

KENT HEALTH AND WELLBEING BOARD

Wednesday, 4th March, 2026

2.00 pm

**Council Chamber, Sessions House, County Hall,
Maidstone**





AGENDA

KENT HEALTH AND WELLBEING BOARD

Wednesday, 4 March 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 Chairman's Welcome
- 2 Apologies and Substitutes
- 3 Declarations of Interest by Members in items on the agenda for this meeting
- 4 Minutes of the Meeting held on 25 September 2025 (Pages 1 - 12)
- 5 Chairman's General Update
- 6 Director of Public Health Verbal Update
- 7 2026 Kent Joint Strategic Needs Assessment (JSNA) Summary Report (Pages 13 - 30)

EXEMPT ITEMS

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

Benjamin Watts
Deputy Chief Executive
03000 416814

Tuesday, 24 February 2026

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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 of 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.

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From: Diane Morton, Cabinet Member for Adult Social Care and Public Health
Dr Anjan Ghosh, Director of Public Health

To: Kent Health and Wellbeing Board, March 2026

Subject: 2026 Kent Joint Strategic Needs Assessment (JSNA) Summary Report

Classification: Unrestricted

Summary:

The JSNA exception report summarises key population health highlights arising from various health needs assessments and other reports and analyses completed this year. This report enables the Kent Health and Wellbeing Board and the Kent and Medway Integrated Care Partnership to be aware of the relevant issues and trends which need to be addressed and reflected in the key priorities and outcomes of the Integrated Care Strategy and district local plans.

Recommendations:

The Kent Health and Wellbeing Board are asked to note and comment on the contents of the Joint Strategic Needs Exception Report, and to APPROVE the selected recommendations from the needs assessments summarised in this 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.

1. Background

1.1 The JSNA exception report is presented annually to the Kent Health and Wellbeing Board (the previous report was presented in February 2025). The format of the report contains:

- An overview of key population highlights taken from various reports and a review of population health intelligence tools.
- Summary of health needs assessments, analyses and insight work conducted in the past year.
- Recent changes to the Kent JSNA development process and any other improvements in data and intelligence across the health system.

1.2 The following needs assessments, insight work and analyses have been completed over the last year by the KCC Public Health team and other partner organisations. Where available, final reports have been published on the Kent Public Health Observatory (KPHO) website after approval from the Director of Public Health:

- [Mid-year population estimates](#)
- [Health and Care Partnership profiles](#)
- [National Child Measurement Programme](#)
- [Pharmaceutical Needs Assessment](#)
- [Adult Healthy Weight](#)
- [SEND Needs Assessment](#)
- [Physical Activity in adults and older adults](#)
- [A&E Attendance Insights from East Kent](#)
- [Mental health crisis support](#)
- [From Service to Civilian](#)

1.3 Governance

1.3.1 The Kent JSNA Steering Group has met regularly for the fourth year running to provide oversight for this process. In addition to needs assessment, analyses and various reports, the steering group have also discussed notable improvements or changes to intelligence tools such as the JSNA Cohort Model and our Research, Innovation and Improvement developments.

2 Key population highlights

2.1 Demographic changes

2.1.1 The [2024 mid-year population estimates](#) show that Kent remains the most populous county council area in the South East with a population of 1,610,300 people. Kent's population grew by 1.0% (15,800 people) between 2022 and 2023. This is equal to the population growth in the South East and England. Kent has a population density of 4.5 persons per hectare. This is higher than England (4.4) but lower than the South East (5.0).

2.1.2 Dartford has the highest population density in Kent of 16.6 people per hectare. Ashford has the lowest population density of 2.4 people per hectare. Maidstone has the largest population of Kent's local authorities with 184,200 people. This is equivalent to 11.4% of Kent's total population.

2.2 Emerging health concerns between 2024 and 2025

2.2.1 The [Health and Care Partnership \(HCP\) profiles](#) are produced by the Medway Public Health Intelligence Team on behalf of all four HCPs across the Kent & Medway Integrated Care System. The profiles have been developed annually since 2019 and describe key health indicators, across the life course, in terms of trend and comparison across HCPs and Primary Care Networks (PCNs). They are updated every year, where data is available. Some of the key highlights from the latest profile updates are:

2.2.2 West Kent HCP

- The prevalence of overweight and obesity in adults has remained constant in Tonbridge & Malling and Maidstone districts which are 63% and 67% respectively and similar to national levels.
- Antibiotic prescribing rates are similar to England and continue to reduce.
- Breast cancer screening rates have improved to 75.9%, up from 69%.
- The rate of attendance at Accident and Emergency (A&E) among those aged under 5 has remained constant but remains above pre-pandemic levels.
- Self-harm hospital admissions in those aged 10 to 24 years show a reduction overall (336 per 100,000), but the rate is worse than other HCPs in Kent, possibly due to different recording practices across different acute trusts.
- The rate for hospital admissions due to substance misuse in those aged 15-24 is 70 per 100,000, which is worse than England. Rates are notably higher in Tunbridge wells (117 per 100,000), Tonbridge and Malling (73 per 100,000) and Maidstone (65 per 100,000).
- Emergency hospital admissions due to hip fracture (persons aged 65+) have reduced and are similar to England.

2.2.3 Dartford Gravesham & Swanley (DGS) HCP

- Smoking prevalence has increased slightly to 14%, this is higher than the Kent and Medway and National average.
- Physically inactive adults have steadily increased to 27%, this is worse than Kent and Medway and England.
- The overall rate of antibiotic prescribing has reduced.
- The rate for hospital admissions due to alcohol specific conditions is 675 per 100,000 which is worse than England.
- Breast screening rates have improved to 70.1% but remains worse than the England average.
- The rate of attendance at A&E among those aged under 5 is highest in DGS HCP and continues to increase above pre-pandemic levels.
- There has been a small increase in Diabetes prevalence among those aged 17 years and over to 8.3%.
- The overall suicide rate has slightly increased but remains similar to national levels.

2.2.4 East Kent HCP

- Life expectancy at birth for males has remained constant at 79.1 years which is worse than Kent and Medway and England.
- Smoking prevalence among those aged 18+ has reduced overall to 9%. However, Thanet (14%) remains higher than the rest of East Kent.
- The prevalence of overweight and obesity among adults has remained constant at 65% which is similar to England.
- The overall rate of antibiotic prescribing has reduced.
- The rate of attendance at A&E among those aged under 5 has reduced to pre-pandemic levels but remains worse than England.
- School readiness has remained constant at 66% which is worse than England.
- Pupil absence has remained constant at 8.3% which is the highest in Kent and Medway and worse than England.
- The rate of depression has slightly increased and is higher than England.

2.2.5 Medway and Swale HCP

- Sittingbourne PCN
 - The overall rate of antibiotic prescribing has reduced and the rate is lower than national levels.
 - A&E attendances for under 5s increased slightly but the rate is better than England level.
 - Pupil absence has reduced slightly but remains worse than England.
 - The rate of obesity prevalence has increased and is higher than England.

- Sheppey PCN
 - Antibiotic prescribing has reduced but remains higher than England.
 - Breast cancer screening has increased to 68% but remains worse than the national average. Bowel cancer screening has slightly increased but remains worse than England.
 - Emergency hospital admissions for asthma (under 19s) have reduced to better than the England average.
 - GP recorded depression among adults has increased (20%) and is higher than England.

2.3 [National Child Measurement Programme 2024/2025](#)

2.3.1 Excess weight in children remains a concern in Kent. The National Child Measurement Programme in 2024/25 found that 24.1% of reception children and 35.2% of year 6 children in Kent have excess weight. Excess weight in Kent is similar to the England average in reception children however, it is significantly better than the England average for year 6 children.

2.3.2 There is variation in excess weight by Kent Districts. Folkestone, Dover and Ashford have significantly higher excess weight than the national average. For year 6, Gravesham and Thanet have a higher excess weight than the national average.

2.3.3 The prevalence of excess weight in Kent has increased since the previous JSNA Exception Report in reception year from 22.7% (23/24) to 24.1% (24/25). The prevalence of excess weight for year 6 children has also increased from 34.9% (23/24) to 35.2% (24/25) in Kent.

2.4 [The Pharmaceutical Needs Assessment \(PNA\) 2025](#)

2.4.1 The 2025 Kent PNA, published 1 October 2025, concluded that no gaps had been identified in the provision of pharmaceutical services deemed necessary by the Kent HWB, either now or in the next three years. NHS pharmaceutical services are well distributed across Kent, serving all the main population centres and there is adequate access to a range of NHS services commissioned from pharmaceutical service providers.

2.4.2 The Community Pharmacy sector has reported workforce and funding challenges. In 2024, the rate of national pharmacy closures was higher than previous years, mainly due to these combined pressures. A recent report commissioned by NHSE found that around 47% of pharmacies were not profitable in their last accounting year.

2.4.3 In Kent there are 251 community pharmacies (which is a decrease from 272 reported in the last PNA (2022)), two dispensing appliance contractors and 41 dispensing doctor practices (44 sites). The majority of community pharmacies

(210 (84%)) are open on Saturdays, 83 (33%) are open after 6 pm on weekdays and 40 (16%) are open on Sundays in Kent.

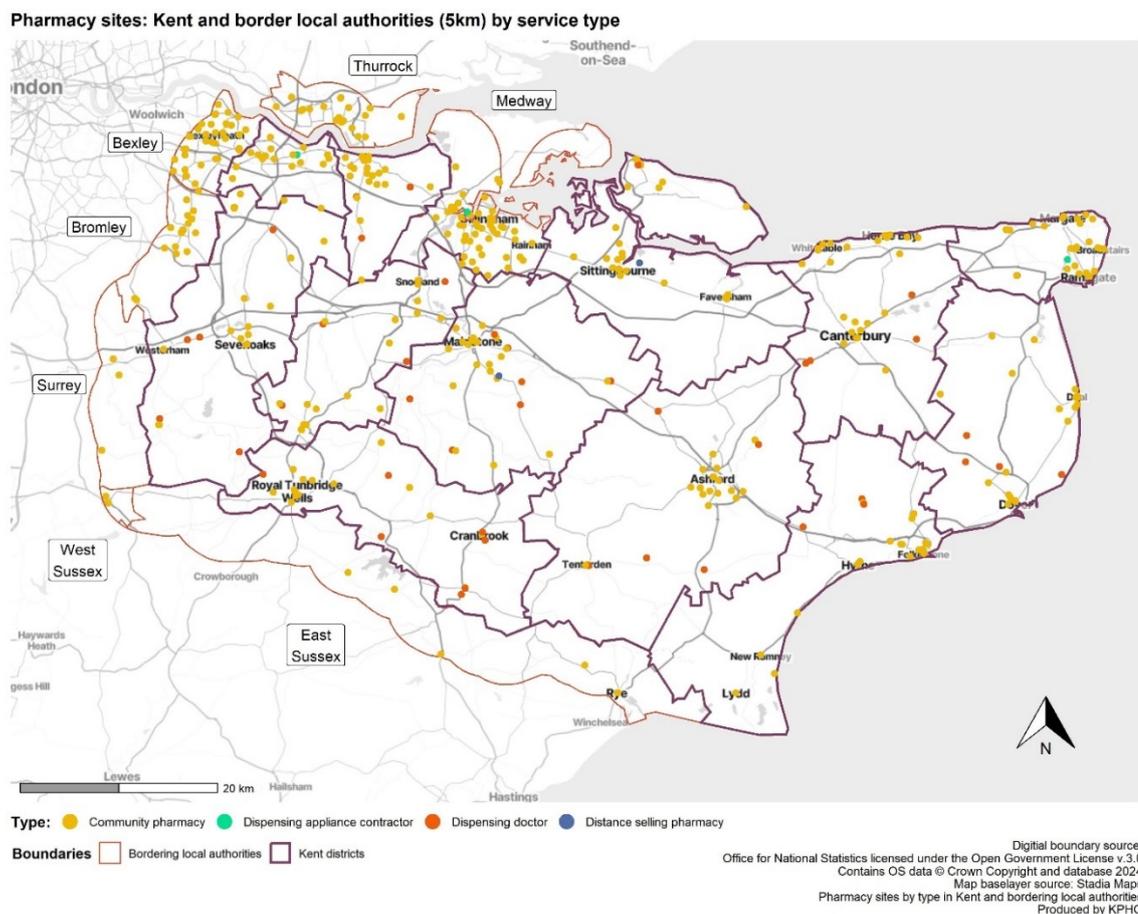


Figure 1: Map of pharmaceutical providers in Kent and across borders (5km)

2.4.4 The number and locations of the community pharmacies across Kent are reflective of the mix of rural and urban make up of Kent. The travel analysis across Kent showed 81% of the population can reach a community pharmacy in 20 minutes walking, 99% of the population who have access to private transport can reach a community pharmacy in 20 minutes in peak and off-peak times and 94% of the population can reach a community pharmacy in 20 minutes by public transport on weekdays, rising to 98% within 30 minutes on a weekday morning. During the weekend, it varies between 84%-93% of the population within 20 minutes and 89%-96% within 30 minutes.

2.4.5 Results from the public questionnaire which explored how, why and when local residents use pharmaceutical services supports the conclusion that no significant gaps exist for the majority of the population, but it also highlights the importance of ongoing monitoring and flexible service models to ensure equity of access and resilience.

2.4.6 Where appropriate, KCC and the ICB should explore the interdependencies between commissioned services to avoid duplication and continue to support the current community pharmacy estate to sign up and provide services where relevant.

- 2.4.7 Pharmaceutical Services should be conscious of the barriers some vulnerable and inclusion groups face. They should provide adaptable and inclusive services that cater to their specific requirements. As required by the Equality Act 2010, it is essential that pharmaceutical services provided remain accessible to all.
- 2.4.8 The PNA recognises the evolving role of community pharmacy in delivering preventive care, reducing health inequalities, and integrating with primary care networks. While no gaps have been identified in the current or future (three-year) provision of pharmaceutical services in Kent, there are opportunities to strengthen pharmacy services in alignment with the proposed NHS 10-year Health Plan and Change NHS initiative. These opportunities focus on prevention, long-term conditions, primary care access, medicines management, health inequalities and integrated care.
- 2.4.9 Kent HWB will continue to assess pharmaceutical service provision in response to changes in access and demand, ensuring provision remains adequate in Kent.

2.5 Adult Healthy Weight

- 2.5.1 Excess weight among adults is an increasing concern nationally and locally, with notable differences based on age, gender, ethnicity, and deprivation. Locally, Kent has higher obesity rates (67%) than the national average, and certain areas, such as deprived and coastal regions, show even higher prevalence.
- 2.5.2 A plethora of evidence indicates that obesity is a significant risk factor for many physical and mental health conditions, as well as impacting quality of life and causing premature deaths. The risk of co-morbidities increases with higher body mass index (BMI) and even more for people from Black and Asian family backgrounds as they are at risk of type 2 diabetes and cardiovascular disease.
- 2.5.3 Proportion of adults with excess weight has progressively increased nationally since 2016. However, in Kent, there has been a steeper trend, with the proportion of adults with excess weight increasing from 61.3% in 2016 to 64.8% in 2023, and the percentage of adults classified as living with obesity increasing from 23.1% in 2016 to 27.8% in 2023.
- 2.5.4 Approximately 800,000 adults in Kent are living with obesity, while weight management services can currently support only around 5,000 individuals across various tiers.
- 2.5.5 The relationship between obesity and the food and physical activity environment is complex. There is an interplay between exposure, deprivation, and urbanisation. Individual factors (such as socioeconomic position, ethnicity, education and self-efficacy) are likely to impact an individual's exposure to the obesogenic environment, for example readily available high

fat, sugar and salt (HFSS) food and low opportunity or access to areas that enable physical activity.

- 2.5.6 Kent's analysis has shown that fast food outlets are generally closer to residents in urban and deprived areas. Access to supermarkets to purchase affordable, healthy food in the context of obesity is complex. In Kent, evidence suggests challenges linked to a lack of local supermarket access and low household car ownership amongst some residents.
- 2.5.7 Kent's data analysis suggests that greenspace is more accessible in urban and deprived areas. However, lack of awareness about the health benefits of green spaces, combined with perceptions of safety may hinder the use of these spaces, particularly among high-risk groups.
- 2.5.8 Kent's analysis shows that sports facilities are generally closer to where people live in urban areas, but no difference was found in their use between the most and least deprived. Residents in the most deprived areas were found to face greater barriers to using leisure centres.

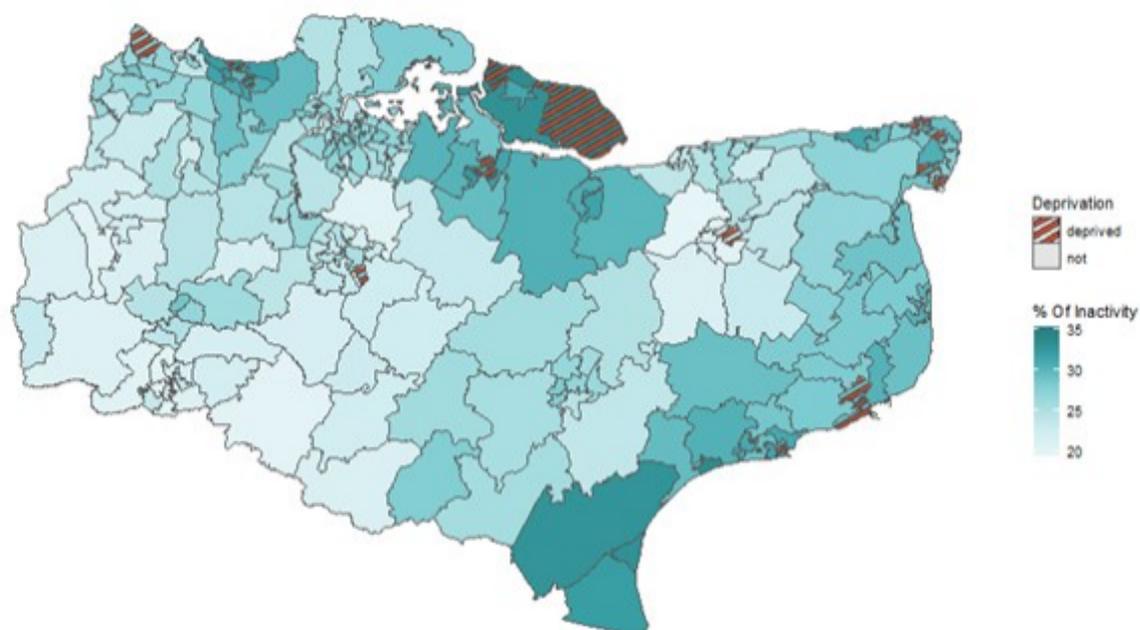


Figure 2: Inactivity rates across Kent and Medway MSOAs with top 10% deprivation highlighted, active lives survey 2021/22

2.6 [SEND Needs Assessment](#)

- 2.6.1 Special educational needs (SEN) and disabilities refers to those children and young people who may have a learning difficulty or disability and need special health and educational support including sensory, physical, social, emotional, mental health, communication, interaction, cognition and learning support needs.
- 2.6.2 Some children and young people require additional support, and this may be presented in an education health and care plan (EHCP) or as SEN support. The EHCP identifies an individual's education, health and social needs and

the support they need. It will outline the outcomes that a person would like to achieve and will be reviewed annually.

2.6.3 In 2023/24, there were 34,112 pupils receiving SEN support and 14,579 students on an EHCP in Kent, totalling 18.0% of the Kent student population combined. This is similar to the England proportion of 18.4%. Figures in 2025 present a continuing increase in EHCPs with these now totalling to 21,000 from independent, special and mainstream schools.

2.6.4 There are variations in identified needs by primary, secondary needs for those with SEN support and EHCP plans. The rate of pupils in secondary school who receive SEN support but did not receive a specialist assessment is significantly higher in Dartford district.

2.6.5 The prevalence of SEN support by ethnic group across combined years 2019/20- 2023/24 demonstrates the significant difference between Traveller of Irish heritage and Gypsy Roma populations compared to other ethnic populations which is subsequently demonstrated when looking at primary and secondary age pupils by primary need.

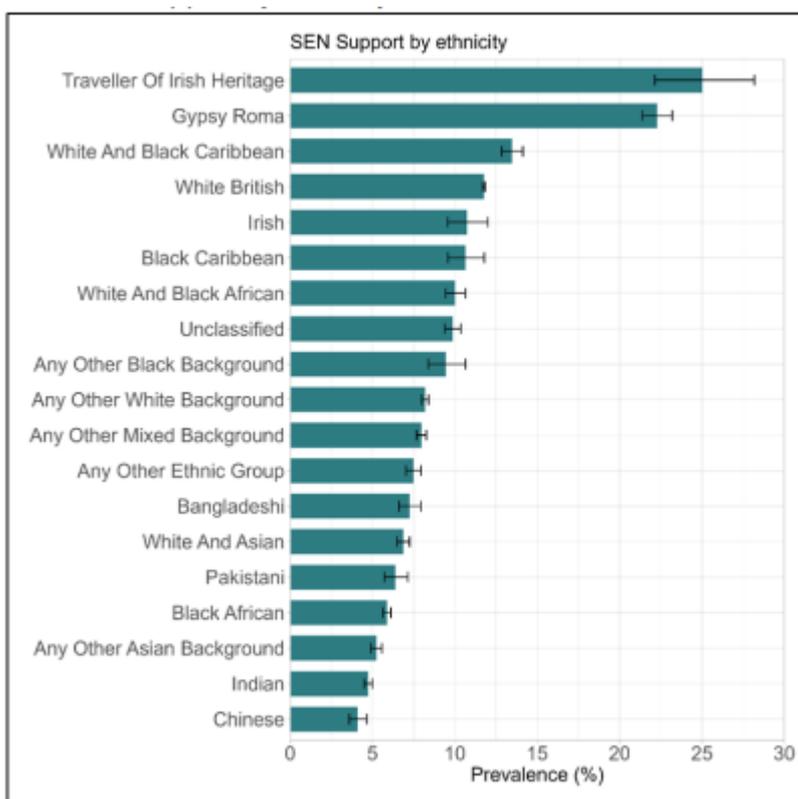


Figure 3: SEN support by ethnicity, 2019/20 to 2023/24 combined, Kent.

2.6.6 Among pre-school children there were differences seen in the health and wellbeing review at 2 –2 ½ years by district. For example, in 2023/24 lower levels in the domains of personal, social skills and fine motor skills were identified in Swale district and lower levels in the domains of gross motor skills and fine motor skills identified in Thanet district.

2.6.7 Swale district had the highest rates of primary and secondary aged pupils with an EHCP, with Thanet district having the second highest rates (per 1000

population). The rates in Swale district are more than double the rates of primary and secondary pupils in Tunbridge Wells district.

2.6.8 National research found up to 12% of individuals with an autism diagnosis (under 19 years) have a co-occurring learning disability. Among pupils with an EHCP the higher proportion of secondary needs are autism and speech, language and communication and among pupils with SEN support the higher proportion of secondary needs are social, emotional, mental health and speech, language and communication.

2.7 Physical Activity in adults and older adults

2.7.1 1 in 6 deaths in the UK is associated with physical inactivity at an estimated cost of £7.4 billion annually (including £0.9 billion to the NHS). The benefits of physical activity and exercise for health and wellbeing is well evidenced.

2.7.2 Overall, Kent continues a positive trend for those aged 55+ meeting the recommended guidelines of at least 150 minutes of exercise weekly. In 2022-23, ages 75+ have seen a statistically significant increase of 1.6%, with 43% being active at recommended levels. However, there are clear variations in activity levels of some groups and places.

2.7.3 Just 15% of older adults are doing exercise at recommended levels to benefit muscle, strength and balance (MSB) which is key to delay the onset of disability, illness, reduce risk of falling, and prolong independence. Least likely to be doing MSB are women in Thanet, men in Gravesend, and women in urban areas. Districts with the lowest levels of activity are those in north Kent.

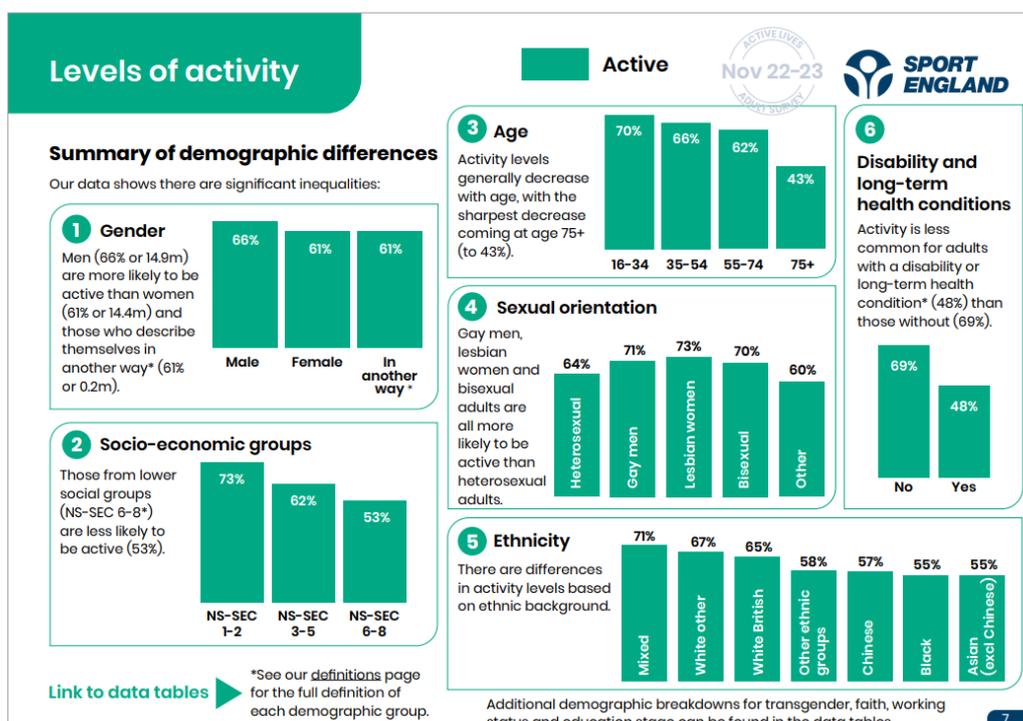


Figure 4: Summary of activity levels by demographic differences. Source: Active lives national survey 2022-23, Sports England.

2.7.4 England data suggests that there are demographic differences with some groups tending to be less active than others. E.g. women, Asian and Black ethnicities, residents of lower socio-economic groups, heterosexual adults, older adults, and people living with disability or long-term conditions. People with Severe Mental Illness (SMI), have a life expectancy of 15-20 years shorter than the general population, with an estimated 2 in 3 premature deaths being from preventable physical illnesses.

2.7.5 A return on investment study for Kent in 2019, reported that the social and economic value of community sport and physical activity saw Canterbury district realising the largest return for physical and mental health outcomes, whilst Maidstone saw the largest return for mental wellbeing, social care and community development.

2.8 A&E Attendance Insights East Kent

2.8.1 Healthwatch Kent was commissioned to conduct visits to William Havey Hospital (WHH) and Queen Elizabeth Queen Mother Hospital (QEQM) in East Kent speaking to people about their journey to the initial assessment area of Accident and Emergency.

2.8.2 Across 2 visits to each site, 50 people shared their experiences which included what services they had interacted with before attending and if they felt their attendance could have been avoided.

2.8.3 In total, almost one-third of participants (32%) believed their A&E visit could have been avoided, while half considered it unavoidable (52%) and a further 16% were unsure. Despite national concerns around inappropriate A&E use, only a small proportion of participants (8%) cited difficulty accessing a GP appointment as the reason for their attendance.

2.8.4 Insights from participants from areas of higher overall deprivation were overrepresented in the sample. It was noted that they were more likely to be unsure as to whether their A&E attendance could have been avoided.

2.8.5 Against a backdrop of rising pressures on emergency departments nationally and regional reviews into Urgent Treatment Centres (UTCs), the study highlighted the growing body of research that challenges simplified assumptions about “inappropriate” A&E use and informs discussions around a shift from Hospital to Community.

2.9 Mental health crisis support

2.9.1 Mental Health Voice, Healthwatch Kent and Healthwatch Medway People collated and analysed engagements and feedback from people on their experiences of support in a mental health crisis. People were invited to share their own or their loved one's health or social care experience, providing detail on what happened, where it happened and when. There were 489 related experiences analysed from January 2024 to February 2025.

2.9.2 People talked about receiving understanding, supportive and helpful care from professionals and how positive interactions had enabled them to manage their mental health, keep them safe and help them to recover. We heard the most positive feedback about voluntary, community and social enterprise services and Kent and Medway Safe Havens.

2.9.3 Other key service types were: community mental health teams, general practice, home treatment and rapid response, the Kent and Medway Mental Health Crisis Line, A&E, children and young people's mental health services, talking therapies, liaison psychiatry and mental health hospitals.

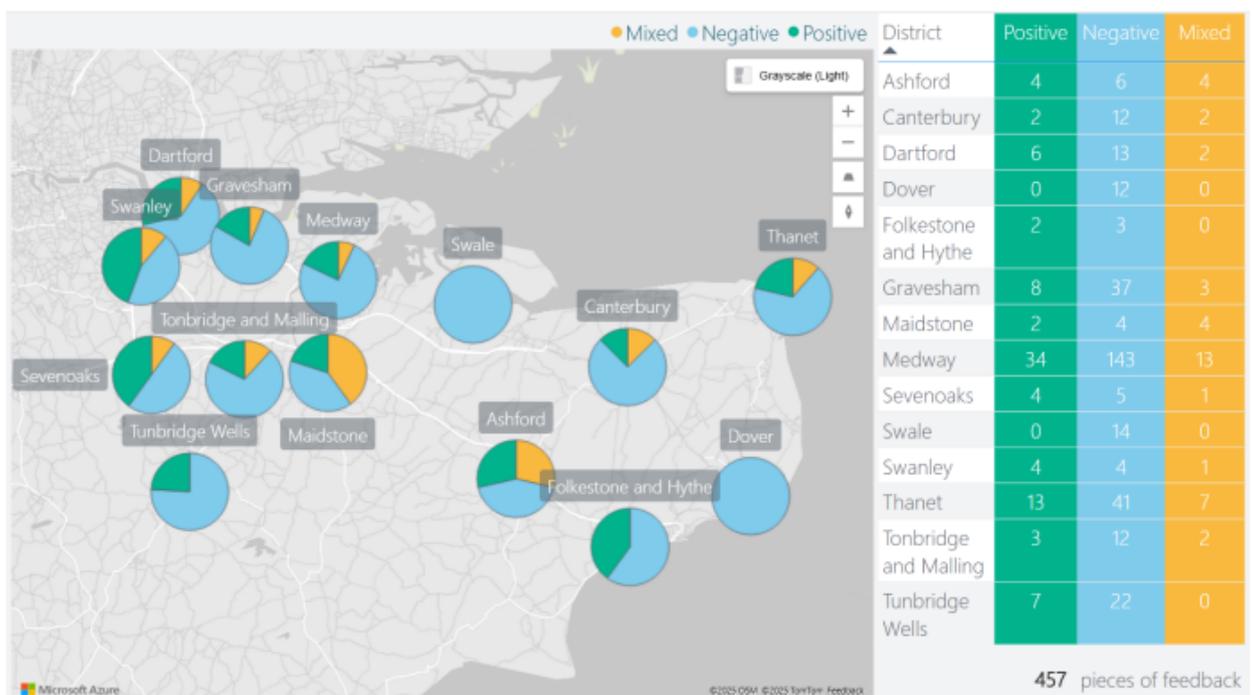


Figure 5: Proportion of positive, negative and mixed feedback by district.

2.9.4 Key issues were waiting times for crisis support, ineffective responses and unsuccessful coordination or continuity of care between services. Time of year was an important factor for consideration in the provision of services that support mental health.

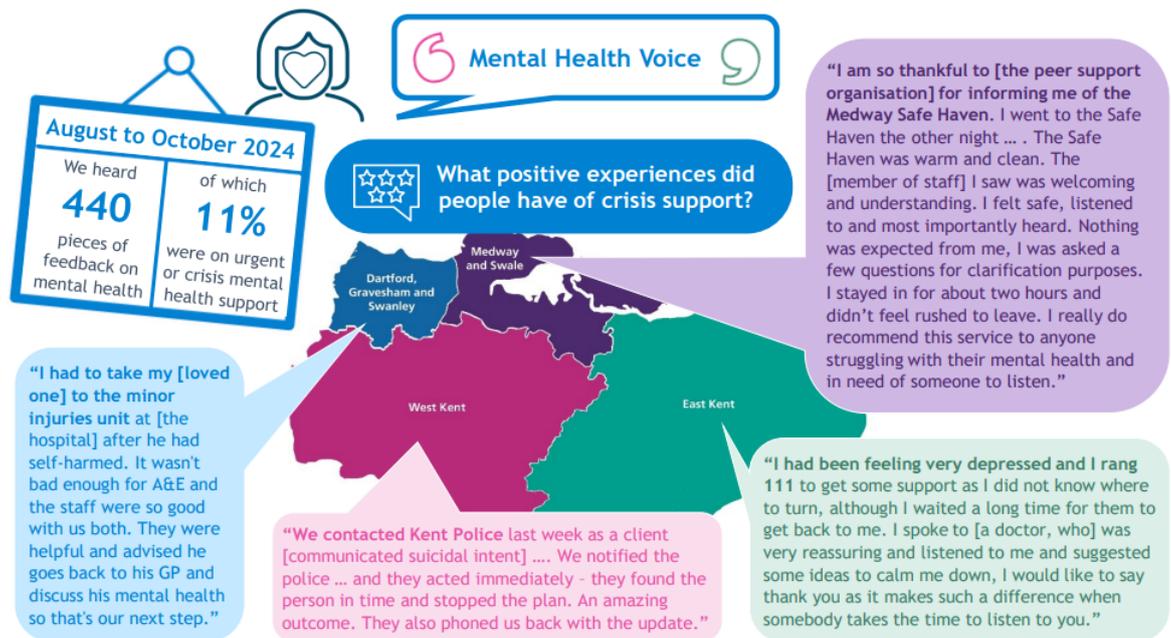


Figure 6: Excerpt from November 2024 summary report – positive experiences

2.10 From Service to Civilian

2.10.1 Healthwatch Kent conducted this engagement following findings from the previous Armed Forces Needs Assessment by Kent Public Health which highlighted that an understanding of veterans’ experiences of health and social care were limited.

2.10.2 A research survey was completed by 115 UK Armed Forces Veterans that live in Kent and Medway, key findings were as follows:

2.10.3 Physical health: The most frequently mentioned issue – difficulty in getting an appointment or seeing their GP – is a common experience within the wider population. However, by understanding that many veterans have a previous experience of healthcare access being fast and exclusive, a combination of signposting and reframing expectations would improve veteran experiences.

2.10.4 Mental health: Within the veteran community that we spoke to, there is an understanding that there is a set of unique needs, particularly in regard to mental health, whereby specially trained staff or staff with their own experience of the Armed Forces could help achieve better health outcomes.

2.10.5 Wider social issues: Some Veterans link employment as an important part of their health and wellbeing, with a lack of support received around post discharge employment. Consideration of integrating employment support into signposting provided around general veteran health and wellbeing could be considered to address this.

2.10.6 Armed Forces Covenant and Veteran Friendly Accreditation: There is an awareness of the Armed Forces Covenant and Veteran Friendly accreditation,

but there is differing ideas of what accessing a 'Veteran Friendly' GP or other health service is like for a veteran. Better communication from the surgery to its veteran patients on how they benefit from the Veteran Friendly accreditation would help alleviate the difference in expectations.

2.10.7 Notable differences within groups of veterans: Nepalese respondents and respondents who are disabled had notably worse experiences. These cohorts would be easy to identify upon discharge from the Armed Forces and in the spirit of the Armed Forces Covenant, pre-emptive measures put in place to mitigate potential negative experiences. The Needs Assessment should highlight that these cohorts currently experience an inequality.

2.11 Needs Assessment in progress

2.11.1 Unpaid Carers

This will focus on adult carers, maintaining carer health and wellbeing and preventing carer breakdown. The needs assessment was requested by the Adult Social Care Carers Strategy Group, to help form a rich evidence base in which to support the ongoing action plan. It adopts a co-production approach from beginning to end, supported by a multi-disciplinary steering group which includes representatives from commissioning, analytics, public health, adult social care, health, people with lived experience and the VCSE. Unpaid carers living in Kent will be involved and their time compensated through a small grant.

3. Other JSNA Products, new information and intelligence

3.1 Use of the JSNA Cohort Model and other simulation modelling tools

3.1.1 The JSNA Cohort model helps to model and forecast population health and care needs and to simulate the impact of various behavioural interventions on health status based on systems dynamics methodology. The outputs continue to enhance public health and NHS practice. A number of papers have been written up in detail and published in peer review publication journals. The links to these publications can be found [here](#).

3.1.2 The 'Prevention Framework' is a practical guide which sets out the strategic direction for Kent County Council to prevent, reduce and delay the need for Adult Social Care, in accordance with The Care Act 2014. In further development, there has been additional Systems Dynamics modelling work to forecast the relative effect of prevention activity on adult social care spend. Whole Systems Partnership (WSP) supported the build of a model which uses the Patient Need Group classification to quantify the potential to reduce the expected increases in NHS costs driven by the ageing population. A paper is being written up a paper for a journal to present the findings.

3.1.3 Kent Public Health Observatory (KPHO) has been supporting the Adult Social Care Prevention framework. A statistical risk score is being developed to

identify older people in the general population who are most likely to start drawing on care and support from Adult Social Services. There are promising opportunities to collaborate with NHS partners because of the presumed overlap between the statistical model in development and the inclusion criteria the NHS is using to define complex care for various population health initiatives.

- 3.1.4 An example is the East Kent remote monitoring pilot of 300 'high-need' individuals. The pilot was evaluated and was shown to reduce healthcare utilisation. KPHO have used the study data and have found that there is strong evidence that the pilot has also lowered the incidence of people starting social care plans over the short-term of the study period of about one year.

3.2 Kent Public Health - Centre of Excellence

- 3.2.1 KCC Public Health's Research Innovation and Improvement function has significant progress since its inception 3 years ago. The team continues to grow and initiate recruitment with several National Institute for Health and Care Research (NIHR) portfolio studies in progress and in the pipeline. The Kent & Medway Research & Innovation Collaborative (our local research network) have over 100 research leads, including NHS Kent & Medway for which we now have a joint coordination function.

- 3.2.2 There is a new and emerging evaluation support team for local commissioning and a commitment to build vital activities and resources to generate a better understanding of our population health and, more importantly, local evidence of service impact.

3.3 Kent Marmot Coastal Region Programme

- 3.3.1 The Kent Marmot Coastal Region Programme is a proactive approach to health inequalities using the Marmot Principles, resulting in a long-term plan for sustained change in coastal areas in Kent. This approach is being employed by a growing number of areas in England and Wales that are declaring themselves 'Marmot Places' to lend traction to their aims.
- 3.3.2 The Kent Marmot Coastal Region Programme represents a critical step towards addressing the deep-rooted health inequalities in Kent's coastal communities. By adopting a focused approach, centred on 'skills for work' and 'work and employment,' this initiative leverages the Marmot Principles to tackle key social determinants of health.
- 3.3.3 Collaborative partnerships, strategic alignment with existing initiatives, and a commitment to evidence-based decision-making form the foundation of this programme. Through robust governance and stakeholder engagement, the programme aims to create sustainable improvements in health equity, drive economic inclusion, and foster long-term systemic change. This pioneering

effort positions Kent not only as a leader in health equity but also as an exemplar for other regions to follow.

3.4 NIHR Work and Health Development Award

3.4.1 The cross-collaborative research team including Canterbury Christ Church University, Kent Public Health, Medway Public Health and voluntary sector partners, Federation of Small Business and others have secured an NIHR Work and Health Award to address youth unemployment in Kent and Medway called the HOPES Project. The project supports regional ambitions of the Kent and Medway Work and Health Strategy (2025-2030) and reflects the Marmot Review's emphasis on good work as a foundation for health.

3.4.2 Working with local authorities, the ICB, community organisations, employers, and young people, the HOPES Collaborative will map existing provision, analyse data, and co-produce insights that improve employment and health outcomes. The work will also strengthen long-term partnerships and position the region for future NIHR investment.

3.5 Progress on the Insight Bank for Kent and Medway

3.5.1 Kent and Medway ICB continue to co-create the Kent and Medway Insight Bank with stakeholders across the Kent and Medway health and care system. The Insight Bank will pool and share valuable knowledge about patient and public experience and views of health, wellbeing, and care services, collecting and collating information from local partner organisations.

3.6 Horizon scanning

3.6.1 The upcoming Local Government Reorganisation (LGR) may require changes to the way the JSNA operates. As the geographical footprints across Kent evolve, further development work will be needed to ensure the JSNA remains aligned with the new structures. Continued review and adaptation will be essential to maintain its relevance and effectiveness.

4. Recommendations

4.1 The Kent Health and Wellbeing Board are asked to note and comment on the contents of the Joint Strategic Needs Exception Report, and to APPROVE the selected recommendations from the needs assessments summarised in this 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 such as Gypsy, Roma and Traveller community, People in contact with the justice system and Asylum seekers

- KCC and the 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.

5. Background Documents

- [Mid-year population estimates](#)
- [Health and Care Partnership profiles](#)
- [National Child Measurement Programme](#)
- [Pharmaceutical Needs Assessment](#)
- [Adult Healthy Weight](#)
- [SEND Needs Assessment](#)
- [Physical Activity in adults and older adults](#)
- [A&E Attendance Insights from East Kent](#)
- [Mental health crisis support](#)
- [From Service to Civilian](#)

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