeing service offering early help, social connection, lifestyle support, benefits advice, housing guidance and carer support. LWK provides a ready-made infrastructure for neighbourhood well being support, strengthening prevention and reducing isolation.
- Easy step up and step down access to mental health support, advocacy and recovery – linking community support to talking therapies
- No Wrong Door approach – trauma informed and peer led approaches to well being and resilience

Further Priority actions

- Enhanced costing and activity modelling for ED step-down beds, ARRS roles and dementia post-diagnostic support, including assumptions on flow, length of stay, avoided admissions and reduced out-of-area placements.
- Development of a clear outcomes and impact framework with defined KPIs to track changes in ED presentations, repeat attendances, crisis escalation and continuity of care.
- Further analysis of high-risk cohorts driving ED activity — including self-harm, trauma-related distress, complex emotional needs and long-term conditions linked to health anxiety - distinguishing between those known and unknown to KMMH and identifying gaps in earlier contact.
- Alignment of the proposed model with the ICB's mental health commissioning review to ensure future commissioning intentions support neighbourhood-based prevention and early intervention.
- System-wide collaboration to develop the detailed investment ask, recognising that recurrent funding requirements will ne

Potential Community Action in Neighbourhoods

Many local Alliances/Partnerships have mental health as a priority, proposed actions to be considered could include:

- Rapid local asset mapping—of trusted routes, gaps, local connectors and opportunities.
- Agree one public mental health “proof of practice” with a defined cohort, local delivery partners, intervention, equity objective, outcome measure and learning plan.
- Strengthen trauma-informed practice, stigma reduction, social connection and community resilience through existing local infrastructure rather than stand-alone NHS schemes.
- Connect this explicitly to existing prevention programmes: suicide prevention, substance misuse, gambling harm, domestic abuse, family support, employment, cultural and physical activity partnerships.

Neighbourhood clinical-community integration

- A route into early help that does not depend solely on specialist thresholds.
- Understanding and implementing links to NHS Talking Therapies and social prescribing and recovery planning
- A defined process for bringing people with complex, repeated or escalating need into an MDT.
- A named coordinator/keyworker and shared recovery plan for the agreed high-need cohort.
- A physical-health and medicines offer for people with serious mental illness.
- Clear links between primary care, community mental health, social prescribing/Live Well, substance misuse, housing and VCSE.
- A robust step-down and post-crisis follow-up arrangement.

Areas for further work

- Primary , specialist and urgent care need to be fully integrated
- Prevention of Suicide, self harm and deaths with despair need to be a key focus
- Every person needs a recovery plan with 72 hour follow up for people who self harm
- A clear plan is needed for people with Addictions
- Ensure optimal adherence to NICE depression pathway in primary care

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LOCAL PILOTS NNHIP and CHATHAM ACCELERATOR

National neighbourhood health implementation programme

Scope:

Build a trusted INT in all 3 District PCNs built on good relationships focussed on the needs of our population providing proactive, reactive and an improved outpatient service model.

Aim is to develop a real world *minimum viable product* of a proactive and reactive cohesive INT and test new outpatient approaches in the Folkestone District during the NNHIP programme. Initial focus will be those with complex needs and frailty, bringing community health, care and VCSE assets together.

QI approach to all 3 workstreams, proactive, reactive and outpatients.

Practical work on key enablers including digital infrastructure (IT), and better use of estate.

The work is delivered through a QI approach and is **data driven for all 3 workstreams, proactive, reactive and outpatients.**

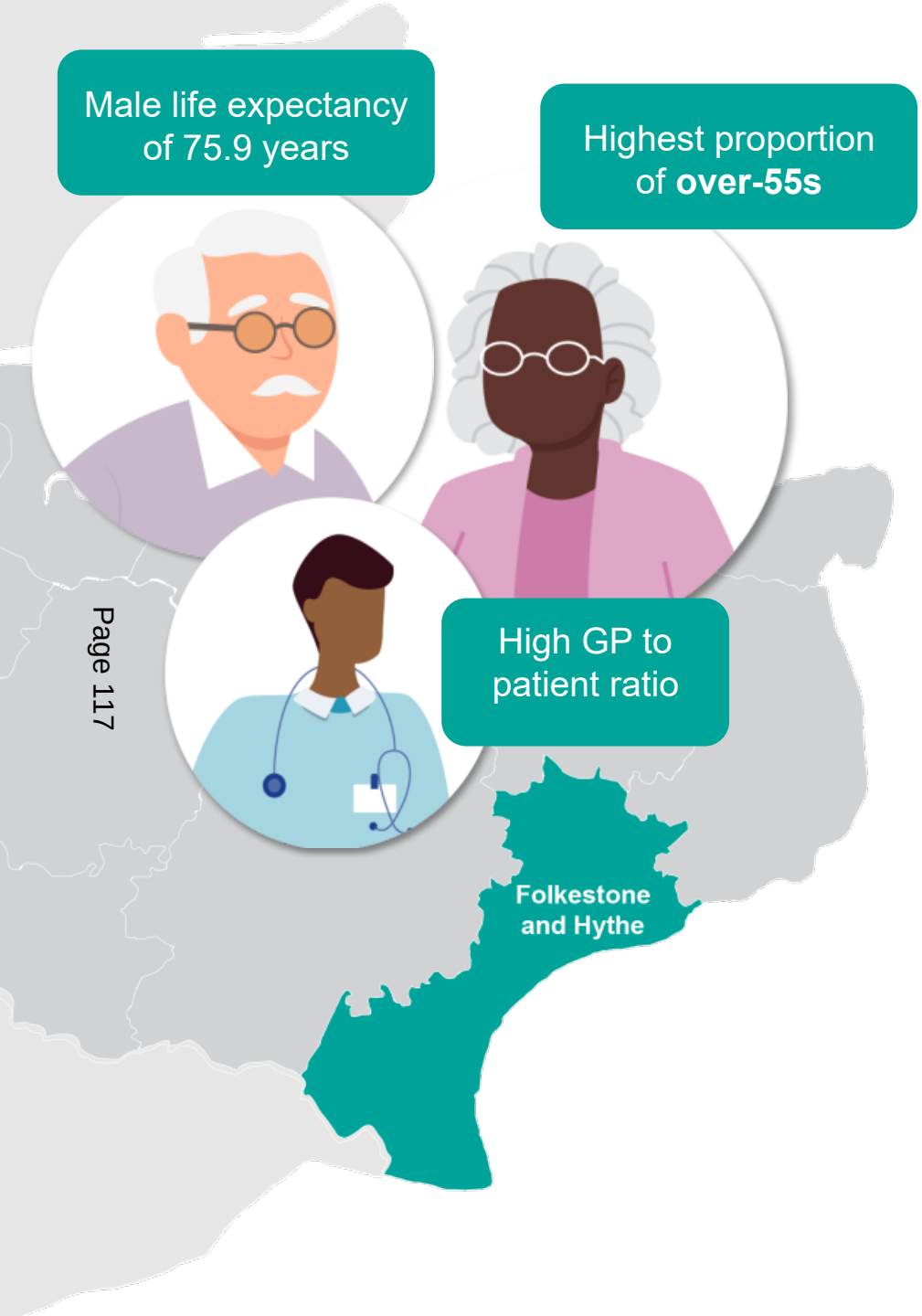
Impact is monitored monthly through a **dashboard** which includes key metrics - people's and staff experience, impact upon unplanned emergency attendance, length of stay and admission to hospital initially for the most complex population cohort.

PDSA testing of change ideas
PDSA 1 – Coordinator role alignment
PDSA 2 – Shared assessment
PDSA 3 - Directory of services
PDSA 4 – Social MDT
PDSA 5 – Patient voice
PDSA 6- Children's and young people

PDSA testing of change ideas
PDSA 1 – Co-location
PDSA 2 – Cohort identification
PDSA 3 –Additional services
PDSA 4 – Directory of services
PDSA 5 – Management of CMR

PDSA testing of change ideas
PDSA 1 – Community out-patient appointments
PDSA 2 – Alternative out-patient provision
PDSA 3 – Patient activation
PDSA 4 – Digital literacy
PDSA 5 – Making every contact count

Next attachment



Folkestone and Hythe District

26 miles of coastline, 4.7million visitors every year and growing in popularity. Distinct communities – urban, rural and coastal geography

Health inequalities

Third highest levels of deprivation across Kent and Medway with some of the lowest life expectancy rates.

Residents experience higher rates of cancer, hypertension, stroke and COPD.

Workforce and demand:

Substantial workforce challenges

3 Primary Care Network area coterminous with District Council Boundary.

GP to patient ratio is **1 to 2637** for the Marsh, 2,695 for Folkestone, Hythe and Rural and 2901 for Total Health Excellence West.

The local acute hospital is William Harvey Hospital. Experiencing some of the most extreme pressure in 12 hour waits in the country

Ageing population

Highest proportion of **over-55s** in county, with **42 care homes** across the district

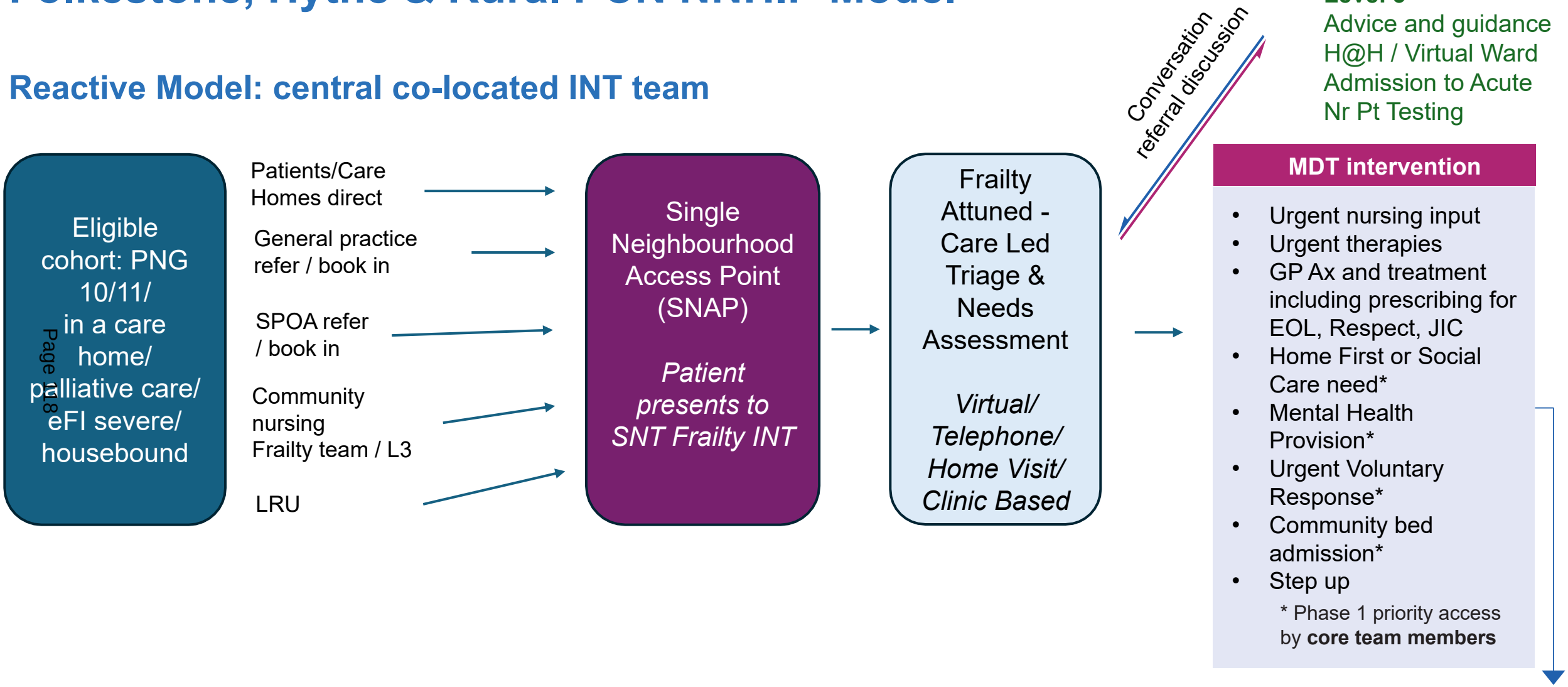
25% is **over 65** and projected to grow the fastest in Kent in the next decade.

48% rise in social care costs **by 2035** projected.

Over 50 care homes – KCC alone place over 400 people across the district

Folkestone, Hythe & Rural PCN NNHIP Model

Reactive Model: central co-located INT team



Proactive Model: Case Finding

Review of “Top 100” from eligible cohort based on mortality risk score to ensure core interventions (e.g. CGA, ReSPECT, Structured Medication Review) in place or offered alongside other appropriate action, e.g. MDT referral

The Proactive Workstream - Total Health Excellence West (THEW) PCN

Discover:
Building on developed proactive neighbourhood MDT, workshops held to identify next steps for improvement and expansion of the model. Areas of success and strength identified in existing model for both adults and children's MDTs.

Design: Key areas of focus identified. These were:

- Integrating workforce further improving collaborative neighbourhood working
- New approach to patient voice
- Digital integration & shared information systems – CGA usage, TEAMs channel
- Widen remit to include reactive element for Complex Care patients
- Children's care MDT considering next improvement aims e.g. reduction in school non-attendance

Deliver: A series of improvement initiatives have started building on existing work and starting new ideas:

- Review of Care Coordinators, Social Prescribers and Age UK Care Navigators to support a one team approach. Engagement with KCC, KCHFT, Age UK and Involve Kent. Single job description.
- Directory of Service – using the JOY platform if compatible with EMIS Clinical Services to build local DOS accessible to all partners
- THEW testing a Social MDT held a staff workshop to support initial design and team development.
- Test single initial assessment across all teams for proactive work
- Patient Participation Group support with identifying opportunities for wider patient and public engagement, including harder to reach communities
- Continuing the MDT's and sharing of the learning with all PCN's across Folkestone and Hythe
- Data driven, early signals in data of reduction in cohort admissions

The Outpatient Workstream – The Marsh PCN

Discover:

Residents reported that accessing care can be difficult due to travel requirements for outpatient appointments, poor coordination between services, communication challenges, appointment booking difficulties, and digital exclusion, all which impact experience and accessibility of care.

Design: Key areas of focus identified.

These were:

- Pre-operative assessment appointments closer to home
- Supported discharge/admission avoidance
- Improved support for patients diagnosed with pre-diabetes/diabetes
- Mental health appointments closer to home
- Accessible Oncology care

Deliver: A series of improvement initiatives have been identified and designed to bring care closer to home, improve coordination between services and test more integrated ways of working:

- Pre-operative assessment – hybrid pathway between the PCN and EKHUFT enabling clinically suitable elective patients to complete elements of their pre-op assessment at a local GP practice.
- Safe to be at home model - designed to enable supported discharge and admission avoidance. The service will provide non-regulated interventions to help people with complex needs to return home sooner.
- Community diabetes improvement - a quality-improvement workstream responding to the Marsh's higher-than-average prevalence of diabetes and pre-diabetes. Delivery includes mapping the current pathway and agreeing priorities for targeted improvement.
- Mental health care closer to home - a six-month test offering eligible patients the choice of attending face-to-face or group Mental Health Together appointments at the Lighthouse on the Marsh rather than travelling to Folkestone or Canterbury.
- Locally accessible oncology support - new-patient conversations and pre-chemotherapy clinics in New Romney, alongside work to improve transport information and support for people travelling to hospital for treatment or outpatient appointments

NNHIP Model - Challenges and Lessons Learned (Note: Pilot still live)

Successful neighbourhood integration requires more than aligning services. It is dependent on shared clinical models, clear roles, compatible infrastructure, accessible estates and a unified cultural shift toward collaboration.

- Estates locally – access to space and associated funding/governance arrangements owing to fragmented estates portfolios across the geography.
- Variance in understanding of urgent care provision through primary care lens vs community staff.
- Clinical responsibility/risk management when adopting news ways of working different to contractual terms. Roles and responsibilities need clarification, so all know the scope of the team/individuals.
- Operational barriers are not typically easy to resolve, especially in a timely manner, e.g. blood tests, primary care IT for community staff, data sharing and information governance processes across systems.
- Challenge to integrate teams at pace to adapt to new ways of working and obtaining estate and resource to enable co-location of staff.
- Data/evidence challenge – quantitative evaluation data is difficult to obtain from EMIS, which is an operational system for primary care which by nature is not episodic, unlike many other healthcare systems which operate with defined pathways.

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Holding slide for Chatham Accelerator pilot

Hi level phasing

The following organizes the effort around five domains of focus together with six enabling workstreams that will need to be addressed. It sets out a phased approach to implementation that builds upon a critical path of development as well as an engagement approach that generates both "bottom up" engagement and learning as well as "top down" strategic direction.

Phased implementation approach:

- **Shorter term (0 – 12 months)**: Focus on establishing the governance and **leadership** of Neighbourhoods, identifying the geographical neighbourhood boundaries and building momentum **and engagement among frontline teams**
- **Medium term (6 months – 2 years)**: Focus on defining the core neighbourhood **delivery model** through a PDSA test and learn approach, **engagement of residents and communities** in co-production of interventions, and expansion of model to effectively **align with system partners**
- **Longer term (1 – 3+ years)**: Focus on **embedding a prevention** focus, use of digital and other tools, **re-alignment and devolution of neighbourhood budgets** and the measurement of impact and evaluation

Engagement layers:

- **Frontline team engagement**: Protected time and headspace to attend PDSA-focused workshops, reflective learning events and facilitated support to test and learn from different neighbourhood models. Collation of best practice models and systemic barriers to progress
- **Operational management engagement**: In addition to attendance at PDSA-focused improvement events, specific coaching and mentoring to build capacity and capabilities across both managerial and clinical/professional leads
- **Senior leader engagement**: Support for scale and spread of best practice models and resolution of systemic barriers, prioritisation of resources to support “left shift”, development of strategic direction of travel in line with learning from the frontline, coaching and mentoring for senior leaders

Illustrative Place/Neighbourhood delivery roadmap – BASE PLAN

Focus of workstream
Maturity Domain
Maturity Enabler

High-level Place and Neighbourhood development roadmap

Shorter term (0 – 12months)

- Leadership, structure and neighbourhood definition
- 1: Develop population health understanding by team
- 2: Agree core team membership
- A: Establish neighbourhood governance and leadership
- B: Map current digital systems, PHM tools – establish data foundations
- E: Mobilise Neighbourhood workforce

- Intelligence, infrastructure and workforce model
- 1: Establish population health management capability
- 2: Develop neighbourhood interventions and model
- 3: Community-led co-production
- C: Identify and engage physical and community assets
- D: Align commissioning intentions
- F: Develop shared outcomes framework

Critical Outputs
- Neighbourhood geographies confirmed
- Leadership, governance and agreed vision in place
- Initial population understanding

Critical Outputs
- PHM priority cohorts defined
- Neighbourhood model development
- Data foundations in place
- Agreed outcomes framework

Medium term (6 months – 2 years)

- Identify integrated neighbourhood core offer
- 2: Identification of neighbourhood blueprint/core offer
- 4: Identify resident & patient engagement approaches
- 5: Improve alignment of teams with acute, VCSE, social care partners
- B: Systematise use of digital and data tools e.g. neighbourhood dashboards
- E: Focus on collaborative leadership and team behaviours

- Mainstream & expand neighbourhood working
- 2: Accelerate and expand implementation of model
- 3: Continue iterative community-led co-production cycles
- 4: Continue resident & patient activation activities
- C: Co-location and hub development aligned with redesigned pathways
- D: Consider opportunities to delegate neighbourhood budgets
- F: Begin programme evaluation

Critical Outputs
- Neighbourhood core offer identification
- Collaborative leadership & culture development
- Resident and patient engagement

Critical Outputs
- Neighbourhood model expanded and embedded
- Strong community role in care delivery
- Opportunities and mechanisms to delegate budgets identified

Longer term (1 – 3+ years)

- Integration and resource alignment
- 1: Refine PHM and cohort prioritisation with prevention focus
- 5: Further develop neighbourhoods in support of care pathways
- D: Ensure commissioning and investment is aligned
- E: Shared workforce planning across system to support neighbourhoods

- Evaluation, learning and scaling of model
- 3: Scale community capacity and prevention programmes
- 4: Expand self-management and digital support
- A: Ensure leadership and governance continues to be fit for purpose
- F: Evaluation of outcomes, experience and activation measures

Critical Outputs
- System and pathway alignment with neighbourhoods
- Identification of resource and investment opportunities

Critical Outputs
- Measurable outcomes & activation improvement
- Leadership & governance arrangements aligned
- Expanded community capacity & prevention focus

Leadership & senior teams: Set strategic direction, foster permissive culture, establish cross-sector governance and accountability frameworks, unblock systemic barriers leveraging support of local, regional and national partners

Operational management: Specific investment in leadership development, collaborative working, enabling innovation and a learning culture

Frontline teams: Frontline trust and relationship development, PDSA test and learn, protected headspace to consider neighbourhood delivery model and new ways of working, bottom-up generated insight and interventions

Programme Management and Oversight

Delivery Journey

The Plan describes a phased three-year transformation journey which will evolve as neighbourhood delivery matures across Kent and Medway.

Year	Focus
Year 1	Foundations and highest-risk cohorts
Year 2	Expansion of neighbourhood delivery, including CYP
Year 3	Mature neighbourhood model

The neighbourhood model should describe a long-term transformation journey, recognising that neighbourhoods are starting from different levels of maturity and that implementation will be phased over several years. Existing local partnership arrangements should be supported and built upon rather than replaced.

Enablers

- Integrated Data and Data Sharing
- Future of KMCR and John Hopkins tool
- IAG solutions
- VCSE Infrastructure

Governance and accountability

Proposed arrangements for strategic ownership, partnership stewardship and delivery assurance

How the Plan will be governed

The Health and Wellbeing Boards provide strategic ownership; councils, the ICB and wider partners jointly steward the Plan; and the Programme Board coordinates implementation and assurance.

Proposed roles and responsibilities

The table sets out the proposed contribution of each partner. Formal decision rights, delegated authority, membership and escalation routes will be confirmed through supporting terms of reference.

PARTNER / GROUP	PROPOSED CORE RESPONSIBILITY
Health and Wellbeing Boards	Strategic ownership of the locally owned Plan; align it with JSNAs and joint local health and wellbeing strategies; oversee progress against agreed population outcomes.
Kent and Medway councils	Bring statutory responsibilities, population intelligence and local priorities; lead prevention, inequalities and wider determinants; align relevant council plans and services.
Integrated Care Board	Align NHS strategic commissioning, planning and investment with the Plan; commission and assure NHS delivery; support data, finance and system-wide enablers.
Neighbourhood Health Collaborative Board	Coordinate development and implementation; maintain the programme plan, dependencies and risks; consolidate assurance and escalate issues to the appropriate statutory body.
NHS providers and Provider Alliances	Co-design and deliver provider contributions; coordinate pathways, workforce and service transformation; provide assurance through existing provider governance.
Health Alliances and local partnerships	Shape local priorities and action; connect district, primary care, VCSE and community partners; support local coordination, engagement and feedback.
Single and Multi-Neighbourhood Teams	Translate the Plan into operational delivery for defined populations; coordinate multidisciplinary activity; test and improve local models; report outcomes, risks and learning.
VCSE, communities and people	Co-produce priorities and delivery approaches; contribute community assets, insight and services; provide feedback on access, experience and what matters locally.

Appendix/ Link

Outputs from meetings with local Alliances

Key Messages from local Health Alliances and partnerships

- **Ashford** Partnership would benefit from more consistant support from NHS leads and PCN reps. Currently have 1 year action plan. Will use current Alliance structure for now but aware will need to change as LGR develops. PH input and support to the Alliance is recognised and applauded.
- **Maidstone.** Who will set priorities and how will they be funded, how will Alliance link with NHS locally, Need to ensure VCSE have key role in strategic commissioning
- **Dover.** Need to align with Pride in Place initiative, need to shift resources with balance focus Kent and Medway wide and local, challenge around access dentist for children, Positivity around F and H pilot and desire that learning from this influences system including strong engagement PCNs with wider local partners and workforce aligned to local needs. Children's navigators mentioned. Recognition cost of VCSE activity, importance of involving local stakeholders in agreeing approach.
- **Gravesham.** Links needed at SNP level to ensure local focus, improve PCN engagement and NHS links with local partnership, bottom-up community led approach is important, need balance of actions between WDH and clinical. Further iterations of local priorities underway, value in qualitative metrices

Key Messages from local Health Alliances and partnerships

- **Folkestone and Hythe**, pilot well considered. Have SPOA with joined up statutory and VCSE working. VCSE integral and need resources, link at ICB level welcomed. Heterogeneity area noted with challenged Romney Marsh around transport and access. Many partnership groups/initiatives within local system may need better join up. Need strong PCN buy in to Alliance and wider working, MH and children issues need focus

- **Thanet,** Strong leadership, Alliance is seen as strategic, PCNs recognise importance WDH but little time to deliver on this, working with the willing in first instance, social prescribers important in delivering wider health and as link to primary care teams with local coordinated approach planned. Strong desire to have full PCN engagement starting with willing. Opportunity for GP surgeries to share local health information with the public.

- **Swale,** ensure mapping of local services already operating in communities that align with system priorities, improve collaboration, use existing local data to understand residents experiences and priorities. The value of the local partnership in collaboration, partnership working, information sharing and collective awareness was raised. Key local barriers to health included funding, transport and education. Recommendations around actions NHS and local partnership can take together included improved communication, service coordination, planning, resident engagement, outreach and use of local intelligence

Key Messages from local Health Alliances and partnerships

- **Canterbury**. Good PCN links with Alliance, Focus needed on wider determinants of health, particularly housing, employment and deprivation. PCNs face increasing pressure to prioritise complex care and frailty with new local contract. Sustainable funding needed for community-based interventions. Stronger neighbourhood working essential. VCSE critical role but faces funding and connectivity challenges, Social Prescribers are a key in linking healthcare with community. Improved coordination around funding opportunities
- **Tunbridge Wells.** Would benefit from improved links with the NHS. Have mental health navigators linked to the health action team partnership but not PCNs or SPOA to NHS leadership. Concern re low GP numbers and how VCSE can best link with primary care operationally with examples from maternity and mental health charities. Rural access to services, access for people who have deafness and women's health cited as issues. Opportunities around creative health mentioned

Summary of Public View of Health Determinants

What Residents Told Us: Emerging Themes from Place-Based Engagement

Theme	Ashford	Rochester	Gillingham	Folkestone & Hythe	Swale	Tonbridge
Mental Wellbeing	●	●	●●	●	●	●●
Community Connection & Social Cohesion	●●	●		●	●●	●●
Community Safety	●	●●	●●		●●	
Crime & Anti-Social Behaviour	●	●●	●●		●●	
Healthy Ageing & Independence	●●	●		●		●
Children & Young People	●				●●	
Prevention & Early Intervention	●		●	●	●●	●
Wider Determinants of Health	●●	●●	●●	●●	●●	●
Health Inequalities	●		●●	●●		●
Cost of Living / Poverty				●●		
Food Security				●●		
Transport & Access	●●			●		
Community Assets / VCSE Support	●			●●	●	●●

● = Theme identified

●● = Strong or dominant theme

Source: EK360/Healthwatch

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Health and Wellbeing Board – Work Programme 2024 – 2027

Frequency	Item	Typical Timing	Notes
Every Meeting	Introduction	Each meeting	Routine committee business.
Every Meeting	Apologies and Substitutes	Each meeting	Standing agenda item.
Every Meeting	Declarations of Interest	Each meeting	Standing agenda item.
Every Meeting	Minutes of Previous Meeting	Each meeting	Standing agenda item.
Every Meeting	Director of Public Health Update	Each meeting	Standing update item.
Every Meeting	Work Programme Review	Each meeting	Standing update item – review of upcoming items
Annual	Membership Review / Renewal	First meeting of the HWB after 1 April	Annual confirmation of Board membership.
Annual	Appointment of Co-opted Members	First meeting of the HWB after 1 April	Annual renewal of co-opted membership.
Annual	Election of Chair	First meeting of the HWB after 1 April	Constitution requires annual election.
Annual	Election of Vice-Chair	First meeting of the HWB after 1 April	Constitution requires annual election.
Annual	Joint Strategic Needs Assessment (JSNA) Review / Exception Report	Early calendar year	Annual review of JSNA and any significant changes.
Annual	Better Care Fund (BCF) Sign-off and Governance	As required within BCF cycle	HWB required to approve/sign off arrangements.
Every 3 Years	Pharmaceutical Needs Assessment (PNA)	Statutory cycle 2025, 2028, 2031, 2034, 2037, 2040, 2043, 2046, 2049, 2052, 2055, 2058	Review, consultation, approval and publication of the PNA. Agreed February 2025 (next date 2028)
When required	Joint Local Health and Wellbeing Strategy Refresh *Decision taken by KCC that the Kent and Medway Integrated Care Strategy (ICS) 2024-2026 be used as the as the Kent Joint and Wellbeing Strategy (JLHWS) – 23/00091 (2024)* *Delivery Plan – 24/00115*	Strategic cycle	Review and refresh of the Health and Wellbeing Strategy Care Strategy. The Joint Strategic Needs Assessment (annual review) is the evidence base that underpins the Joint Local Health and Wellbeing Strategy. Annual JSNA review and exception reports enable the Health and Wellbeing Board to monitor changes in local need and determine whether any amendments to the strategy are required.

25th April 2024		
No.	**Item**	**Additional Comments**
1	Introduction	Routine Committee business
2	Appointment of co-opted member(s)	Requires renewal for Dr Bowes' continued membership – See 19.18
3	Election of Chair	Requires renewal (meeting post 1 April) – See 19.31
4	Election of Vice-Chair	Requires renewal – See 19.31
5	Apologies and Substitutes	Routine Committee business
6	Declarations of Interest	Routine Committee business
7	Minutes of the meeting held on 6 December 2023	Routine Committee business
8	Director of Public Health Verbal Update	Routine Committee business
9	Joint Local Health and Wellbeing Strategy for Kent	
10	Integrated Care Strategy Delivery Plan	
Include in item 10	Board Development	
11	Safeguarding Adults Board Annual Report	
12	Kent Safeguarding Children Multi-agency Partnership Annual Report	(removed – no longer requires to be presented at the KH&WB)
15th October 2024 (CANCELLED)		
No.	**Item**	**Additional Comments**
1	Introduction	- Routine Committee business
2	Membership	- Members will be asked to note that Mrs Penny Cole has joined the Kent Health and Wellbeing Board to fill the long-standing vacancy
3	Apologies and Substitutes	- Routine Committee business
4	Declarations of Interest	- Routine Committee business
5	Minutes of the meeting held on 25 April 2024	- Routine Committee business
6	Director of Public Health Verbal Update	- Routine Committee business
7	The Kent Health and Wellbeing Board function	-
8	Kent Health and Wellbeing Board Work Programme	- Routine Committee Business (for noting only)
11th February 2025		
No.	**Item**	**Additional Comments**

1	Introduction	- Routine Committee business
2	Apologies and Substitutes	- Routine Committee business
3	Declarations of Interest	- Routine Committee business
4	Minutes of the meeting held on 15 October 2024	- Routine Committee business
5	Director of Public Health Verbal Update	- Routine Committee business
6	Joint Strategic Needs Assessments (JSNA)	- Reviewed annually – HWB Decision
7	Pharmaceutical Needs Assessment Decision	- HWB Decision (every 3 years)
25th September 2025		
No.	**Item**	- Additional Comments
1	Introduction	- Routine Committee business
2.	Membership	- Requires annual renewal (meeting post 1 April) – See 19.31
3	Appointment of co-opted member(s)	- Requires renewal for Dr Bowes' continued membership – See 19.18
4	Election of Chair	- Requires annual renewal (meeting post 1 April) – See 19.31
5	Election of Vice-Chair	- Requires annual renewal (meeting post 1 April) – See 19.31
6	Apologies and Substitutes	- Routine Committee business
7	Declarations of Interest	- Routine Committee business
8	Minutes of the meeting held on 11 February 2025	- Routine Committee business
9	Director of Public Health Verbal Update	- Routine Committee business
10	Pharmaceutical Needs Assessment Decision (sign off)	
11	Transformation Programme update	
12	Update from the Integrated Care Board on the NHS 10 Year Plan	
4th March 2026		
No.	**Item**	- Additional Comments
	Introduction	- Routine Committee business
1	Apologies and Substitutes	- Routine Committee business
2	Declarations of Interest	- Routine Committee business
3	Minutes of the meeting held on 25 September 2025	- Routine Committee business
4	Director of Public Health Verbal Update	- Routine Committee business
5	Joint Strategic Needs Assessment – Annual exception report	
Thursday 23rd July (additional HWB requested)		
No.	**Item**	- Additional Comments
	Introduction	- Routine Committee business
1	Membership	- Requires annual renewal (meeting post 1 April) – See 19.31
2	Appointment of co-opted member(s)	- Requires renewal for Dr Bowes' continued membership – See 19.18
3	Election of Chair	- Requires annual renewal (meeting post 1 April) – See 19.31

4	Election of Vice-Chair	- Requires annual renewal (meeting post 1 April) – See 19.31
5	Apologies and Substitutes	- Routine Committee business
6	Declarations of Interest	- Routine Committee business
7	Minutes of the meeting held on 4th March 2026	- Routine Committee business
8	Director of Public Health Verbal Update	- Routine Committee business
9	Kent Health and Wellbeing Board – Terms of Reference (ToR) and Priorities	- HWB decision to endorse proposed changes
10	Development of the Neighbourhood Health Plan	
11	Update on the Marmot Review	
30th September 2026		
	Item	**Additional Comments**
	Introduction	- Routine Committee business
1	Membership	- If the ToR are agreed by Selection and Member Services and Full Council, the new HWB will be in place with new membership . - Updated September 2026 – announcement from government that LGR is to be paused. ToR to be deferred to later S&M services Oct 2026 and Full Council 5th Oct once membership reviewed following announcement on LGR.
2	Apologies and Substitutes	- Routine Committee business
3	Declarations of Interest	- Routine Committee business
4	Minutes of the meeting held on 23rd July 2026	- Routine Committee business
5	Director of Public Health Verbal Update	- Routine Committee business
6	Priorities of the Kent Health and Wellbeing Board	**HWB Priorities:** - marmot costal region - mental health - Better Care Fund
7	Governance of the Kent Health and Wellbeing Board	- Informal working groups that sit under the HWB
8	Progress Report on the Neighbourhood Health Plan	- Update item
9	ToR update item	- Added 02-09-26 – update item
10	Work Programme (NEW)	- Routine Committee business – for noting only
Wednesday 28th April 2027		
No	**Item**	**Additional Comments**
	Introduction	- Routine Committee business
1	Membership	- Routine Committee business
2	Appointment of co-opted member(s)	- Requires annual renewal (meeting post 1 April) – See 19.31
3	Election of Chair	- Requires renewal for Dr Bowes' continued membership – See 19.18
4	Election of Vice-Chair	- Requires annual renewal (meeting post 1 April) – See 19.31
5	Apologies and Substitutes	- Requires annual renewal (meeting post 1 April) – See 19.31

6	Declarations of Interest	-
7	Minutes of the meeting held on (insert date)	-
8	Director of Public Health Verbal Update	-
9		-
10		-
11		-

Items not on the agenda for a future date	
Better Care Fund (governance / sign off needs to align to HWB as the HWB needs to sign this off (collective decision by board)	Date TBC

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