KENT HEALTH AND WELLBEING BOARD

Thursday, 23rd July, 2026

2.00 pm

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

KENT HEALTH AND WELLBEING BOARD

Thursday, 23 July 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	Membership Update
2	Appointment of Co-opted Member(s)
3	Election of Chair
4	Election of Vice-Chair
5	Apologies and Substitutes
6	Declarations of Interest by Members in items on the agenda for this meeting
7	Minutes of the Meeting held on 4 March 2026 (Pages 1 - 10)
8	Director of Public Health Verbal Update
9	Kent Health and Wellbeing Board Terms of Reference (ToR) and Priorities (Pages 11 - 26)
10	Development of the Neighbourhood Health Plan (Pages 27 - 44)
11	Update on the Marmot Review (Pages 45 - 52)

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

Wednesday, 15 July 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 Wednesday, 4 March 2026.

PRESENT: Miss D Morton (Chair), Dr B Bowes (Vice-Chair), Ms L Kemkaran, Mr M Mulvihill, Waller, Cllr M Blakemore, Dr A Ghosh, Mr R Goatham, Ms S Hill (Substitute for Mrs S Hammond), Cllr Mrs H Perkin, Cllr K Moses and Ms C McInnes

IN ATTENDANCE: Ms D Springer

UNRESTRICTED ITEMS

67. Chairman's Welcome
(Item 1)

68. Apologies and Substitutes
(Item 2)

Apologies for absence were received from Mr Doyle, Mrs Palmer and Sarah Hammond. Sydney Hill was in attendance as a substitute for Sarah Hammond.

69. Declarations of Interest by Members in items on the agenda for this meeting
(Item 3)

No declarations of interest were made by Members in relation to items on the agenda.

70. Minutes of the Meeting held on 25 September 2025
(Item 4)

RESOLVED that the minutes of the meetings held on 25 September 2025 were an accurate record and that they be signed by the Chairman.

71. Chairman's General Update
(Item 5)

1. The Chair provided a verbal update. She welcomed new attendees and particularly welcomed representatives from the Local Government Association (LGA), who were attending to support the forthcoming workshop.

2. The Chair explained that a workshop would be held following the meeting to support the refresh and reinvigoration of the Health and Wellbeing Board, which included consideration of its membership, scope, ways of working and future focus.

3. She reported on recent discussions with the Director of Public Health and NHS colleagues regarding neighbourhood health, the NHS 10-Year Plan and opportunities to strengthen partnership working. She emphasised that the Board was not a political forum and that its focus must remain on improving outcomes for Kent residents and achieving value for money.

4. The Chair provided a detailed update on the Better Care Fund (BCF). She explained that, due to the timing of national guidance and the ongoing development of local budgets, it had not been possible to bring a substantive report to the Board at this meeting on the 2026/27 Better Care Fund. She advised that guidance required BCF plans to be developed collaboratively and agreed by the Health and Wellbeing Board; however, where deadlines had previously fallen between Board meetings, sign-off had been undertaken by the Chair on the Board's behalf.

   The Chair advised that the 2026/27 Better Care Fund guidance had recently been updated to align with proposed reforms linked to the NHS 10-Year Plan. The guidance required Integrated Care Boards and local authorities, working with Health and Wellbeing Boards, to submit an assurance return demonstrating compliance with national funding conditions and planning requirements. This included information on the use of Better Care Fund expenditure, local priorities, and assurance statements in relation to value for money.

   It was reported that the assurance return was required to be submitted to the national team by 19 May 2026. As the Health and Wellbeing Board was not scheduled to meet before this deadline, the Chair sought the Board's support to review the assurance return in detail once received and to sign it off on behalf of the Board. She confirmed that a full report would be brought back to a future meeting of the Board for information and scrutiny.

5. RESOLVED that, by general agreement, the Chairman's update be noted.

72. Director of Public Health Verbal Update
(Item 6)

1. Dr Anjan Ghosh, Director of Public Health, reported on recent local and national events he had attended, along with Dr Ellen Schwatrz, Assistant Director of Public Health. He advised that the events focused on work and health, as well as the links between planning and public health, and that he had contributed to a panel discussion on how planning could support healthier places and improved health outcomes.

2. He advised that Kent continued to be a training site for future public health consultants and that a recent visit from training programme directors had provided positive assurance regarding the breadth and quality of work being undertaken.

3. Dr Ghosh outlined early work with Kent universities to explore the development of a centre of excellence for public health, aiming to strengthen research, innovation and national recognition.

4. He highlighted the forthcoming Marmot Coastal Region launch on 13 March 2026 as a key milestone in Kent's commitment to addressing health inequalities.

5. In terms of other updates, Dr Anjan Ghosh, Director of Public Health, advised that the Kent Public Health Observatory had developed a new alcohol licensing tool in collaboration with partners. He explained that the tool brought together data on hospital admission rates, mortality, deprivation scores, and the proximity of off-licences, pubs and schools, and would support more informed decision-making in relation to alcohol licensing. He confirmed that public health continued to have a role within the alcohol licensing process.

6. In preparation for the launch of the Kent Marmot Coastal Region Programme, Dr Ghosh reported that analysis had been undertaken on inequalities between coastal and non-coastal areas. He noted that this was a complex and nuanced issue, but highlighted a key finding that life expectancy in coastal communities was, on average, 2.1 years lower than in non-coastal areas.

7. Dr Ghosh advised that Kent Public Health had worked with colleagues across the Integrated Care System to produce an updated set of mental health indicators, strengthening the shared evidence base to support system-wide planning and improvement.

8. The Board was informed that, as part of work focused on older adults, Ashford and Gravesham had applied for and been formally accepted into the UK Age-Friendly Communities Network. Dr Ghosh explained that age-friendly communities aimed to support people to age well and to live healthy, independent later lives.

9. Dr Ghosh reported that the former postural stability and falls prevention service had been subject to extensive consultation and redesign. The re-imagined service, now known as Forever Active, was an evidence-based programme supporting Kent residents aged over 50 to remain active, mobile, strong and independent, and was showing early signs of success.

10. It was further reported that health alliances had now been established across all districts and boroughs. Dr Ghosh highlighted that Canterbury Health Alliance had recently received a Healthwatch Award for Excellence in Integrated Working at Local Level, in recognition of targeted work. He advised that this demonstrated how a hyper-local neighbourhood model could operate effectively in practice.

11. Dr Ghosh also advised that work was continuing to prepare for the opening of the Discovery Centre sexual health clinic in Dover later in the month.

12. RESOLVED that the Director of Public Health's verbal update be noted.

73. 2026 Kent Joint Strategic Needs Assessment (JSNA) Summary Report *(Item 7)*

Davinia Springer (Public Health Specialist) was in attendance for this item

1. Dr Ghosh (Director of Public Health), introduced the item and set the context for the annual Kent Joint Strategic Needs Assessment (JSNA) Summary Report. He explained that the report was produced each year at this time and provided an overview of the state of health and wellbeing in Kent. He advised that the summary report was underpinned by extensive detailed analysis and acted as a comprehensive, single source of population health intelligence. He recommended the report to the Board as a valuable tool for understanding current trends and future direction across different aspects of health. Dr Ghosh invited Davinia to present the key findings.

2. Ms Davinia Springer (Public Health Specialist) explained that the JSNA Summary Report brought together key changes in population health needs, findings from in-depth thematic analysis, and intelligence work completed over the previous year, alongside improvements and developments across the system. She highlighted that, as a local authority, Kent County Council had a statutory duty to continually assess both current and future population health needs and health inequalities. She confirmed that the JSNA was overseen by a JSNA Steering Group which was in its fourth year.

3. In relation to demographic change, Ms Springer reported that Kent remained the most populous county council area in the South East, with an estimated population of 1.61 million residents. Population growth had remained steady at approximately 1%, in line with national trends. Population density varied significantly across the county, ranging from 16.6 people per hectare in Dartford to 2.4 in Ashford, and this variation continued to influence patterns of service demand and access.

4. Across the four Health and Care Partnerships, several consistent themes were identified. Levels of overweight and obesity remained high across Kent, with some districts exceeding national averages. Accident and Emergency attendances for children under five years of age remained above pre-pandemic levels in several areas. Smoking prevalence had improved in some districts but remained high in others, particularly Thanet. Mental health indicators continued to show pressure points, with self-harm admissions being of particular concern among young people. Alcohol-related hospital admissions were notably high in Dartford, Gravesham and Swanley. These patterns reinforced the importance of targeted, place-

based prevention approaches. The National Child Measurement Programme data showed rising levels of excess weight in both Reception and Year 6 children. Districts including Folkestone and Hythe, Dover, Ashford, Gravesham and Thanet were significantly above national averages.

5. The Pharmaceutical Needs Assessment concluded that there were no significant gaps in pharmaceutical provision across Kent. However, the sector continued to face national workforce and financial pressures. Overall access remained good, with the majority of residents able to reach a pharmacy within 20 minutes.

6. Adult obesity continued to increase, with 67% of adults in Kent living with excess weight. Davinia highlighted the influence of environmental factors, including the concentration of fast-food outlets in deprived and urban areas, uneven access to affordable healthy food, and variable awareness and use of green spaces, particularly among higher-risk groups.

7. The Special Educational Needs and Disabilities (SEND) Needs Assessment identified continued growth in Education, Health and Care Plans, which had reached approximately 21,000 children. Swale and Thanet had the highest rates, and inequalities persisted for Gypsy, Roma and Traveller communities.

8. Physical activity levels among older adults had improved overall; however, participation in muscle-strengthening activity remained very low. Inequalities continued to exist across gender, ethnicity and levels of deprivation.

9. Accident and Emergency insight work in East Kent indicated that, while some attendances may have been avoidable, difficulty accessing GP appointments was not a major driver, challenging commonly held assumptions.

10. Feedback from mental health crisis services highlighted very positive experiences of voluntary sector provision and safe havens. However, concerns were raised regarding waiting times, coordination of services, and seasonal pressures. Engagement work with veterans identified that expectations shaped by previous military healthcare could influence satisfaction, and that disabled veterans experienced the greatest inequalities.

11. Ms Springer reported significant progress within the intelligence modelling and innovation programme. Kent County Council was described as being at the forefront of linking datasets to enable more sophisticated analysis that revealed needs not visible through population averages. The JSNA cohort model continued to support forecasting and prevention planning. New system dynamics modelling was helping to quantify the impact of prevention on future adult social care demand. A statistical risk score was

being developed to identify older adults most likely to require care, and the research, innovation and improvement function continued to expand, with multiple National Institute for Health Research (NIHR) supported studies underway.

12. Two major research programmes were highlighted. The Kent Marmot Coastal Region Programme focused on skills, employment and long-term health inequalities in coastal communities. The NIHR HOPES project supported youth employment and improved health outcomes across Kent and Medway.

13. Ms Springer summarised that the JSNA Summary Report presented a picture of growing need, persistent inequalities, and significant opportunities to strengthen prevention, improve services and make more effective use of intelligence. She advised that the work completed during the year provided a strong evidence base to support strategic decision-making across the system and drew attention to the collective recommendations for the Board's consideration.

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

    (a) Mr Waller (Deputy Chief Executive at NHS Kent and Medway and Chief Commissioning Officer) asked for clarification regarding a conclusion within the report relating to potential duplication in commissioned pharmacy services, noting that the issue was not fully clear as described and seeking further explanation to enable appropriate action. Furthermore, Mr Waller also highlighted an opportunity, in light of the Integrated Care Board's (ICB) move towards a strategic commissioning operating model, for closer and more structured collaboration between public health teams, the County Council and multidisciplinary commissioning teams, and offered support for joining up this work.

    In response, Miss Springer explained that the intention of the conclusion was to emphasise the importance of collaboration and collective working to avoid duplication of effort across the ICB, pharmacy providers and Kent County Council. Dr Ghosh added that the reference was primarily intended to highlight a potential risk, rather than a confirmed duplication, arising from pharmacies delivering both public health-commissioned and NHS-commissioned services, and the need to ensure these were aligned. He confirmed that this aligned with the first point made regarding integrated and strategic commissioning and agreed that the evolving role of the ICB presented a clear opportunity to better join up commissioning activity and expertise across organisations

    (b) Clarity was sought as to how the forthcoming government legislation relating to Special Educational Needs and Education, Health and Care Plans (EHCPs) was expected to impact the report's recommendation to explore the reporting and transition of EHCPs and Special Educational

Needs. In response, Ms Christine McInness (Interim Corporate Director for Children, Young People and Education), advised that the recently published government White Paper, Achieving and Thriving, placed SEND within a wider education reform context rather than being a standalone SEND White Paper, and was accompanied by a consultation proposing a ten-year implementation plan. She explained that the proposals represented significant and potentially contentious reform and were therefore unlikely to progress quickly through Parliament. As a result, she confirmed that the current work around EHCPs would remain relevant for some time and that Public Health and Children's Services would revisit and revise this work once there was greater clarity on the timing and scope of legislative implementation.

(c) A query was raised regarding the variation in breast screening uptake highlighted in the report and whether further work was required to address accessibility, particularly given the loss of mobile breast screening units and the need for some residents to travel to larger centres. In response, Ms Springer agreed that there was an opportunity to better understand local variation and barriers within communities. She noted that previous research indicated that accessibility was a key issue, alongside wider challenges such as competing day-to-day priorities for individuals, and advised that further community-focused work would be beneficial to ensure breast screening services were accessible and available to all who needed them.

(d) Concerns were expressed as the report did not include a specific recommendation on mental health, particularly in light of a reported 20% increase in residents experiencing depression in the Sheppey area and the absence of positive experience indicators for Swale within the report. Dr Ghosh acknowledged that mental health was not as prominent within the recommendations but assured Members that significant work was underway across the system. He highlighted ongoing partnership activity, the forthcoming prioritisation workshop, and plans for an annual Public Health report focused specifically on mental health. He also confirmed that a mental health needs assessment was available via the Kent Public Health Observatory and explained that current challenges related more to fragmentation and inconsistency of provision, despite pockets of good practice. He emphasised that work was ongoing to develop a more coherent and strategic approach to mental health across Kent.

(e) In response to what action was being taken to address excess weight in children, particularly in relation to the concentration and expansion of fast-food outlets in deprived areas, Dr Ghosh explained that Kent County Council was working closely with district and borough councils through the Whole Systems Obesity Programme, which addressed both individual behaviours and the wider obesogenic environment. This included work on planning policy, advertising and promotion of fast food, and engagement with local communities to increase awareness of

healthy choices. He advised that where local plans were being reviewed, Public Health was supporting the inclusion of measures such as minimum distances between fast-food outlets and schools and reducing clustering on high streets, with a focus on widening healthy food choices rather than restricting options. He noted that while progress would take time, early data was beginning to show small but positive changes.

(f) In terms of the work that was underway to reduce potentially avoidable Accident and Emergency attendances, Mr Waller advised that that the numbers of primary care presentations at Emergency Departments was not the major issue, the focus was to address underlying causes. He explained that work was underway to redirect patients to appropriate primary care services, including the Pharmacy First model, alongside national and local initiatives to improve GP access, triage and capacity. He further outlined work to strengthen alternative pathways for people experiencing mental health crises and to improve the balance between community and acute mental health services, noting that many individuals attending A&E were already known to community services. He also highlighted the development of neighbourhood health models, using risk stratification to support people with complex needs, including frail residents and care home populations, to remain in their usual place of residence and avoid hospital admission. Dr Bob Bowes added that perceptions of faster access in hospital influenced attendance and emphasised the importance of improved communication and integrated working across community services to support care outside hospital settings.

(g) In response to queries raised as to whether the Council and partners were prepared for a potential increase in mental health need linked to rising unemployment, particularly in deprived areas such as East Kent, Dr Ghosh acknowledged the likely relationship between unemployment and worsening mental health outcomes and confirmed that this risk was recognised. He advised that preventative work was already underway across partners to address emerging need and that efforts were being made to act early and at scale, despite the challenges of delivering consistent support across a large and diverse geography.

(h) Members asked how the recommendations, particularly those relating to improving living and working conditions and other wider determinants of health, would be translated into action and how success would be measured. Dr Ghosh advised that this work was at an early stage and was complex and long term, with Public Health's role focused on highlighting issues, convening partners and building momentum across the system. He explained that the Marmot programme was a key area of activity, currently focused on employment and pathways into work, alongside broader structural factors such as housing, transport, food and access to services, noting that progress would require sustained effort over several years. Dr Ellen Schwartz (Assistant Director of Public

Health) added that many drivers of health inequalities were outside the direct remit of Public Health and the NHS and required collective ownership across local government and the wider system, including through the role of anchor institutions. Mr Waller provided a further example, and advised that the Integrated Care Board was developing a joint bid to the national Work Well programme to support people out of work where improved employment outcomes would also deliver health benefits, particularly in relation to mental health and musculoskeletal conditions.

15. RESOLVED that the Health and Wellbeing Board note and comment on the contents of the Joint Strategic Needs Exception Report, and approve the selected recommendations from the needs assessments summarised in the paper for incorporation into the Joint Strategic Needs Assessment:

- Pharmaceutical service providers must ensure services remain accessible to all; services should be adaptable and cater to the needs of inclusion health groups.
- Kent County Council (KCC) and the Integrated Care Board (ICB) should work collaboratively to avoid duplication and continue supporting the current community pharmacy estate to sign up and deliver services where required.
- There is an urgent need to support a Whole Systems Approach to prevent obesity and to fund more population-targeted programs delivered in the community, workplaces, and schools
- There is a need to expand the range of interventions that address the broader influences on health, such as living and working conditions and other wider determinants, to create a more comprehensive and impactful approach
- Kent's weight management pathway is undersized for the need and requires more comprehensive support to engage priority groups.
- Explore the reporting and transition of Educational Health and Care Plan (EHCP) and special educational needs support to those with Special Educational Needs and Disability (SEND) in education after 16 years.
- Increase the physical activity offer for older adults including frail, older adults through whole system action including infrastructure change, education and accessible service provision.
- Promote the adoption of Age Friendly Communities across Kent to support healthy ageing, physical activity, active travel and allow older adults to help shape the place that they live in.
- Develop and embed Intervention and Brief Advice for Physical Activity (IBA-PA) into health and care professional practice as part of a mandatory workforce education programme.

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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** 23 July 2026
Subject:	Development of the Kent Health and Wellbeing Board and Terms of Reference
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	Kent Health and Wellbeing Board, Selection and Member Services Committee and County Council

Summary

1. The purpose of this paper is to **update, inform, and promote** member discussion around the future role and working of the Kent Health and Wellbeing Board (HWB) with a focus on endorsing proposed changes to the Terms of Reference (ToR).
2. The Health and Wellbeing Board was established in 2013 to lead on partnership endeavours to improve health and wellbeing, and reduce health inequalities across Kent. Its working is informed by the Joint Strategic Need Assessment (JSNA) detailing the health challenges faced by the people of Kent. Delivery is through the Joint Local Health and Wellbeing Strategy (JHWS).
3. The DHSC Neighbourhood Health Framework places the local Health and Wellbeing Board at the centre of developing a local Neighbourhood Health Plan with the key leadership role. In parallel work has been in train with the Local Government Association to rethink the Kent Health and Wellbeing Board to optimise its value.

5 In view of the enhanced responsibilities of the Board, the increasing recognition of the importance of local partners and their approaches in tackling the wider determinants of health, and the revised NHS architecture, a number of changes to the ToR are proposed with a focus on role and membership.

Recommendation(s):

The Kent Health and Wellbeing Board is asked to:

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.

1 Introduction

1.1 This paper outlines the increasingly important role that the Kent Health and Wellbeing Board (HWB) will play in the next few years. This will include leadership in the development of the required Neighbourhood Health Plan for implementation from April 2027.

1.2 Additionally at the recent workshop, a range of initial priorities for the Kent Health and Wellbeing Board have been agreed including leadership around mental health challenges, the Marmot Coastal Region initiative, Neighbourhood Health and the Better Care Fund.

1.3 Work has been undertaken to review the purpose and membership of the Health and Wellbeing Board resulting in the revised Terms of Reference attached for discussion and approval.

2 Background to the Health and Wellbeing Board locally

2.1 To remind members, Health and Wellbeing Boards (HWBs) were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. They became fully operational on 1 April 2013 in all 152 local authorities with adult social care and public heath responsibilities.

2.2 Under the Health and Social Care Act 2012, it was required that Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies

(JHWS) be developed through Health and Wellbeing Board and that these formed the basis of NHS and local authority commissioning plans, across all local health, social care, public health and children's services that would both improve the health and wellbeing of the local community and reduce inequalities.

2.3 The role of the Health and Wellbeing Board defined within the NHS Neighbourhood Health Framework has become even more important. Neighbourhood Health Plans are a key part of the DHSC expectations around the delivery of Neighbourhood Health and our understanding is that they will be made a statutory requirement in due course..

2.4 The time is therefore right for a review of the Kent Health and Wellbeing Board terms of reference and membership to ensure it can optimally lead health improvements in the coming years.

3 The Strategic Approach to Health and Wellbeing In Kent

3.1 Given the complexity of the local system in Kent and Medway and the need to develop an Integrated Care Strategy, the decision was taken in Kent that the Kent and Medway Integrated Care Strategy be adopted as the Kent Joint Local Health and Wellbeing Strategy.

3.2 The Strategy is driven by a number of key principles. These include the importance of the full range of health determinants, a focus of prevention and the need to address inequalities. There was a strong recognition of the key role of local partnerships and the need to ensure a strong "bottom up" approach.

3.3 Additionally the wider role and impact of key local players on improving health was recognised including the role of the County Council around growth, employment and transport and the potential of large NHS trusts both as system anchors and in enabling support around the wider determinants of health.

3.4 It is proposed that to ensure the optimal effectiveness of the Board, that membership changes be agreed to best reflect strategic direction and approach.

4 The Neighbourhood Health Plan

4.1 The Department of Health and Social Care (DHSC) have produced a Neighbourhood Health Framework detailing actions required to deliver neighbourhood health from now until 2029. This is the subject of a separate paper to Board. A key issue 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.

4.2 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.

4.3 The Health and Wellbeing Board will additionally have a key role in the development of the Better Care Fund (BCF) plans. These will need to strongly link with the Neighbourhood Health Plan. Pooled funding under the BCF will need to be used in line with BCF 2026/27 guidance with funding decisions consistent with the national conditions for the BCF, including required increases in the Integrated Care Board's minimum contributions to adult social care over the next three years.

4.4 There is an expectation that the Health and Wellbeing Board will agree 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.

4.5 Neighbourhood health plans are a key part of the DHSC expectations around the delivery of Neighbourhood Health and our understanding is that they will be made a statutory requirement in due course. As NHPs will form part of the short- and medium-term work of the HWB, it makes sense to include this in the terms of reference. As and when the statutory requirements of the HWB are changed, the TOR will be reviewed to ensure it is aligned.

5 Review of the Kent Health and Wellbeing Board

5.1 A review of the Kent Health and Wellbeing Board has taken place led by the Local Government Association (LGA). This included interviews with key stakeholders as well as a workshop.

5.2 There were a range of challenges captured through interviews. These can be summarised:

- Health inequalities across Kent are stark, with significant disparities.
- Coastal communities experience disproportionate ill health and inequality.
- The Board is not functional and needs to change. It is not an effective strategic partnership, being a passive meeting.
- It is a missed opportunity, is too transactional, and needs the right people having impactful conversations to effect change.
- The purpose of the Board is unclear, with no consensus on what good looks like.
- The Integrated Care Partnership has taken the lead in areas the Health and Wellbeing Board should be leading.
- Many elected members are new with little experience of the Health and Wellbeing Board role.
- Meetings are too formal with long reports and need to be more focussed.
- There are too many meetings, the partnership landscape is complex with duplication.
- The potential impact of Local Government Reform and NHS changes in Kent.
- Unresolved, longstanding disagreements between the NHS and councils around funding often impede partnership working.

5.3 A raft of opportunities were also identified:-

- The dissolution of the Integrated Care Partnership is an opportunity to reimagine and redesign the Health and Wellbeing Board.
- Recreate the Health and Wellbeing Board as the strategic partnership to lead around inequalities and wider health determinants.
- The Marmot Coastal Region initiative and the Folkestone and Hythe Neighbourhood Health Pilot are recognised as opportunities to prioritise and galvanise action.
- Tangible focus on the coast aided by Marmot, could be a powerful way to gain traction around neighbourhood planning.
- We can develop a compelling narrative and shared sense of purpose with a clear plan and priorities to bring partners along.
- The Health and Wellbeing Board can make the economic argument for addressing wider determinants and inequalities that reflects the current political reality.
- Good feedback about the health alliances in relation to place and system leadership and the opportunity to build on them.
- The DPH and Public Health are respected across the system and appear to have the authority to lead and support change.
- Make meetings less formal, with fewer papers and create the space for discussion using a workshop format with expert input.

5.4 The workshop then went on to consider next steps for the Health and Wellbeing Board. This included discussion around what is needed to ensure partnership working is addressing the priorities agreed for health and wellbeing. The workshop further considered the values, behaviours and ways of working that will foster collaboration to impact our shared priorities.

6 Terms of Reference changes to reflect enhanced roles and responsibilities

6.1 There are a number of key additional responsibilities the Board is charged with that need to be reflected in the Terms of Reference. These include the central leadership role around the Neighbourhood Health Plan, at sections 19.12 (e) and 19.12 (f) in the attached draft ToR and further duties around the Better Care Fund, at 19.12 (i) ii.

7 Terms of Reference changes to Membership to optimise working

7.1 The recent workshop considered the need to enhance membership informed by the Boards strategic approach around the wider determinants of health and the importance of local places in improving local health. A number of changes to the Membership are proposed to better enable this.

7.2 Additionally, membership has been revised to reflect changes to NHS organisation since the last review of the ToR. The proposed membership is detailed in sections 19.14 to 19.22 in the attaches draft.

7.3 It is proposed the Kent County Council Corporate Director of Growth, Environment and Transport be a member. This reflects the importance of these wider determinants of health in our strategic approach.

7.4 The importance of local place and local partners suggests a need for an enhanced local place focus within the Board. It is therefore proposed that three local Health Alliance representatives and a representative local district/borough/city Chief Executive become members. This would be in addition to the existing three local elected members.

7.5 The importance of communities in improving health and wellbeing is recognised as a key strategic approach. To reflect this it is proposed that a representative of the VCSE Alliance become a member of the Board.

7.6 The important role of NHS trusts in delivering healthcare and improving health through wider endeavours is recognised and it is proposed that two provider trust members be appointed.

7.7 There will need to be changes to reflect the change in NHS architecture. It is proposed that the current leadership be represented by two Integrated Care Board representatives and a GP representative. These would replace the three current defunct ToR roles relating to Clinical Commissioning Groups and the Local Area Team.

8 Governance

8.1 The Health and Wellbeing Board is being asked to consider the evolving national and local context for Health and Wellbeing Boards, endorse the proposed future role, membership and ways of working of the Kent Health and Wellbeing Board, and endorse the proposed revisions to the Board's Terms of Reference.

8.2 The Board's endorsement of the proposed future role and operating model will inform the development of the Board going forward.

8.3 As the Terms of Reference form part of Kent County Council's governance framework, any revisions endorsed by the Health and Wellbeing Board will be referred to the Selection and Member Services Committee for consideration and onward recommendation to Full County Council. The revised Terms of Reference will only take effect following formal approval and adoption by Full County Council.

9 Conclusions and Outputs

9.1 The Kent Health and Wellbeing Board is charged with an enhanced role in improving local health and wellbeing with a focus on delivering the Neighbourhood Health Plan

9.2 Internal workshop thinking and a strong set of strategic principles outlined in the Local Joint Health and Wellbeing Strategy (Integrated Care Strategy) help us to consider what further changes to Terms of Reference and Membership are required.

9.3 Changes to the role of the Board reflect the new enhanced role around the Neighbourhood Health Plan and the Better Care Fund

9.4 Changes to Membership reflect our strategic principles including the importance of wider determinants of health, the role of community and the need to develop local responses to local issues.

9.5 Further membership changes are needed to reflect changes in NHS architecture.

9.6 Subject to endorsement by the Health and Wellbeing Board, the revised Terms of Reference will be submitted to the Selection and Member Services Committee and, if supported, referred to Full County Council for formal approval and adoption.

10 Recommendation(s):

Recommendation(s):

The Kent Health and Wellbeing Board is asked to:

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.

11 Contact details

Author

Dr Mike Gogarty

Interim Strategic Lead for Public Health

Mike.gogarty@kent.gov.uk

Relevant Director

Dr Anjan Ghosh

Director of Public Health

Anjan.ghosh@kent.gov.uk

03000 412633

Role

18.1 The Kent Health and Wellbeing Board (HWB) is a multiagency strategic partnership for Kent, covering matters relating to the health and wellbeing of the County's residents.

18.2 The HWB leads and advises on work to improve the health and wellbeing of the people of Kent through a coherent strategic vision underpinned by the Joint Health and Wellbeing Strategy, informed by the Joint Strategic Needs Assessment (JSNA) and a more joined up strategic commissioning approach across the NHS, social care, public health and other services (that the HWB agrees are directly related to health and wellbeing) in order to:

(a) secure better health and wellbeing outcomes in Kent,

(b) reduce health inequalities, and

(c) ensure better quality of care for all patients and care users.

18.3 The HWB has a key strategic role in promoting integrated health and care services, improving population health, and reducing health inequalities.

18.4 The HWB also aims to increase the role of elected representatives in health and provides a key forum for public accountability for NHS, public health, social care and other commissioned services that relate to people's health and wellbeing.

Terms of Reference:

18.5 The HWB:

(a) Commissions and endorses the Kent Joint Strategic Needs Assessment (JSNA), subject to final approval by relevant partners, if required.

(b) Commissions and endorses the Kent Joint Health and Wellbeing Strategy (JHWS) to meet the needs identified in the JSNA, subject to final approval by relevant partners, if required.

(c) Commissions and endorses the Kent Pharmaceutical Needs Assessment, subject to final approval by relevant partners, if required.

(d) Reviews the commissioning plans for healthcare, social care (adults and children's services) and public health to ensure that they have due regard to the JSNA and JHWS, and to take appropriate action if it considers that they do not.

(e) Oversees, in relation to the development of the Neighbourhood health model and the Neighbourhood Health Plan, the creation of jointly owned neighbourhood health plans. These plans must:

i. Be informed by the Joint Strategic Needs Assessment (JSNA), which identifies local health inequalities and priorities.
ii. Align with ICB five-year commissioning plans and local outcomes frameworks.
iii. Include a minimum set of interventions to establish foundational neighbourhood services, while allowing flexibility for local adaptation.
iv. Promote multidisciplinary, cross-sector working, integrating NHS, social care, and community services to improve access and outcomes

(f) Facilitates collaboration between ICBs, local authorities, and providers to:

i. Define neighbourhood footprints that reflect population needs.
ii. Agree on pooled funding arrangements under the Better Care Fund.
iii. Ensure services are person-centred, preventive, and digitally enabled.
iv. Support the development of neighbourhood health centres, which serve as hubs for integrated care and community engagement.

(g) Works alongside the Health Overview and Scrutiny Committee (HOSC) to ensure that substantial variations in service provision by health care providers are appropriately scrutinised. The HWB itself will be subject to scrutiny by the HOSC.

(h) Considers the totality of the resources in Kent for health and wellbeing and considers how and where investment in health improvement and prevention services could improve the overall health and wellbeing of Kent's residents.

(i) Discharges its duty to encourage integrated working with relevant partners within Kent, which includes:

i. endorsing and securing joint arrangements, including integrated or other joint commissioning where agreed and appropriate,
ii. use of pooled budgets for joint commissioning (s75) in the place and the co-ordination of NHS and local authority commissioning, including Better Care Fund plans,
iii. the development of appropriate partnership agreements for service integration, including the associated financial protocols and monitoring arrangements,
iv. making full use of the powers identified in all relevant NHS and local government legislation.

(j) Works with existing partnership arrangements, e.g., children's commissioning, safeguarding and community safety, to ensure that the most appropriate mechanism is used to deliver service improvement in health, care and health inequalities.

(k) Considers and advises Care Quality Commission (CQC) and NHS Integrated Commissioning Board; monitors providers in health and social care with regard to service reconfiguration.

(l) Works with the HOSC and/or provides advice (as and when requested) to the County Council on service reconfigurations that may be subject to referral to the Secretary of State on resolution by the full County Council.

(m) Is the focal point for joint working in Kent on the wider determinants of health and wellbeing, such as housing, leisure facilities and accessibility, in order to enhance service integration.

(n) Identifies a set of priorities annually. Progress against these priorities will be made to the Board on a regular basis.

(o) Reports to the full County Council as and when requested on its activity.

(p) Represents Kent in relation to health and wellbeing issues in local areas as well as nationally and internationally.

(q) May delegate those of its functions it considers appropriate to another Committee established by one or more of the principal Councils in Kent to carry out specified functions on its behalf for a specified period of time (subject to prior agreement and meeting the HWB's agreed criteria). This includes existing sub-committees under the Kent and Medway ICP – the Prevention and the Health Inequalities Sub-committees and the Strategic Partnership for Health and Economy.

Membership

18.6 The Chair and Vice-Chair are elected by the HWB.

HWB: Membership

18.7 Kent County Council:

(a) The Leader of Kent County Council and/or their nominee*.
(b) Three elected Members of Kent County Council nominated by the Leader of Kent County Council.
(c) Director of Public Health*.
(d) Corporate Director Adult Social Care and Health*.
(e) Corporate Director Children, Young People and Education*
(f) Corporate Director of Growth, Environment and Transport

18.8 Two representatives from the NHS Kent and Medway ICB*

18.9 A representative from Kent's General Practitioners.

18.10 A representative of the local Health Watch* organisation for the area of the local authority.

18.11 Representation from NHS England for the purposes set out in section 197 of the Health and Social Care Act 2012*.

18.12 Three representatives from the NHS Provider Trusts – one from the NHS Kent Community Health Foundation Trust, one from the NHS Acute Trusts and one from the NHS Kent and Medway Mental Health Trust

18.13 A representative from the VCSE Alliance. The representative will be proposed to be second vice-chair.

18.14 One representative from each network of Health Alliances to a total of three (one from East, West, and North Kent).

18.15 A Chief Executive representation from the 12 Kent Districts/ Boroughs/City Councils (nominated through the Kent Joint Chiefs).

18.16 Three elected Members representing the Kent District/Borough/City Councils (nominated through the Kent Council Leaders).

18.17 A representative from Kent and Medway Adult Safeguarding Board (KMASB).

18.18 Three standing frontline operational representatives drawn from adult social care, acute services, and emergency services (ambulance).

18.19 Provision for other frontline sectors to be called upon where required by the agenda.

18.20 Any other person or representatives as the Health and Wellbeing Board considers appropriate may be co-opted with the agreement of the Board. Such co-optees will be non-voting members of the Board and their membership will be reviewed annually by the Board.

18.21 Notes to 19.14-19.23 - *denotes statutory member.

Procedure Rules

18.22 Conduct. Members of the HWB are expected to subscribe to and comply with the Kent County Council Code of Conduct. Non-elected representatives on the HWB (e.g., GPs and Officers) will be co-opted members and, as such, covered by the Kent Code of Conduct for Members for any business they conduct as a member of the HWB.

18.23 Declaration of Disclosable Pecuniary Interests. Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by a single member) applies to the HWB and any Sub Committee of it. A register of disclosable pecuniary interests is held by the Clerk to the HWB, but HWB members do not have to leave the meeting once a disclosable pecuniary interest is declared.

18.24 Frequency of Meetings. The HWB meets at least quarterly. The date, time and venue of meetings is fixed in advance by the HWB in order to coincide with the key decision-points and the Forthcoming Decision List.

18.25 Meeting Administration.

(a) HWB meetings are advertised and held in public and administered by the County Council.
(b) The HWB may consider matters submitted to it by local partners.
(c) The County Council gives at least five clear working days' notice in writing to each member of every ordinary meeting of the HWB, to include any agenda of the business to be transacted at the meeting.
(d) Papers for each HWB meeting are sent out at least five clear working days in advance.
(e) Late papers may be sent out or tabled only in exceptional circumstances.
(f) The HWB holds meetings in private session when deemed appropriate in view of the nature of business to be discussed.
(g) The Chair's decision on all procedural matters is final.

18.26 Meeting Administration of Sub-Committees. The HWB is able to establish sub-committees. The administration arrangements will be agreed at the time of establishment, and with the agreement of the partner taking on responsibility for administration. The sub-committees will be subject to the provisions stated in these Procedure Rules.

18.27 Special Meetings. The Chair may convene special meetings of the HWB at short notice to consider matters of urgency. The notice convening such meetings shall state the particular business to be transacted and no other business will be transacted at such meeting.

18.28 The Chair is required to convene a special meeting of the HWB if they are in receipt of a written requisition to do so signed by no less than three members of the HWB. Such requisition shall specify the business to be transacted and no other business shall be transacted at such a meeting. The meeting must be held within five clear working days of the Chair's receipt of the requisition.

18.29 Minutes. Minutes of all HWB meetings are prepared recording:

(a) the names of all members present at a meeting and of those in attendance,
(b) apologies,
(c) details of all proceedings, decisions, and resolutions of the meeting.

18.30 Minutes are printed and circulated to each member before the next meeting of the HWB, when they are submitted for approval by the HWB and are signed by the Chair.

18.31 Agenda. The agenda for each meeting normally includes:

(a) Minutes of the previous meeting for approval and signing.
(b) Reports seeking a decision from the HWB.
(c) Any item which a member of the HWB wishes included on the agenda, provided it is relevant to the terms of reference of the HWB and notice has been given to the Clerk at least nine working days before the meeting.

18.32 The Chair may decide that there are special circumstances that justify an item of business, not included in the agenda, being considered as a matter of urgency. They must state these reasons at the meeting and the Clerk shall record them in the minutes.

18.33 Chair and Vice Chair's Term of Office. The Chair and Vice Chair's term of office terminates on 1 April each year, when they are either reappointed or replaced by another member, according to the decision of the HWB, at the first meeting of the HWB succeeding that date.

18.34 Absence of Members and of the Chair. If a member is unable to attend a meeting, then they may provide an appropriate alternate member to attend in their place. The Clerk of the meeting should be notified of any absence and/or substitution within five working days of the meeting. The Chair presides at HWB meetings if they are present. In their absence the Vice-Chair presides. If both are absent, the HWB appoints from amongst its members an Acting Chair for the meeting in question.

18.35 Voting. The HWB operates on a consensus basis. Where consensus cannot be achieved the subject (or meeting) is adjourned and the matter is reconsidered at a later time. If, at that point, a consensus still cannot be reached, the matter is put to a vote. The HWB decides all such matters by a simple majority of the members present. In the case of an equality of votes, the Chair shall have a second or casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chair.

18.36 Quorum. A third of members form a quorum for HWB meetings. No business requiring a decision shall be transacted at any meeting of the HWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chair either suspends business until a quorum is re-established or declares the meeting at an end.

18.37 Adjournments. By the decision of the Chair, or by the decision of a majority of those members present, meetings of the HWB may be adjourned at any time to be reconvened at any other day, hour and place, as the HWB decides.

18.38 Order at Meetings. At all meetings of the HWB it is the duty of the Chair to preserve order and to ensure that all members are treated fairly. They decide all questions of order that may arise.

18.39 Suspension/disqualification of Members. At the discretion of the Chair, anybody with a representative on the HWB will be asked to reconsider the position of their nominee if they fail to attend two or more consecutive

meetings without good reason or without the prior consent of the Chair, or if they breach the Kent Code of Conduct for Members.

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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** – July 2026
Subject:	Development 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 **update, inform,** and **promote** member discussion around Neighbourhood Health**,** the development of the Kent Neighbourhood Health Plan (NHP) and the role 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. These will be delivered through the NHP with the Board having a critical role in the plane development and delivery.
5. There will be new local NHS provider structures based on local geographies. The Board is responsible for confirming these as developed by the System Neighbourhood Health Programme Board.
6. Board membership will need to help ensure the opportunity afforded through the NHP is fully realised. The Board will wish to agree a local mechanism to develop the plan including input from key stakeholders.

7. 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 need progress within prevailing systems.

Recommendation(s):

The Kent Health and Wellbeing Board is asked to **COMMENT** on and **AGREE** the outlined approach.

1 Introduction

1.1 This paper outlines the important role of the Kent Health and Wellbeing Board (HWB) in leading the development of the required Neighbourhood Health Plan (NHP) for implementation from April 2027.

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 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.

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 Work has been undertaken to review the membership and purpose of the health and wellbeing board which will have an increasingly central role in local health following the dissolution of the Integrated Care Partnership (ICP).

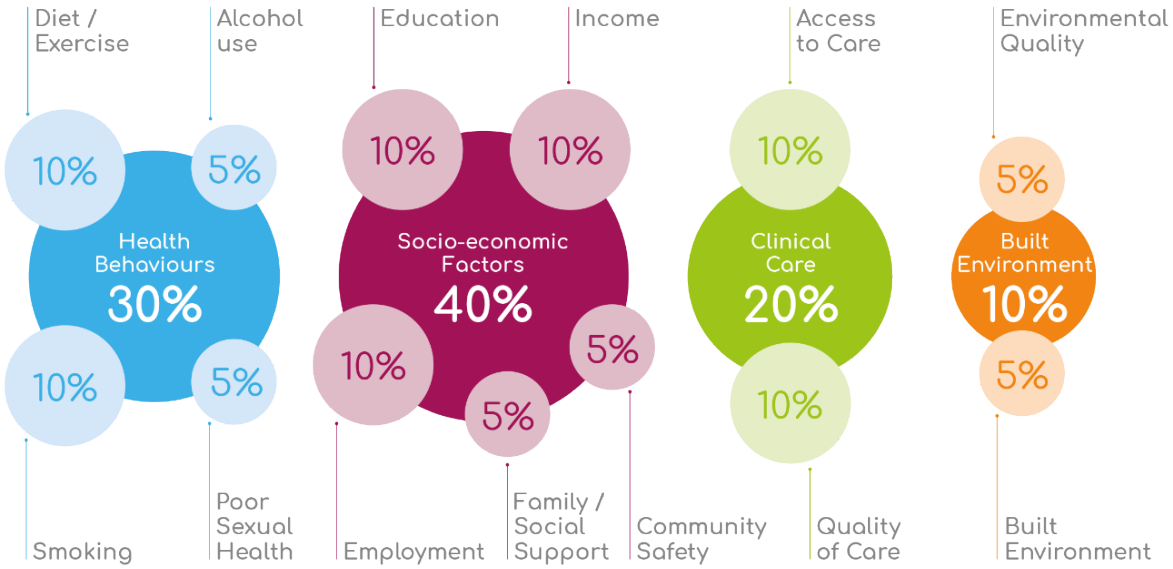
1.6 Following the recent workshop, a range of initial priorities for the Kent Health and Wellbeing Board have been agreed including leadership around mental

health challenges, the Marmot Coastal Region initiative, Neighbourhood Health and the Better Care Fund. Many of these will be embraced within with the NHP

2 Background to Health In Kent

2.1 There remain many challenges to improving the health and wellbeing of the people of Kent. These are well outlined within the local Joint Health Needs Assessments. The key challenges are common to Kent and the developed world and 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. 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 concept of Neighbourhood Health (NH) arose largely from the need for the NHS to adopt a different approach to helping people remain healthy and to avoid hospitalisation. This both makes sound sense in terms of health and additionally would best ensure system sustainability in the future. It aligns with the key drivers of the NHS plan with shifts from treatment to prevention, hospital to community and analogue to digital

3.2 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.

3.3 The delivery of these services is to be as close to a person's home as possible with the concept of local NH teams delivering prevention and care. These are discussed further below.

3.4 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.

3.5 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.

4. The Providers of Neighbourhood Health

4.1 There have been changes to healthcare commissioning, with the Integrated Care Board (ICB) assuming a strategic commissioning role and with more emphasis on potential health and social care integration. In terms of delivery, Health and Wellbeing Boards are charged with defining the geography of neighbourhoods through the Neighbourhood Health Plan. The multi-partner NHS led Neighbourhood Health Programme Board has determined a proposed structural geography and needs now to seek the agreement of the Health and Wellbeing Board on this. Broadly NHS Neighbourhood Health

services will be delivered at two levels, Single Neighbourhood Providers (SNPs) and Multi Neighbourhood Providers (MNPs)

4.2 Single Neighbourhood Providers (SNPs) will deliver services through Integrated Neighbourhood Teams in a defined area with a population of around 50 thousand people. Primary care will be able to provide some of these new services in addition to their current contracts, alongside the local Single Neighbourhood Provider contract holder.

4.3 Additionally there will be Multi-Neighbourhood Providers (MNPs) with a clear relation to the Single Neighbourhood Providers providing services to a population of around 250 thousand people where it makes more sense for the services to be delivered at that scale. It is further important that these align with current and future local authorities

4.4 There are also plans to introduce Integrated Health Organisations (IHOs). These will be selected local providers with a whole population health budget for a given geography, covering one or more Multi-Neighbourhood Providers. The Integrated Health Organisation will allocate resources and plan services, and may hold contracts with other local providers. They will develop the infrastructure to shift resources from acute to community. NHS trusts will be designated by the Department of Health and Social Care (DHSC) and NHS England to hold Integrated Health Organisation contracts. These designated trusts can then be commissioned by Integrated Care Boards using a newly developed Integrated Health Organisation contract.

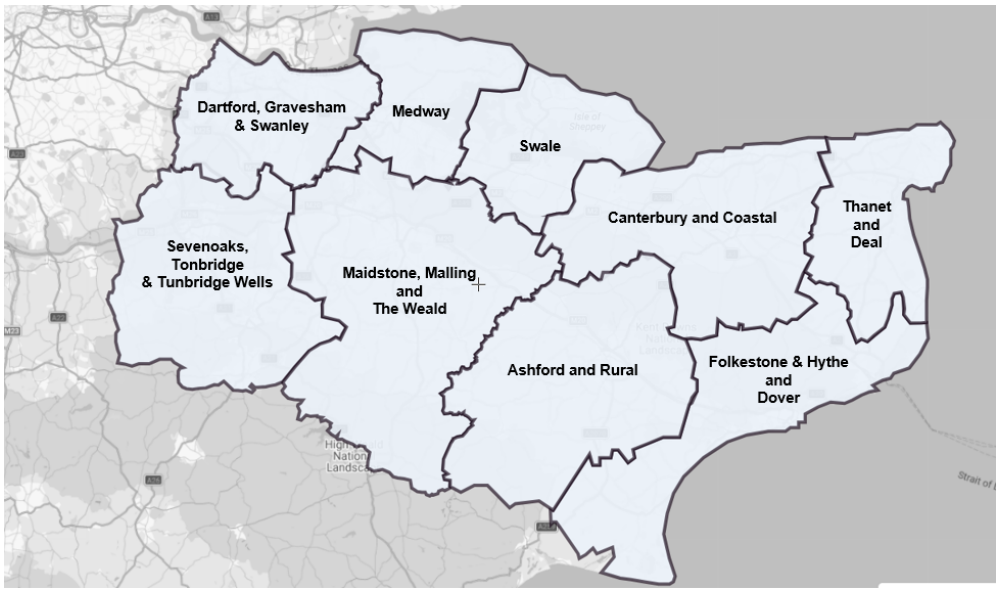
4.5 Kent and Medway ICB have been considering potential footprints for Multi-Neighbourhood Providers locally. There is a clear understanding that the footprints will need to evolve over time and that the “boundaries” of these footprints should not be so fixed that they become a barrier to care and support inequity of service by being too fixed.

4.6 In Kent and Medway, nine multi-neighbourhood footprints have been proposed each ranging from 109,000 to 339,000 residents. These are designed to be large enough to enable collaboration, yet local enough to maintain a strong sense of place and identity, providing the right balance for effective joint planning and delivery. Each footprint brings together several single neighbourhoods to strengthen integration across health, care, and community services, support shared workforce planning, and align resources around local population needs. There are a total of 45 local Single Neighbourhood Providers in Kent and Medway based around existing primary care networks (PCNs).

4.7 It is recognised that Local Government Reform (LGR) is progressing. MHP footprints have been developed within this context with consideration of

possible LGR outputs. It is recognised that if agreed future boundaries do not align with proposed MNPs then the footprints will need to be revisited.

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



5 The Neighbourhood Health Plan

5.1 The Neighbourhood Health Framework details actions required to deliver neighbourhood health from now until 2029. As discussed, a key element 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.

5.2 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.

The agreed Neighbourhood Health Plan will be part of the Integrated Care Board's 5 year commissioning plan.

5.3 The Health and Wellbeing Board will additionally have a key role in the development of the Better Care Fund (BCF) plans. These will need to strongly link with the Neighbourhood Health Plan. Pooled funding under the BCF will need to be used in line with BCF 2026/27 guidance with funding decisions consistent with the national conditions for the BCF, including required increases in the Integrated Care Board's minimum contributions to adult social care over the next three years.

5.4 There is an expectation that the Health and Wellbeing Board will agree 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.

5.5 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.

5.6 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.

6 The Kent System Opportunity from the NHP

6.1 It is important that we do not miss the opportunity to align action across the system to best improve health and care outcomes. Our Plan will need to ensure systems and structures are developed at a local and higher level to deliver key evidence based interventions that will deliver defined system priorities. Local clinical leadership, supported by proposed Modern Service Frameworks will be key to this for those elements led by NHS colleagues.

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

6.3 It is fair to say that the NHF has expanded in scope from earlier thinking to embrace a far wider range of NHS challenges including around access to elective and primary care. It has also, through the NHP, embraced a wider approach to health and its delivery. This is to be welcomed although the initially cited approach to supporting system sustainability through prevention with a focus on avoiding both hospital and residential care admissions remains critical for the NHS and the County Council.

6.4 District Councils are already building further on their role in improving health including through local health partnerships (in some called Health Alliances) which already engage local NHS and VCSE partners and focus on, often defined local communities. Development of the NHP will benefit from understanding and including their local priorities.

6.5 County Council priorities have been defined and must be included within the NHP. In Kent County Council, the Adult Social Care Prevention Framework defined the need to prevent people losing their independence. Additionally there are agreed Public Health Priorities (attached as Appendix A). The Council will define key opportunities and asks to help deliver its ambitions.

6.6 The NHS asks of NH have been clearly articulated in the NHF and the NHP will need to define how partners will, in turn, play their role in ensuring success in these ambitions.

6.7 There are additional wider system groups who have a role to play and are keen to engage in the NHP. These include the Kent Housing Group and the VCSE Health Alliance.

6.8 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.

6.9 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.

7 Developing the NHP

7.1 Appendix B provides a draft outline of what the plan might include and how it might be structured. Appendix C is an outline of the tasks defined by the NHS, required within the system between now and April 2027

7.2 The Health and Wellbeing Board will wish to ensure proposed priorities and actions align with the JSNA asks and the JHWS. In Kent and Medway, strategy has been driven by the Kent and Medway Integrated Care Strategy that was developed with wide partner input and has been widely agreed. This Strategy runs until 2029 and has been adopted as the Kent JHWS. Given that the population health challenges have broadly remained the same, and the level of buy in, it is proposed that the current JHWS and ICS Strategy remain relevant.

7.3 The system Clinical Leadership Group has defined key interventions that will prevent hospital admissions. This work, with similar emphasis on avoiding residential care admissions (many interventions enable both) will remain key in aiding future system sustainability which must remain a key driver for the NHP.

7.4 Kent County Council have developed an internal group to ensure both optimal corporate support for NH and that council priorities, asks, actions and metrices are clearly defined. This approach will provide clarity around the role and expectations of the Council.

7.5 Lead officers with responsibility for health across each District are involved in discussions around how best they feel district and local partner priorities and actions can be included in the NHP as well as how they can strengthen links with new NHS structures. The majority of Health Alliances are now arranging initial workshops to better understand NH and to agree how they wish to ensure that NH best benefits local populations.

7.6 Meetings have also been agreed with other partners such as the Kent Housing Group who are keen to play a role. It is important to define how local housing support links to NHS services. This could be at SNP, MNP or acute trust level or a combination of these. There has also been a conference led by the VCSE Health Alliance with further work planned to ensure optimal input from VCSE colleagues.

7.7 It is important that colleagues leading on Mental Health and on Children and Young People are engaged, to ensure opportunities to use NH to improve health in these areas are captured and actioned.

8 Making the NHP work

8.1 It goes without saying there is no value in a detailed, tick box, tome type document unless specifically required by the NHS centre. It is proposed that the NHP be as concise as possible, including a plan on a page.

8.2 It must however drive key actions at a system and local level that will enable sustainability through reduction in acute and residential care admissions.

8.3 The NHP can describe how the local system will work as well as flagging local priorities but detailed action in these areas need to be included within local action plans. These are planned at SNP and MNP level with more work required on how best to play in district level priorities and actions.

8.4 Currently local Health Alliances include Primary Care Networks (PCNs) that will become the SNPs to a variable extent with some PCNs fully engaged and others with less involvement. We need to work with NHS colleagues to agree how best to ensure that these links are strong.

8.5 Linked to the above, it is recognised that LGR will impact on future local structures with some clarity by July. It is proposed that given the need for action from 2027 and the longer timescale for LGR implementation, that current local district level plans are captured at MNP level. Additionally, hyperlocal partnership activity can be included in SNP plans although a mechanism to enable this will need more thought.

8.6 As the proposed plan will be short, following the NHS approach of a few key overarching indicators, it is proposed that the number of wider partnership measures in the plan is small and they are restricted to key metrices that all partners will own.

8.7 It is fair to say that the need to develop the plan within DHSC timescales that overlap with impending LGR adds additional complexity. Currently the Board is responsible for the people of Kent and additionally local Health Alliances are concerned with the specific needs of local populations. Post LGR, we will likely see a different model with large Unitary authorities.

8.8 Health needs and the best interventions to address these will not however change. It is important then that we develop a widely owned and agreed NHP with metrices that make sense at different geographies so that we can start to deliver in April and have some confidence that agreed endeavours will continue regardless of structural change.

9 Delivering the Neighbourhood Plan through the Health and Wellbeing Board

9.1 A separate paper discusses the opportunities to strengthen the HWB.

9.2 To optimally deliver, the recent HWB workshop suggested there may be a need to reconsider membership. This included wider NHS membership to include provider trusts e.g. an acute trust CEO and the community trust CEO and initial conversations suggest these officers are keen to be members.

9.3 There is also a need to consider officer leads to aid the action required between meetings or an officer led operational delivery subgroup. This will be needed to optimally deliver the Neighbourhood Health Plan. It could include KCC public health, ASC and CYP officers as well as NHS, District Council and VCSE officers with an even smaller group to produce the actual plan. There would need to be strong supportive data analytics.

10 Conclusions

10.1 The Neighbourhood Health Framework details actions required to deliver neighbourhood health from now until 2029. A key element 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.

10.2 The NHP will describe how NHS objectives will be delivered and how Neighbourhood Health will support local goals around inequalities and health outcomes .It will link local objectives to the JSNA, confirm NH geographies and organisational responsibilities and describe how other local initiatives align with Neighbourhood Health e.g. Family hubs, housing, VCSE, employment support

10.3 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.

11. Recommendation(s):

11.1 The Kent Health and Wellbeing Board is asked to **COMMENT** on and **AGREE** the outlined approach.

12. Appendices

- Appendix A: Kent Public Health - six strategic priorities for 2026/27
- Appendix B: Draft Structure of Neighbourhood Health Plan
- Appendix C: NHS Key priorities steps for 2026/27

13. Contact details

Author

Dr Mike Gogarty

Interim Strategic Lead for Public Health

Mike.gogarty@kent.gov.uk

Relevant Director

Dr Anjan Ghosh

Director of Public Health

Anjan.ghosh@kent.gov.uk

03000 412633

Kent Public Health -six strategic priorities for 2026/27

Kent & Medway Integrated Care Strategy: *Putting Prevention and Equity at the centre of what we do as a system. Develop the role of local Health Alliances, NHS trusts and the Health and Wellbeing Board*

Development and delivery of specific Prevention Programmes

ASC Prevention Framework, Stop Smoking service, Family Hubs – Best Start in Life, NHS Trust Prevention Pilots

Tackling Health Inequalities across Kent

E.g. *Kent Marmot Coastal Region*

Improving and re-imagining mental health provision in Kent including, Six Ways to Wellbeing

Evidence based to support a systemwide mental health provision for Kent residents based on the recommendations from Mental Health Needs Assessment.

Supporting the development of new models of care – Neighbourhood Health

Development of the Kent Centre of Excellence for Public Health

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DRAFT STRUCTURE Neighbourhood Health Plan

Purpose: include NH Framework, HWBs

Strategic Context:

- NHS Plan and NH Framework,
- Local JSNA, JHWS and links to and relevance of IC Strategy.
- Other key inputs eg Kent ASC Prevention Framework, Health Alliance priorities
- Children and Families and mental health flagged here?

Key Priorities and Measures:

Local priorities and measures

- System level and hyper-local
- ASC targets around independence and reduced care home use
- DC priorities as defined from bottom up
- MH and children

NHS system wide: Reiterate NHS central priorities

Delivery:

Structure and organisations: MNTs, SNTs, DC, hyperlocal, role trusts, role social care providers and VCSE

System wide interventions:

- Clinical priorities for adults and prevention inc. CGA, CVD prevention, continence . Role partners including acute trusts, MNT, SNT in each of these ie level organised. Include BCF
- Will need Children and MH chapters/sections

Enablers:

- Structures and partnerships
- Clinical leadership
- Finance
- Commissioning
- Performance management
- Digital
- Workforce
- Infrastructure

Governance:

- HWBs
- ICB plans and role Region
- Local DC ownership
- KCC and Unitary mechanisms

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Key priorities steps for 2026/27

- A Co-develop a single vision and narrative for neighbourhood health that address all ages, all needs.
- B Engage core providers to build ownership and consensus.
- C Agree the delivery mechanisms: Governance, leadership & accountability, workstream leads and programme delivery support
- D Stand up the INTs: Agree footprints, design principles, define the leadership, priorities (in and out of hospital) and delivery plan
- D Map the workforce (and budgets) to the INT footprints.
- E Invest in team development. Bring together the people from primary, community, mental health, social care and VSCE.
- F Agree metrics and outcome and track through a single shared dashboard.
- G Address the barriers including digital and estate infrastructure needs of INTs
- H Establish the incentive and investment mechanisms through a broader logic model / business case
- I Define the Operational model for INTs, what does business as usual look like?
- J H & W Board ownership of the longer-term plan and business case

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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, 23 July 2026

Subject: **Kent Marmot Coastal Region**

Classification: Unrestricted

Past Pathway of Paper: None

Future Pathway of Paper: None

Electoral Division: All

Summary:

This report outlines the Kent Marmot Coastal Region, a long-term flagship initiative aimed at reducing health inequalities in Kent's coastal communities.

The Marmot Coastal Region was formally launched in March 2026 and is one of the priorities in KCC's strategic statement as well as one of the HWBB priorities as agreed during the recent HWBB workshop.

The report sets out the evidence around the 'coastal excess' of ill health and premature mortality and introduces the Marmot Approach to tackling health inequalities by addressing the underlying social determinants of health. The document outlines the three-tier approach to the Marmot Coastal Region: long-term culture change, system alignment around work and pathways into work, and the Marmot Accelerator Programme of local projects to support people into work and training.

At the launch in March 2026, KCC made three pledges to help people with high levels of need into education and jobs, to be delivered by April 2028. These pledges are part of the Accelerator Programme.

At the end of the document, opportunities are highlighted on how the Marmot Coastal Region can be embedded into other local plans and initiatives to achieve traction around health equity and social determinants of health.

Recommendation(s):

The Health and Wellbeing Board is asked to **NOTE** the key components of the Kent Marmot Coastal Region and to **DISCUSS** how to support the initiative.

1. Introduction

1.1. Kent has 350 miles of coastline and nearly a quarter of the population is living in coastal towns (23.5% in 2020). While many coastal areas are places of great natural beauty and rich history, many of the worst health outcomes in Kent can be found in coastal communities.
Nationally, many coastal areas have suffered long-term historical decline and lack of investment, and coastal communities show some of the worst health inequalities as a result. The underlying causes of poor health and limited life expectancy often lie in social determinants such as education, employment, housing, transport, and the environment. While it is important to ensure that appropriate health and social care services are available and equitably utilised in coastal areas, the living conditions of our residents need to be enhanced to achieve sustained improvement in health and equitable outcomes.

1.2. Today, there are more than 50 'Marmot Places' in the UK that use the Marmot Approach based on eight Marmot principles to tackle health inequalities. Kent is the first region in the UK to call itself a Marmot Coastal Region and is increasingly attracting interest from neighbouring areas and areas wider afield.

2. Background and evidence of coastal health inequalities

2.1. Several reports and calls for action have highlighted the deep inequalities in coastal areas in the UK and the need for better and more granular understanding of underlying issues, sustained commitment, and investment.

2.2. The Chief Medical Officer in England, Dr Chris Whitty, pointed out in his annual report ***Health in Coastal Communities 2021*** that coastal communities have been overlooked and suffer significant deprivation resulting in ill health.

2.3. The Kent ***Annual Public Health report 2021*** focuses on the health and wellbeing of coastal communities. Just as in the national CMO report, Kent shows a '**coastal excess**'. This refers to health outcomes in coastal towns that are worse than those in non-coastal towns, the county as a whole and England. This 'coastal excess' is often combined with poorer access to health and social care facilities, a lack of employment opportunities and difficulty recruiting and retaining health and social care workers.

2.4. NHS England recognised coastal communities in their ***CORE20 PLUS5 approach to reducing healthcare inequalities*** as one of the PLUS groups, groups who are experiencing social exclusion and poor health outcomes.

2.5. Despite a considerable body of evidence and calls for action, there has not yet been sustained change for residents in coastal areas in Kent that would address the underlying structural causes of inequality and ill health.

2.6 Employing a Marmot approach aims to bring partners together with a clear focus on coastal communities, and a long-term plan with specific actions where evidence suggest that change can be achieved. In addition, recommendations for regional and national bodies will add traction to factors that cannot be addressed locally.

3. Political and policy context around work and skills

3.1. UK Government

3.1.1. The UK Government's skills and work agenda is built around improving productivity, tackling labour shortages, and helping people progress into better-paid jobs.

3.1.2. **Get Britain Working** is the Government's overarching employment reform programme aimed at reducing economic inactivity. The main elements are to:

- Tackle economic inactivity, especially due to ill health
- Replace the traditional Jobcentre model with a more integrated Jobs and Career Service
- Create a Youth Guarantee so that young people have access to apprenticeships, education or training, and get help to find employment

3.1.3. **Skills England** was established in 2024 as a central body to identify national and local skills shortages and help align training with labour market demand.

3.1.4. '**Connect to Work**' is a DWP supported employment programme that aims to help people who face significant barriers to employment to enter work and sustain employment. KCC is leading this fully funded programme for Kent & Medway.

3.2. Kent County Council

3.2.1 **Reforming Kent** is Kent County Council's three-year strategy that was implemented in 2025 and has four objectives: 1. Putting Kent residents first 2. Reforming Kent County Council 3. Supporting residents that need help and 4. Building better communities. The Marmot Coastal Region is mentioned as one of the priorities in the KCC strategic statement. KCC has created a cabinet role for Coastal Regeneration in recognition of the need for action in this area.

3.3. Kent and Medway Integrated Care Partnership

3.3.1. The ***Kent and Medway Integrated Care Strategy's*** Shared Outcome 2- Tackle the wider determinants of health to prevent ill health, Outcome 5 – Improving the Health and Care Service, and Shared Outcome 6 – Support and Grow our Workforce address the importance of employment and good work as well as that of a strong and inclusive workforce for Kent and Medway.

3.4. Kent and Medway Economic Partnership

3.4.1. The Kent and Medway Economic Partnership (KMEP) recognises the interconnectedness of health and economic outcomes, which is a central theme in the ***Kent and Medway Economic Framework***. The Kent Marmot Region aligns well with the Kent and Medway Economic Framework's five ambitions to: enable innovative, creative, and productive businesses; widen opportunities and unlock talent; secure resilient infrastructure for planned,

sustainable growth; place economic opportunity at the centre of community wellbeing and prosperity; and create diverse, distinctive and vibrant places.

3.4.2. The ***Kent and Medway Integrated Work and Health Strategy*** is overseen by KMEP and aims to address the barriers that individuals with long-term health conditions and disabilities face in the workplace.

3.4.3. **The *Get Kent and Medway Working Plan*** was finalised in October 2025 and is a collaborative strategy developed by Kent County Council, Medway Council, Jobcentre Plus, and the NHS Kent and Medway Integrated Care Board**.** The plan aims to tackle barriers to employment, address skills gaps, and improve workforce participation across Kent and Medway.

3.4.4. ***Connect to Work*** is a voluntary employment support programme in Kent and Medway and part of the Get Britain Working Strategy. It is designed to support individuals facing barriers such as disabilities, long-term health conditions, neurodivergence, homelessness, caring responsibilities, or experiences of the justice system.

These and other local initiatives and locally implemented Government programmes as well as the Marmot Coastal Region come together for expert advice and join-up in the **Kent and Medway Strategic Partnership for Health and Economy** (SPHE), one of the three sub-committees formerly reporting to the Integrated Care Partnership. Going forward, there could be scope for the SPHE to report into the HWBB.

4. Marmot Reviews, Places, and Principles

4.1. In 2008, Professor Sir Michael Marmot chaired an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England. In 2010, ***Fair Society, Healthy Lives (The Marmot Review)*** was published.

4.2. In 2020, the ***Marmot Review 10 Years On*** was released that showed that for the first time in more than 100 years, life expectancy in England had failed to improve. Between 2010 and 2020, health inequalities in England had widened and the amount of time people spent in poor health had increased.

4.3. Supported by the ***UCL Institute of Health Equity***, a growing number of areas in England and Wales are declaring themselves ‘Marmot Places’. A ‘Marmot Place’ recognises that health and health inequalities are shaped by the social determinants of health, the conditions in which people are born, grown, live, work and age, and takes action to improve health based this understanding.

Based on eight Marmot Principles, Marmot Places develop and deliver interventions and policies to improve health equity, embed health equity approaches in local systems and take a long-term, whole-system approach to improving health equity.

4.4. The **Marmot Principles**:

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together.

5. Kent Marmot Coastal Region

5.1. Kent adopted a layered approach to becoming a Marmot Place, starting in the geographical area with the starkest inequalities, the coastal strip, and focusing initially on three of the eight Marmot principles: 'Enabling young people and adults to maximise their capabilities and have control over their lives', 'Creating fair employment and good work for all', and 'Ensure a healthy standard of living for all'.
For the purposes of this document, we will call them '**work'** and **'pathways into work'**.

In the autumn of 2024, KCC Public Health commissioned the UCL ***The Institute of Health Equity - IHE*** to support the initial stages of the initiative for a period of two years to the end of December 2026.

The geographical scope of the initiative encompasses **six districts and boroughs** along the Kent Coast, Swale, Canterbury, Thanet, Dover, Folkestone and Hythe, and Ashford. While not a coastal district, Ashford has close links coastal neighbours and is included in the Region.
The Kent Marmot Coastal Region has four main objectives:

• **To create strategic alignment** between all the work being undertaken across various sectors and settings, so that we achieve maximal impact. This includes avoiding duplication, amplifying the work already underway and perhaps expanding the scope.

• **To identify a set of new high impact actions**: In addition to the actions already being undertaken, a set of new actions that will have a high impact on our efforts to address the three Marmot principles being focussed on. We test these actions as part of the Marmot Accelerator Programme.

• **To change the culture in Kent**: Through the system-wide ownership and commitment towards our aims, objectives and actions, we wish to embed a prevention and an outcomes-based approach in everything we do. This includes making every contact count, person centred care planning and a whole person approach, thinking how we can optimise prevention in our strategic commissioning, and leveraging anchor institutions.

• **To achieve critical mass**: Through the effective implementation of Marmot Accelerators and existing actions that will be amplified, we hope to generate a critical mass to deliver measurable impact to address 'work and pathways into work', both in terms of improved outcomes and reducing health inequalities.

In addition to the work focused on coastal areas, there is an open invitation to inland District and Borough Councils in Kent to adopt an approach based on Marmot principles and to benefit from the insights and connections gained from our coastal work.

5.2. Governance

The current governance of the Marmot Coastal Region consists of a Steering Group with a membership consisting of local partners across local authorities, the NHS, education and academia, and VCSE organisations. An expert Advisory Board, chaired by Sir Michael Marmot has met once and is due to meet again later this year. Going forward, there will be regular updates to the HWBB.

5.3. The Launch and KCC's three pledges

The Marmot Coastal Region was officially launched in Dover in March 2026 with Sir Michael Marmot as the keynote speaker and speeches from both the Leader and the Chief Executive of KCC. The Leader made three pledges as KCC's contribution to the Marmot Accelerator Programme to be delivered by April 2028:

- To support at least **200 young people** into education and employment who would otherwise be **Not in Education Employment or Training** (NEET).
- To get **150 people on probation** on the Kent Coast into education and employment.
- To support **100 people with additional disadvantages** such as care leavers, carers, and people with mental ill health into work based on in-depth research done as part as part of the Connect to Work scheme.

5.4. Three tiered approach

The Marmot Coastal Region takes a three tiered approach:

- **Tier 1**: **Long-term culture change** working towards health equity on the coast supported by the Institute for Health Equity (IHE).
  IHE have produced an ***IHE - Kent Report*** consisting of a data-led report and a deep dive into work, income and health. IHE are currently consulting on a number of recommendations that will aid to inform the strategic direction of the Marmot Coastal Region over the next 10 years.
  Part of the support from the IHE is the development of a coastal indicator set and an evaluation framework to monitor progress over time.

- **Tier 2**: **System alignment** of the plethora of programmes addressing work and pathways into work is taking place to ensure that there is a focus on the coast, that the link to health is understood, that duplication is avoided and impact is maximised.

- **Tier 3:** The **Marmot Accelerator Programme** consists of ground-level, innovative projects to support people with high levels of need into work and improve their skills for work. These initiatives are funded by KCC Public Health. Focus is initially on creating work in the health and social care sector, and on young people aged 16 to 24 who are not in education, employment and training, and other high-need groups such as people in the justice system, care leavers, homeless, substance users, and other 'inclusion groups'. Marmot Accelerators will create an evidence base for what works that can be shared and implemented across Kent to improve the impact of local interventions.

  Accelerator Projects will:

  - Test innovative approaches to support people into education, work or training in coastal communities.
  - Produce evidence, learning and models that can lead to sustained change, either through shared guidance, replication and scalability across Kent or embedded practical changes.
  - Translate the strategic Marmot principles into tangible delivery.
  - Focus resources on coastal inequalities in Kent, prioritising Accelerator projects from organisations that are Kent-based and provide local employment, education and training opportunities.
  - Align with existing work-based strategies and programmes such as Connect to Work, Get Kent & Medway Working Plan and the Kent and Medway Work and Health Strategy 2025-2030.

  The **Launch Pledges** are part of the Accelerator Programme and will be met by April 2028. A commissioning strategy is currently in development to ensure that allocation of public health funds is transparent and opportunities are spread across the whole Marmot Coastal Region.

  The **Marmot Accelerator Commissioning Strategy** has two phases. In **Phase 1**, the focus is on NEET prevention with a project in development in Folkstone & Hythe. In addition, a grant-award scheme will enable local organisations from areas of the Marmot region to bid for projects on NEET prevention.
  Phase 2 will focus on projects to deliver against the pledge to get people on probation into education and jobs. This phase will take place in the financial year 27/28. This phase will include a grant-award scheme for projects to people with additional disadvantages into education and jobs.

  The first Marmot Accelerator started in June on the Isle of Sheppey and aims at preventing young people from being not in employment, education and training (NEET). The project name is '**Sheppey Career Readiness Initiative**' and is provided by Breaking Barriers Innovations (BBI). This project was commissioned prior to the Accelerator Commissioning strategy but will count towards fulfilling the first Launch pledge. It aims as getting 36 young people into training and employment over 12 months.

6. Opportunities

6.1 Sustained focus on health inequalities in Kent's coastal areas and interventions to address the underlying social determinants will lead to a more joined-up and effective system approach to improving health and to creating vibrant coastal communities.

6.2 Evidence from Marmot Accelerators of what works in the Coastal Region will be systematised, collated and shared to inform policy and practice across Kent.

6.3 Embedding the Marmot Coastal approach and a focus on wider determinants of health into the Kent and Medway Neighbourhood Health Plan can strengthen prevention and reduce pressure on health services in the long term.

6.4 Joining the Marmot Coastal work with that of community health and wellbeing workers, community wardens and similar roles can reduce barriers to access to education and work. Discussions on how to use social prescribing platforms to improve access to education and employment are already taking place.

6.5 There is an increasing number of research opportunities such as the NHIR funded ***HOPES*** (Health of our young people for employment success) collaborative for Kent and Medway to develop local evidence.

7. Outlook

7.1 Once efforts around improving work and pathways to work on the coast have shown significant impact, we will address other Marmot principles such as housing as another fundamental building block of health.

8. Recommendation(s):

8.1 The Health and Wellbeing Board is asked to **NOTE** the key components of the Kent Marmot Coastal Region and to **DISCUSS** how to support the initiative.

9. Contact details

Report Author:
Dr Ellen Schwartz
Email: ellen.schwartz@kent.gov.uk

Relevant Director:
Dr Anjan Ghosh
Director of Public Health
Email: anjan.ghosh@kent.gov.uk