KENT COUNTY COUNCIL

KENT HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Kent Health and Wellbeing Board held in the Council Chamber on Thursday, 25 September 2025.

PRESENT: Dr B Bowes (Vice-Chair), Cllr M Blakemore, Mrs S Hammond, Ms L Kemkaran, Miss D Morton (Chair), Mr M Mulvihill, Mrs C Palmer, Mrs S Crouch (Substitute for Dr A Ghosh) and Cllr Mrs H Perkin

IN ATTENDANCE: Oluwatoyin Sosanya (Public Health Pharmacy and Quality Lead) , Mrs V Tovey (Assistant Director of Integrated Commissioning) and Georgina Little (Democratic Services Officer)

UNRESTRICTED ITEMS

55. Chairman's Welcome

(Item 1)

56. Membership Update

(Item 2)

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

- Mrs Linden Kemkaran (Leader of Kent County Council)
- Miss Diane Morton (Cabinet Member for Adult Social care and Public Health)
- Mrs Christine Palmer (Cabinet Member for Integrated Children's Services)
- Mr Mark Mulvihill (Deputy Cabinet Member for Adult Social Care and Public Health)
- Mr Ed Waller (Chief Strategy and Partnerships Officer *and* Chief Delivery /Commissioning Officer (interim) – NHS Kent and Medway - Integrated Care Board)
- Cllr Hannah Perkins (Swale Borough Council)
- Cllr Keji Moses (Canterbury City Council)

57. Appointment of Co-opted Member(s)

(Item 3)

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

58. Election of Chair

(Item 4)

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

2. Following the election of Chair, Mrs Morton took her seat and gave an opening speech, outlining her priorities for the year ahead.

3. RESOLVED that Miss Morton be elected as Chairman of the Kent Health and Wellbeing Board.

59. Election of Vice-Chair
(Item 5)

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

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

60. Apologies and Substitutes
(Item 6)

Apologies for absence were received from Mr Smith, Cllr Moses, Mr Goatham and Dr Ghosh, who was substituted by Mrs Crouch

61. Declarations of Interest by Members in items on the agenda for this meeting
(Item 7)

There were no declarations of interest.

62. Minutes of the Meeting held on 11 February
(Item 8)

RESOLVED that the minutes of the meetings held on 11 February 2025 were an accurate record and that they be signed by the Chairman.

63. Director of Public Health - Verbal Update
(Item 9)

1. Mrs Crouch (Consultant for Public Health) provided a verbal update on the following:

(a) The Baton of Hope visited Kent on the week commencing 22nd September 2025 as part of the ongoing suicide prevention and anti-stigma campaign. Events took place across Maidstone, Canterbury, and Margate, concluding with an evening event at Dreamland. The Suicide Prevention Strategy remained open for public consultation until 6 October. Mrs Crouch expressed her thanks to Miss Morton (Cabinet Member for Adult Social Care and Public Health) and all those who participated in supporting the baton holders.

(b) The NHS winter flu vaccination programme opened for children and pregnant women, with full roll-out due to start in October 2025. The campaign had two phases:

- Encouraging pregnant women to vaccinate for flu, RSV, and whooping cough.
- Promoting flu vaccination uptake among those with long-term conditions.

Kent also participated in national pandemic preparedness exercises under Exercise Pegasus.

(c) Public Health continued to work closely with Adult Social Care to advance prevention initiatives, helping Kent residents live well and independently for as long as possible. This approach aimed to prevent, reduce, and delay social care needs in line with Council priorities. The approved framework was supported by a delivery plan built around five core components, including actions on employment and housing aligned with the Marmot Coastal Region programme. Efforts were focused on developing a small set of accelerator schemes with local partners to demonstrate how KCC could help residents access quality jobs.

(d) Work was underway to implement actions following the population needs review. A new sexual health clinic in Dover was supported to address service gaps and inequalities. Gonorrhoea and Monkeypox (Mpox) vaccinations were rolled out opportunistically in clinics, with data collection in progress to assess impact. Strategic projects included work on ChemSec and evaluation of the online STI testing service, with outcomes to follow.

(e) Healthy weight stigma training had been launched to enable staff to hold inclusive conversations confidently. A new booklet was also developed to raise awareness of available services and support residents in maintaining a healthy weight.

(f) A new place-based infant feeding service was due to start mobilisation in October. Further details on aspects of the public health transformation programme were due to be provided by Vicki Tovey in agenda item 11.

(g) A health needs assessment for secondary-aged children was nearing completion. Focus groups were held with young people to understand attitudes and behaviours around vaping. This helped inform how the disposable vape ban had impacted youth vaping and the measures needed to reduce use among young people in Kent. The work also supported Trading Standards in reducing underage sales of vape products.

(h) Early years nutrition training had been launched, with strong engagement from settings and noticeable improvements in practice. Overall, significant progress was underway with many positive developments reported.

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

(a) A query was raised on whether there would be concerted efforts to debunk false information around vaccines, particularly for pregnant women. It was noted that the issue had been debated at Full County Council. Vaccination was highlighted as one of the most important and

cost-effective public health interventions. Declining immunisation rates represented a serious public health risk. Public Health continued to act on barriers to access and counter misinformation where identified, with the aim of improving coverage rates to protect all residents, especially vulnerable populations

64. Pharmaceutical Needs Assessment (PNA) 2025-2028
(Item 10)

Oluwatoyin Sosanya (Public Health Pharmacy and Quality Lead) was in attendance for this item

1. Mrs Crouch (Consultant for Public Health)introduced the report and noted that, in accordance with statutory requirements, the Council was required to regularly review and publish the pharmacy services needed in Kent, both currently and in the future. This analysis was presented in the Pharmaceutical Needs Assessment (PNA) included within the papers. The assessment informed commissioning decisions by NHS England and the Integrated Care Board (ICB), ensuring that services met population needs and addressed identified gaps.

2. Mrs Sosanya reiterated that the Pharmaceutical Needs Assessment (PNA) was a statutory document designed to assess the current and future need for pharmaceutical services in Kent over the next three years. It considered the health needs of the Kent population and how these could be met by services commissioned by the NHS, including pharmacies, appliance contractors, and dispensing GPs. The PNA was a key document used by NHS England, Integrated Care Boards (ICBs), and local authorities to inform commissioning decisions, including market entry decisions to the pharmaceutical list, which were determined by the ICB.

3. The PNA had been developed with the support of a specialist provider, commissioned through a competitive tender process, and overseen by the Kent PNA Steering Group. The steering group included representatives from system partners such as the Local Medical Committee, Local Pharmaceutical Committee, Healthwatch, and the ICB. It met four times at critical stages for review, discussion, and sign-off. Early in the process, engagement took place with the public and pharmaceutical providers through a questionnaire, followed by a statutory public consultation. Both activities informed the final document. At the time of writing, no gaps had been identified in the provision of pharmaceutical services across Kent, and monitoring would continue on behalf of the Health and Wellbeing Board.

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

   (a) In response to concerns regarding the PNA's conclusion of no gaps, raised in light of pharmacy closures, increased queue times, and the ability to meet growing needs, particularly regarding prevention and an ageing population, Mrs Sosanya explained that a robust, evidence-based process had been followed. She confirmed the PNA considered

population needs and financial stability, and the steering group agreed that the network was sufficient at the time. She emphasised that the PNA was a snapshot in time, monitoring would continue with ICB and system partners, and supplementary statements would be published as needed to inform future applications.

(b) Clarification was sought as to the process that would be followed should gaps be identified in pharmaceutical services. Mrs Sosanya explained that the landscape would continue to be monitored and minor changes addressed through supplementary statements, which would signal to the ICB that updates to the pharmaceutical list should be considered in future applications. She confirmed that the Health and Wellbeing Board was required to publish a new Pharmaceutical Needs Assessment every three years, but could do so earlier if there were significant demographic changes or risks to health and wellbeing in Kent.

(c) Queries were raised as to the defined thresholds that would automatically trigger a review of the PNA, such as a pharmacy closure, rather than relying on resident complaints. Mrs Sosanya advised that changes to the pharmaceutical list, including closures or altered opening hours, were notified by the ICB and analysed for impact on service needs. Significant changes, such as the closure of Lloyd's Pharmacy in the past, had prompted detailed discussions with the ICB. She confirmed that monitoring was continuous, and where changes were deemed significant, the Health and Wellbeing Board could decide to revise the entire PNA. She noted that much depended on what was considered significant.

(d) Concerns were expressed regarding the ICB's "one-size-fits-all" approach and issues were highlighted regarding pharmaceutical closures in rural wards, with exceptions for those who were disabled or very elderly continuing to receive prescriptions locally with other residents forced to travel three miles to the nearest pharmacy. It was felt that the new system was less efficient, with delays of up to 10 days for prescription acknowledgements. Mrs Sosanya explained that the distribution of community pharmacies reflected both rural and urban needs, and that dispensing GPs remained available in rural areas under strict criteria, such as residents living more than 1.6 km from a pharmacy. She also highlighted the option of online pharmacies that delivered nationwide. Mr Waller *(Chief Strategy and Partnerships Officer and Chief Delivery /Commissioning Officer (interim) – NHS Kent and Medway - Integrated Care Board)* added that the PNA was based on a detailed regulatory framework for assessing need, which was separate from how providers delivered services. He clarified that NHS managed pharmacies and dispensing doctors through contracts and could act if services failed to meet contractual standards, with elected members able to provide feedback to support this process. Should the public have concerns regarding individual contractors' performance and compliance with contractual obligations, this matter could be addressed via complaining to the pharmacy , and if not resolved, via the ICB complaints procedure or Healthwatch

5. RESOLVED that the Health and Wellbeing Board approve the final 2025-2028 Pharmaceutical Needs Assessment and note that the previously approved PNA process had occurred

65. Public Health Service Transformation Programme Update
(Item 11)

Vicky Tovey (Assistant Director of Public Health) was in attendance for this item

1. Mrs Tovey introduced the paper outlining the Public Health Service Transformation Programme (PHSTP), its progress, and planned work. The programme, which began in summer 2023, aimed to improve services funded by the Public Health Grant by targeting resources to those most in need, addressing health inequalities, meeting prevention obligations, and ensuring best value.

2. The programme covered a broad range of mandated and statutory services, from early years health visiting and infant feeding to older people's exercise. It followed the natural end of several partnership contracts, including with Kent Community Health Foundation Trust, creating an opportunity to review services collectively and maximise impact.

3. Areas for improvement included low-level cannabis use, which was given greater focus within lifestyle and health visiting services. The paper detailed an evidence-based commissioning approach, including data analysis, best practice review, resident engagement, and market engagement.

4. The programme had reached its implementation stage, involving procurement, transition to new models, and communication of changes to residents and the wider system. Service changes ranged from minor refinements to significant redesigns, such as moving community-based infant feeding groups out of health visiting into a separate place-based service and transitioning children and young people's counselling to a therapeutic model aligned with ICB commissioning to increase capacity.

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

   (a) In response to queries on the referral process for the Children and Young People's Emotional Well-being Service, Mrs Tovey confirmed that referrals were accepted via multiple routes, including self-referrals, schools, and wider system partners. Communications had been issued to inform stakeholders. Services were also dual-run to avoid gaps, and young people on existing waiting lists were contacted to offer a choice between the current and new service.

   (b) With regard to comments made in relation to improving the transition for young people up to the age of 19, Mrs Tovey noted that this remained a key focus. The service provided mild to moderate support up to age 19

and worked closely with ICB services, which covered older age ranges, and Live Well Kent, which supported those from aged 17. Services collaborated to assess individual needs and determine the most appropriate provision, ensuring smoother transitions between children's and adult services. Mr Waller *(Chief Strategy and Partnerships Officer and Chief Delivery /Commissioning Officer (interim) – NHS Kent and Medway - Integrated Care Board)* also confirmed that earlier in the year, the intention had been announced to move Children's Mental Health Services, currently provided by North East London Foundation Trust, into a joint arrangement for children's and adults' mental health delivery within KMPT. The strategic driver for this change was to enable a single provider to manage the transition period, ensuring continuity of care for children and adolescents with more significant mental health needs.

(c) Further information was sought on place-based prioritisation of the smoking cessation service, particularly in light of the high smoking levels in Swale. Mrs Tovey advised that Public Health had received additional grant funding dedicated to smoking, aligned with the national strategy. This enabled commissioning of bespoke services, including an outreach-based, place-focused offer targeting high-prevalence areas such as Swale. Alongside traditional stop-smoking services, an organisation called Allen Carr's Easyway was commissioned to deliver one-day seminars, which had proven popular and effective and a pharmacy-based offer was also available, all of which continued to provide choice and accessibility for residents.

(d) In response to queries relating to Kent's Family Hub programme and place-based infant feeding, Mrs Tovey explained that KCC supported the Family Hub initiative, which had received extra funding to promote Best Start in Life. Family Hubs operated across the county with both physical and virtual delivery. Providers of services such as health visiting and infant feeding were required to deliver from, or be aligned to, Family Hubs. Community-based infant feeding services formed part of that network, ensuring multi-agency working and clear access for parents. Mrs Palmer (Cabinet Member for Integrated Children's Services) also confirmed that there were 52 Family Hubs in Kent, one of the highest numbers nationally. Kent had secured part of £550 million funding through the Family First initiative, with a significant portion allocated to Family Hubs for early intervention, enabling support for young children showing behavioural or learning difficulties. Family Hubs offered a wide range of services, including feeding clinics, health visitors, portage, and language therapy, and were regarded as a forward-thinking initiative.

(e) With regard to what was being done to support children who were on the pathway to being diagnosed with neurodiversity and waiting for an EHCP, particularly those in mainstream education, Mrs Tovey explained that school health services supported neurodiverse children in several ways. They provided advice to schools and recognised that mental health and wellbeing were major challenges for young people awaiting assessment. Uptake of counselling and therapeutic services

among neurodiverse children was high, and adjustments had been made to improve accessibility. Insight work showed that some preferred web chat over phone calls or face-to-face contact, so alternative contact methods were introduced. The therapeutic offer also allowed flexibility between one-to-one and group sessions to meet individual needs. Additionally, specific packages of care for parents were available to address behavioural and wellbeing concerns. All SEND-related services formed part of the local offer, which included public health prevention services.

(f) Further information was sought on the targeted approach to adult weight management services and the use of digital solutions, amongst concerns that this could have a detrimental impact on service quality. Mrs Tovey confirmed that procurement was live and evaluation was underway. She explained that the targeted approach was based on needs assessments and learning from previous pilots, which highlighted the need for bespoke offers for certain groups, such as culturally tailored materials, support for people with learning disabilities, and alternatives for men who preferred options like football-led programmes over traditional groups. The new provider was asked to offer greater choice to encourage engagement while maintaining core services. On digital solutions, Mrs Tovey clarified these were intended to enhance services, not replace them, by introducing tools such as apps, text invitations, and virtual follow-ups. This aimed to improve accessibility and efficiency while preserving service quality.

6. RESOLVED that the Health and Wellbeing Board note the information contained within the update report

66. Update from the Integrated Care Board on the NHS 10 Year Plan
(Item 12)

Ed Waller *(Chief Strategy and Partnerships Officer and Chief Delivery /Commissioning Officer (interim) – NHS Kent and Medway - Integrated Care Board) was in attendance for this item.*

1. Mrs Crouch (Consultant for Public Health) introduced the item and noted that, from a public health perspective, the team fully embraced the 10 Year Plan and supported the NHS in maintaining its focus on keeping people well rather than solely treating illness. She highlighted that this approach aligned closely with the services offered by public health and confirmed their commitment to continued collaboration in addressing the major factors influencing health.

2. Mr Waller continued to provide an overview of the 10 Year Plan and outlined how it would be taken forward, much of which would require collaboration across Kent and Medway. The plan centred on three key shifts: moving NHS service delivery from hospitals into the community, shifting focus from treatment to prevention, and transitioning from analogue to digital. While these themes were not new, the plan emphasised delivering them at scale, which had not previously been achieved.

3. The plan also described changes to the health system, including the merger of NHS England and the Department of Health, larger ICB footprints, and a new operating model for the ICP in Kent and Medway focused on strategic commissioning, separate from provider trust management. Additional themes included transparency and quality of care, workforce transformation, innovation, and a revised financial and productivity framework.

4. Particular emphasis was placed on neighbourhood health, bringing together NHS services, GPs, community health teams, acute hospitals, mental health services, and council services such as adult social care and housing to deliver integrated care locally. The clinical model would prioritise the most frail and highest users of healthcare, aiming to prevent deterioration and reduce hospital admissions.

5. It was noted that Kent had secured a place on a national accelerator and pilot programme in Folkestone and Hythe, through a joint bid by KCC and partners, to test the neighbourhood model. This area was chosen due to its high concentration of citizens who would benefit from a different approach. The pilot would enable testing of new methods, moving away from traditional models, and generating evidence to inform wider changes across Kent.

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

   (a) In response to concerns regarding the problems that may transpire as a result Local Government Re-organisation (LGR), Mr Waller acknowledged the need for a very close relationship between health services and council-run services. He noted that the ICB currently covered two upper-tier councils and that NHS provider trusts straddled those boundaries. He explained that any new local government structure would require clarity on how the footprints of local government and the NHS aligned, and how systems would relate to deliver services effectively. He emphasised that these challenges would need to be overcome as it was essential they worked well together. Mrs Crouch added that local health alliances had already been established, bringing partners together across local patches beyond organisational boundaries. She highlighted this as a positive foundation for building neighbourhood health.

   (b) Concerns were raised regarding the closure of Faversham's cottage hospital and whether plans were in place for its reopening. Clarification was also sought on how cottage hospitals fitted within the 10 Year Plan. Mr Waller advised that he had attended a public meeting in Faversham three weeks earlier, where Kent Community Health explained its decision to close the hospital based on patient safety and staffing challenges. Steps were being taken to reverse this position. He noted that neighbourhood health would consider the role of beds in facilities like Faversham Hospital and what services could shift from the acute sector to community settings. Evidence showed that being at home was generally best for patients, and most preferred not to be in NHS

facilities unnecessarily. He highlighted successful models such as *Home First*, developed during COVID, which supported patients to remain at home post-discharge. The aim was to define the best future model for neighbourhood health.

(c) In response to comments regarding staff burnout and the recent decision to halt international recruitment into the NHS, clarification was provided on the plans in place to support domestic recruitment. Mr Waller explained that there was a general consensus to rely more on a domestic supply of healthcare staff for several reasons. He noted that Kent and Medway already delivered strong healthcare professional training. While international agreements might still feature in long-term workforce planning as described in the 10 Year Plan, the short-term focus was on making the best use of nurses completing training in the UK. Recent communications had highlighted efforts to ensure newly qualified nurses were placed in productive roles locally. Mr Waller added that the ideal position would be for Kent to train as many healthcare staff as possible to work within the area, and much progress was already being made toward that goal.

(d) Mr Waller advised that significant NHS, social care, and other public sector resources were already being directed toward supporting people, though care was often experienced as fragmented. He noted that there was an opportunity to use existing resources more effectively. Patients frequently received multiple types of care from different parts of the NHS in ways that felt uncoordinated. A key aim of Neighbourhood Health was to bring those services together in a more integrated way, improving the experience for patients, making better use of resources, empowering staff, and ultimately addressing the problem more effectively.

(e) Members commented that whilst the aims of the 10 Year Plan; shifting care from hospitals to community, focusing on prevention, and embracing digital, were laudable, they were not new and had been discussed for decades. It was further noted that delivery continued to face challenges, particularly due to financial pressures on acute trusts, which limited investment in community services. There was an emphasis on the need to break down organisational barriers to enable collective responsibility for change. It was further highlighted that there was a difficulty for acute trusts, community services, and GP practices to share business and clinical risk, which often resulted in patients being directed to A&E as the easiest option. It was suggested that the Health and Wellbeing Board could play a role in promoting shared responsibility and to ensure that changes reflected residents' needs. In response to the points made, Mr Waller commented that the 10 Year Plan explicitly referenced the role of Health and Wellbeing Boards in creating neighbourhood health plans. He agreed with previous points, noting that these changes were significant and required organisations and boards to support and encourage people to take risks and try approaches that had not been attempted before. Miss Morton (Chair) expressed that it was important for the neighbourhood pilot to be

presented to the Health and Wellbeing Board at an appropriate later date.

(f) It was noted that the home-first approach for hospital discharges was supported; however, concerns were raised about the loss of step-down and rehabilitation facilities in Kent. Poor communication between hospitals and care agencies was highlighted as a major barrier, with care packages often failing due to the lack of home visits and risk assessments, leading to readmissions and higher costs. The need for joint assessments and a return to previous practice of inspecting homes before arranging care was emphasised. An example was shared of a woman discharged under a six-week care package who had to sleep on a sofa after surgery because no risk assessment had been completed for upstairs access.

(g) In response to the comments made, Mr Waller noted that that while some patients needed to remain in hospital for clinical reasons, prolonged stays could become detrimental once the primary issue was resolved. The importance of finding the right discharge solution for each individual was highlighted, which could include rehab or step-down facilities. The Home First scheme run by KCHFT aimed to replicate such support in patients' homes to achieve better outcomes. Early discharge planning, starting at admission, was emphasised as critical to ensure timely arrangements. It was noted that this would remain a major NHS focus during winter pressures, and the neighbourhood health pilot was expected to help identify community resources to support improved discharge planning.

7. RESOLVED that the Health and Wellbeing Board note the update.