KENT COUNTY COUNCIL

KENT HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Kent Health and Wellbeing Board held in the Council Chamber, Sessions House, County Hall, Maidstone on Tuesday, 11 February 2025.

PRESENT: Mr D Watkins (Chairman), Dr B Bowes (Vice-Chairman), Cllr M Blakemore, Mrs S Chandler, Mrs P T Cole, Mr R W Gough, Dr A Ghosh, Mr R Goatham, Mrs S Hammond, Cllr Mrs A Harrison, Cllr J Howes and Mr R Smith

IN ATTENDANCE: Dr M Gogarty (Strategic Lead Public Health Consultant), Ms M Varshney (Consultant in Public Health), Sosanya (Public Health Pharmacy and Quality Lead) and Dr A George (Consultant in Public Health)

UNRESTRICTED ITEMS

47. Chairman's Welcome
(Item 1)

48. Apologies and Substitutes
(Item 2)

Apologies were received from Mr Paul Bentley, representative of the Integrated Care Board. Ms Malti Varshney was in attendance.

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

Ms Varshney declared that she was a non-executive Director in one of the voluntary sector organisations in Maidstone.

50. Minutes of the Meeting held on 25 April 2024
(Item 4)

RESOLVED that the minutes of the meeting held on 25 April 2024 were an accurate record and that they be signed by the Chairman

51. Director of Public Health Verbal Update
(Item 5)

1. Dr Ghosh provided a verbal update on the following:

   (a) Kent County Council had been awarded a Public Health Grant of £81,469 for 2025-26 which was the second highest grant in the country, with Birmingham receiving the largest allocation and Lancashire receiving the third highest. However, in terms of allocation per head in terms of size of population, there was a level of discrepancy with Birmingham receiving £92.48 per head, Lancashire approximately £65 per head, and Kent £49

per head. However, the allocation and early announcement would ensure earlier planning compared to previous years.

(b) The 9th March was the Covid Day of Reflection and marked the 5th year of the start of the Covid pandemic. A number of events were set to take place across Kent, with the locally adopted theme focussed on Healing and Hope. KCC would also be launching a virtual remembrance wall for staff and members to share experiences.

(c) KCC's public health priorities had been developed for 2025-26, these were as follows:

1. Three priorities which were set to continue from the previous year:
   - delivery of the integrated care strategy
   - public health service transformation program
   - prevention program, really putting a rocket booster under prevention, although everything that public health does in a way is prevention, but this is specifically looking at how we can prevent, reduce, and delay the use of adult social care strategy services through the adult social care prevention framework that we're working very closely with adult social care colleagues on
2. Family hubs and Start For Life Programme
3. Stop Smoking Services and vaping
4. Tackling health inequalities across Kent through the Marmot Coastal Region, the Work and Health Strategy and the Housing Strategy.
5. Mental health and the reimagining of mental health services to create better integration between children's and adults

(d) The strategic work underway was set to be delivered through the Integrated Care Strategy's Delivery Plan which featured as an agenda item.

(e) Coastal Kent would be the first region in the UK to call itself a Marmot Coastal Region. KCC Public Health has commissioned the UCL Institute of Health Equity (IHE) for a period of two years from October 2024 to October 2026 to support the initial stages of the programme. The plan for Kent was to adopt a layered approach starting with two of the eight Marmot principles, 'skills for work' and 'work and employment' which focussed on tackling health inequalities by improving deprivation through jobs, which was one of the most important sustainable wider determinants of health. The six areas are Swale, Canterbury, Thanet, Dover, Folkestone and Hythe, and Ashford. The senior leadership of all these districts and boroughs had endorsed the programme and committed to support it. Kent Marmot Coastal Region Programme

(f) The consultation on Kent and Medway's Work and Health Strategy was due to close on 20th March 2025. This strategy had been designed to support employers in creating healthier workplaces and to support people with all long-term health conditions and disabilities to start, stay and succeed in work

(g) The Pharmaceutical Needs Assessment was a statutory requirement of the Heath and Wellbeing Board and featured as an agenda item.

(h) The transformation program was at its business end, making this year pivotal for several services. The 0-2 Health Visiting Services, Community Infant Feeding Services, 5-19 School Nursing, and Children's Emotional and Mental Well-being Therapeutic Services had all undergone key decision-making processes and were about to start procurement. Following these, lifestyle services such as One You Kent, NHS Health Checks, and Sexual Health Services will also be taken through the governance process for key decisions in the coming year.

(i) In terms of health protection, COVID, flu, and other infections, had put significant pressure on NHS trusts. Unfortunately, vaccine uptake among healthcare workers had been low, and therefore a strong focus remained on learning from the past and improving this in the coming year. Similarly, norovirus cases were high in winter, nearly double the seasonal average, both in Kent and nationally. Work was underway to strengthen efforts with care homes, particularly around infection prevention and control.

(j) Public Health continued to work closely with children, young people and education to enhance integrated working. KCC had received notification of the 2025-26 family hubs allocation, which was a positive step.

(k) One of the focal areas for Public Health was mental health. Work was underway to complete a mental health needs assessment, which would serve as the evidence base for work throughout the year. Additionally a mental health summit was scheduled to be held in April, to bring together key stakeholders from across Kent to discuss this important issue.

(l) Regarding suicide prevention, the strategy was due for an update later in the year. Encouragingly, the most recent OANIS data showed that suicide rates in Kent were falling despite them rising in other parts of the country. However, it was important to note that even one death was too many, and Public Health continued to deliver a range of projects in this area.

(m) On the 22nd September the Baton of Hope was scheduled to visit Kent as part of its national tour. The baton would be carried across Kent by members of the public, touched by the painful issue of suicide, in an attempt to raise the profile of suicide prevention activity, as well as bring people together to explore the concept of hope.

(n) Regarding substance misuse, there were renewed efforts to get people on opiates into treatment, with some improvement in numbers, though more work was needed. There was also a continued focus on reducing drug-related deaths in Kent. While it was difficult to predict the number of deaths in the last quarter, real-time surveillance suggested a slight decrease. Additionally, efforts were being strengthened on the supply side by working with the police and improving continuity of care for individuals coming out of the criminal justice system.

2. In response to comments and questions from Members of the Board, it was noted:

   (a) Queries were raised regarding the disappointing allocation per head and whether this was partly due to the diversity in the Kent population. It was noted that previous allocations for public health efforts were based on lower super output area (LSOA) deprivation, and that Tunbridge Wells had an LSOA in the bottom decile, which it did not have previously. Dr Ghosh advised that the government was being lobbied on two main points: creating multi-year settlements for better service planning and clarifying the current allocation pattern. He acknowledged that deprivation played a role in allocations, citing Birmingham's higher per head allocation compared to Kent. However, he noted that historical allocations and other factors also influenced the current pattern. Dr Ghosh emphasised the need to review the allocation formula, which had been a complex and ongoing issue. He expressed hope for more clarity on how allocations were to be calculated in the future.

   (b) In response to queries raised regarding what the Marmot programme would like in practice, Dr Ghosh confirmed that the two-year program was in its early stages, with initial focus on compiling and analysing existing data to create a monitoring dashboard. Efforts were being made to map ongoing work across the coast to prevent duplication. Key focus areas included the adult social care workforce, NHS workforce (excluding doctors and nurses), children not in education, employment, or training, looked-after children, rough sleepers, the homeless, and individuals transitioning from the criminal justice system. Collaboration with various partners, including the education and private sectors, aimed to create job pathways and support the exploration of new initiatives.

   (c) Concerns were raised about the allocation of funding, noting the wide variety of demographics in Kent and the potential disadvantage to rural communities due to the emphasis on deprivation. Dr Ghosh provided assurance that this was a significant area of focus with an opportunity to utilise the alliances with districts and boroughs for hyperlocal work. He highlighted models that had been used in Canterbury, Tonbridge and Malling, Folkestone and Hythe, where specific locations had been chosen based on deprivation or rural poverty with a focus on improving outcomes for those communities over a year.

   (d) Members commented on the importance of the prevention program in adult social care and the need to take a proactive approach in the immediate term to help prevent costs in the long term.

3. RESOLVED to note the verbal update

52. 2025 Kent Joint Strategic Needs Assessment (JSNA) Summary Report
(Item 6)

Abraham George, Consultant in Public Health was in attendance for this item

1. Mr George introduced the 2025 Kent Joint Strategic Needs Assessment (JSNA) exception report which highlighted the health needs assessments, reports and analyses completed in 2024, as well as key population health figures. The JSNA allowed both the Board and the Kent and Medway Integrated Care Partnership to be aware of the relevant issues and trends which needed to be addressed and reflected in the key priorities and outcomes of the Integrated Care Strategy and district local plans. Mr George highlighted that there had been a total of 12 needs assessments completed over the last year (highlighted throughout the report) by the KCC Public Health team and other partners organisations . Where available, final reports were published on the Kent Health Observatory (KPHO) website . Mr George highlighted the key findings from the report and welcomed questions.

2. In response to comments and questions from Members of the Board, it was noted:

(a) In response to members interest regarding the Kent and Medway Care Record (KMCR) and its promising application, Mr George explained that the KMCR which had been developed over several years as part of the NHS's national digital and data infrastructure program, was a shared care record contracted to GraphNet. Initially intended for direct care planning, its use expanded during COVID to include population health intelligence, aiding JSNI-related work. Despite its benefits, Mr George highlighted the need for a strategy to incorporate non-social care NHS datasets to better understand the broader at-risk population. Efforts were underway, particularly in West Kent Health and Care Partnerships (HCP), to explore data integration from local councils and voluntary organisations. The record's risk stratification tools had been useful for profiling high-risk patients

(b) Members expressed appreciation for the data available and noted its usefulness in addressing inequalities, with specific reference made to Tunbridge Wells. A request was made that the maps from the KPHO were better labelled to help focus on communities with problems. Mr George agreed to further discuss the suggested improvements offline.

(c) With regard to A&E admissions for children and whether there was any assessment of other influencing factors, such as primary care availability or temporary housing conditions, which identified commonality of need; Mr George explained that the current public health data sets were high-level and did not allow for detailed analysis. However, with the Kent care record, there was potential to link multiple data sets to better understand these risk factors. He emphasised the need to collaborate with NHS healthcare partnership colleagues to ensure accurate interpretation of the analysis.

(d) In response to the healthy weight statistics for children and whether local efforts had made an impact on trends becoming more static as opposed to worse, Dr Ghosh emphasised the importance of looking beyond Kent and comparing its data with similar areas like Hampshire or Surrey, but with caution. He acknowledged that maintaining current obesity levels ("standing still") might have seemed counterintuitive, but it was a debated and agreed-upon target in the log frame. The goal was to prevent obesity rates from increasing and eventually reduce them. Achieving a stable state was still seen as progress, though its duration was uncertain due to various influencing factors. Dr Ghosh noted that if

they could maintain the current level of stability and begin to see a decline by next year, it would be an achievement.

(e) In response to the recommendation regarding “Online parenting courses should be available and promoted, with a focus on “understanding your child” and developing personal, social, and emotional skills in families”, a point was raised that parenting courses were a significant factor in the delivery of Family Hubs, delivered both in-person and online, and this would help to address one of the selected recommendations from the needs assessment.

(f) Members commented on the stakeholder insight, specifically in relation to transgender men and non-binary patients with a cervix invited for cervical screening and inquired whether any discussions had taken place, given that these programs were nationally commissioned and delivered. It was suggested that the recommendation might be better phrased to ensure that anyone with a cervix is offered screening. Furthermore, a better understanding was needed of the National Screening Commission's role, as the cervical screening program was commissioned nationally and it was therefore important to assess the feasibility of the recommendation and determine whether it should be directed to GPs or the national commissioners. Dr Ghosh advised that it was currently an aspiration to implement the recommendation, however, further liaison was needed with the relevant leadership groups to determine if the recommendation could be actioned as the findings were specific to analysis in East Kent practices.

(g) Ms Varshney offered support from the NHS perspective, referencing section 3.3.4 of the report in relation to health characteristics of Kent residents in receipt of social care services.

(h) A suggestion was made to revise the statement in section 2.6.1 on page 20 to indicate there are 1,310 serving UK Armed Forces personnel, including 900 Gurkhas, to avoid upsetting the Nepalese community by not considering Gurkhas as UK serving personnel.

(i) Members queried the high rate of dementia in Folkestone and Hythe and whether this correlated with the higher age profile in the area, or whether it was becoming more prevalent in younger people. Dr Ghosh Advised that it was common practice in public health to standardise for age when examining prevalence rates of long-term conditions like dementia across different sub-geographical areas. This meant that the data was adjusted to account for age distribution in those areas

3. RESOLVED that the Kent Health and Wellbeing Board approve the actions to be undertaken in relation to the specific recommendations outlined in the JSNA exceptions report, specifically:

Health needs assessment for 5-11 year olds in Kent

• Online parenting courses should be available and promoted, with a focus on “understanding your child” and developing personal, social, and emotional skills in families.

• Trauma informed approaches should be used more widely, and all professionals working with children should be trained.

• Activities which address wider determinants of health should be undertaken, for example addressing damp and mould in housing and reducing excess weight in children.

Sexual Health Needs Assessment

• Increasing monitoring and methods to prevent human immunodeficiency virus (HIV) transmission by increasing collaboration with wider partners to help identify at risk individuals and refer them for testing, for example drug and alcohol services, adult social care, domestic abuse.
• Raise awareness to increase visibility of sexual health services through marketing and campaigns.

Armed Forces and Veteran Community in Kent Needs Assessment
• Service providers in Kent should be "veteran aware" to accommodate their treatment needs.

Kent & Medway Housing Strategy Evidence
• Kent County Council (KCC) and partners should commit to activities which prevent, reduce and delay the need for Adult Social Care including, monitoring and evaluating the impact of interventions on falls in the elderly.

Dartford, Gravesham and Swanley HCP Needs Assessment
• Local survey data should be collected to explore the efficiency of service utilisation for children aged 0-4 in Dartford, Gravesham and Swanley Health Care Partnership (HCP), such as GP, pharmacy and urgent care.

East Kent HCP Needs Assessment
• A dedicated mental health needs assessment should be carried out to review services for mental health and evaluate the increase in the burden of depression in East Kent.

Stakeholder insight
• GP surgeries should also invite transgender men and non-binary patients with a cervix for their cervical screening, if they are not registered as female and keep an updated register.

Kent JSNA Evaluation
• KCC Public Health will coordinate with the Kent JSNA Steering Group to put in place a regular online process for disseminating reports, updates or any new data to the public.

53. 2025 Pharmaceutical Needs Assessment
(Item 7)

Oluwatoyin Sosanya MPH, MRPharmS, Public Health Pharmacy and Quality Lead) was in attendance for this item

1. Dr Ghosh introduced the report which set out the plan to update the Pharmaceutical Needs Assessment (PNA) and proposed sign-off process to ensure 2025 PNA was published according to legislative requirements. The current Kent PNA was published in September 2022 and was due to be revised by October 2025. A specialist provider called Soar Beyond Limited had been

commissioned, via a competitive tender process, to support delivery of the 2025 PNA. The PNA was a key document used by the National Health Service (NHS) and Kent County Council (KCC), to support commissioning decisions; including, but not limited to, approving applications to open new pharmacies and commissioning services through pharmacies based on population health needs. Dr Ghosh advised that due to the scheduled 2025 Health and Wellbeing Board meetings and local Kent election, approval was sought from the Health and Wellbeing Board to delegate authority to the Director of Public Health, in consultation with the Chair of the Health and Wellbeing Board, to draft and approve the first iteration of the PNA to go out to statutory consultation.

2. Ms Sosanya added that the PNA would assess the current pharmaceutical services in Kent, including pharmacies, dispensing doctors, and appliance contractors. The goal was to identify gaps and make recommendations for improvement across the county. The current PNA was published in September 2022, and a revised version must be published within three years.

3. The process of refreshing the PNA began in September last year, and a steering group had been established. Members include representatives from Kent County Council engagement, the Kent Public Health Observatory, the local medical committee, the local pharmaceutical committee, Health Watch, and the ICB. The steering group had met twice and completed several activities, including data collection, stakeholder engagement via questionnaires, validation of the current pharmaceutical list, mapping exercises, and drafting the health needs chapter based on the Joint Strategic Needs Assessment (JSNA). The information was being triangulated, and the first draft was scheduled to be ready by the end of March or beginning of April. Once approved, it would go to consultation for 60 days. The final draft would be brought to members at the September Health and Wellbeing Board for approval and publication before October.

4. In response to comments and questions from Members of the Board, it was noted:

   (a) In response to whether online pharmaceutical providers are captured within the needs assessment, Ms Sosanya clarified that online pharmacies within the health and wellbeing board boundary would be included in the pharmaceutical list, and that they had the capability to supply medicines nationwide.

   (b) With regard to whether the assessment focused solely on providers based in the area rather than accessibility. Ms Sosanya confirmed that online pharmacies were counted as providers within the Kent boundary, although essential services such as picking up prescriptions required physical pharmacies. Ms Sosanya clarified that the scope of the pharmaceutical needs assessment aimed to evaluate the population's access to pharmaceutical services. This included tests, locally commissioned services, services by the Integrated Care Board (ICB), and nationally commissioned services for dispensing medication. The assessment would consider dividing Kent into districts to ensure each district's population could access essential services listed by the NHS, as well as advanced services under the NHS contract.

   (c) The discussion underscored the importance of ensuring comprehensive access to both essential and advanced pharmaceutical services for all

residents within the Kent boundary. The assessment will involve a detailed analysis of service availability and accessibility across different districts, addressing any gaps in provision.

(d) It was noted that online pharmacies supplied medicines similarly to high street pharmacies, however, concerns were raised regarding the lack of additional services , such as treating minor illnesses and conducting health checks, which were beneficial to primary care and assurance was sought that future assessments would include additional services. Ms Sosanya confirmed that discussions had taken place with ICB colleagues and a list of advanced services provided by each pharmacy had been obtained. This would be highlighted in the PNA.

5. RESOLVED that the Kent Health and Wellbeing Board:

(a) AGREE the production plan and sign-off process of the Pharmaceutical Needs Assessment (PNA) 2025

(b) DELEGATE authority to the Director of Public Health, in consultation with the Chair of the Health and Wellbeing Board, to draft and approve the first iteration of the PNA to go out to statutory consultation.

(c) DELEGATE authority to the Director of Public Health, in consultation with the Chair of the Health and Wellbeing Board, to revise the PNA following the statutory consultation and identify if a subsequent consultation period is required.

(d) CONFIRM that approval of the PNA will be subject to decision making by the Health and Wellbeing Board in the autumn of 2025

54. Kent County Council Integrated Care Strategy (KCC ICS) Delivery Plan
(Item 8)

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

1. Dr Ghosh and Dr Gogarty introduced the report which provided members of the Board with a overview of the Kent County Council Integrated Care Strategy (ICS) Delivery Plan. The plan and priority actions were endorsed by the Health Reform and Public Health Cabinet Committee on 21st January, and approved by Cabinet on 30th January. The Kent Health and Wellbeing Board were asked to endorse the ICS Delivery Plan in its role as the delivery plan for Kent's Joint Local Health and Wellbeing Strategy. Dr Gogarty advised that the Delivery Plan was one facet of the work needed to shift health and wellbeing. Concurrently, work was being done at the district level to develop district plans, supported by the Kent Association of Local Councils. Collaborative work was also underway with the NHS, particularly through the acute trust, to deliver health and wellbeing. Dr Gogarty thanked colleagues within Kent County Council for their hard work and enthusiasm despite conflicting priorities. The Plan captured ongoing work and also defined new priorities and actions for the next one to three years to improve the population's health. It was recognised that this work would need to be done against a challenging financial background, with many options being low or no

cost. Credit was given to the Director of Public Health and Mr Watkins (Chair of the Kent Health and Wellbeing Board and Cabinet Member for Adults Social Care and Public Health) for their leadership.

2. In response to comments and questions from Members of the Board, it was noted:

   (a) Members commented on the path-breaking approach for the Council in its commitment to the level of detail in delivering the Integrated Care Strategy (ICS). Whilst recognising that there were initial questions about the substance of the ICS, the actions of the Council and other partners had brought real practical meaning to it, demonstrating its trackable delivery.

   (b) In response to the level of accountability that would be placed on individuals within the public health system, Dr Ghosh advised that multiple stakeholders, including KCC and NHS trusts in Kent, were involved and were keen to contribute. Direct conversations had also been held with the executives of NHS trusts who were eager to be involved. Dr Gogarty's work over the next year involved working with NHS trusts and internally within KCC's directorates to embed and hardwire the initiatives. KCC's directorates were jointly accountable for the strategy, and work was underway to develop mechanisms for implementation, monitoring, and accountability. The collaborative approach aimed to capitalise on the momentum and intentions of all partners involved.

   (c) With regard to targets and how these would be measured and reported, Dr Ghosh confirmed that the Integrated Care Partnership (ICP) was ultimately accountable for delivery, along with the Health and Wellbeing Board. There was also a log frame that linked with the JSNA work, which contained a set of indicators developed to provide a sense of progress rather than performance management. The first two shared outcomes, childhood obesity and mental health and employment, would be reported at the integrated care partnership. The Strategic Oversight Group (SOG) would then review the indicators and make recommendations on areas to focus on. This approach aimed to ensure delivery was managed in practical sections of work, as opposed to trying to solve all problems at once.

   (d) In response to how the priorities would be communicated at a local level to ensure that the initiative could be contributed to effectively, Dr Ghosh advised that there were eight functioning health alliances out of twelve districts, with more expected soon. Each health alliance had developed local priorities, often involving children, mental health, and employment. Communication strategies were under development at both professional and public levels as whilst it was recognised that there were channels within KCC, more work was required to ensure effective communication with residents through parish councils, health alliances, and other local organisations.

3. RESOLVED that the Health and Wellbeing board endorse the Kent County Council Integrated Care Strategy (KCC ICS) Delivery Plan in its role as the delivery plan for Kent's Joint Local health and Wellbeing Strategy.