Ashford Health and Wellbeing Board

ASHFORD
BOROUGH COUNCIL

Notice of a meeting, to be held in Committee Room 2 (Bad Münstereifel Room), Civic Centre, Tannery Lane, Ashford, Kent TN23 1PL on Wednesday, the 22nd July 2015 at 09.30 am

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The Members of this Board are:-

Dr. Navin Kumta – Clinical Lead and Chair Ashford Clinical Commissioning Group

Cllr Brad Bradford – Lead Member for Highways, Wellbeing and Safety, Ashford Borough Council

Cllr Peter Oakford – Cabinet Member for Specialist Children's Services, Kent County Council

Simon Perks – Accountable Officer at NHS Ashford and NHS Canterbury and Coastal Clinical Commissioning Groups

Bill Millar – Chief Operating Officer, NHS Ashford Clinical Commissioning Group

Neil Fisher – Head of Strategy and Planning (Ashford and Canterbury), Clinical Commissioning Group

Paula Parker – Commissioning Manager – Community Support, lead for urgent and intermediate care, Kent County Council

Faiza Khan – Public Health Specialist, Kent County Council

Mark Lemon – Policy Advisor, Kent County Council

Caroline Harris – HealthWatch representative

Tracy Dighton – Voluntary Sector representative

Martin Harvey – Patient & Public Engagement (PPE) Ashford Clinical Commissioning Group

Philip Segurola – Acting Director of Specialist Children's Services, Kent County Council

John Bunnett – Chief Executive, Ashford Borough Council

Sheila Davison – Health, Parking and Community Safety Manager, Ashford Borough Council

Christina Fuller – Cultural Projects Manager, Ashford Borough Council.

Agenda

Page Nos.

1. **Welcome and Apologies**

2. Election of Chairman and Vice Chairman of the Ashford Health and Wellbeing Board

3. Election of Chairman of the Ashford Health and Wellbeing Board Lead Officer Group

4. **Declarations of Interest:-** To declare any interests which fall under the following categories, as explained on the attached document: 1

Page Nos.

10. Update on the Kent Health & Wellbeing Board – 15th July 2015 – Mark Lemon (link to reports below)
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=790&MId=5834

11. Update on the Kent Health and Wellbeing Strategy event and KCC Health and Wellbeing Review – Mark Lemon (to follow)

12. Forward Plan

October 2015 – Progress Report and Refreshment of AHWB Priorities and Voluntary Sector Focus

January 2016 – Mental Health Update

13. Date of Next Meeting – 21st October 2015

Other dates: 20th January 2016

Under the Council's Public Participation Scheme, members of the public can submit a petition, ask a question or speak concerning any item contained on this Agenda (Procedure Rule 9 Refers).

KRF/VS
13 July 2015

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Declarations of Interest (see also "Advice to Members" below)

(a) **Disclosable Pecuniary Interests (DPI)** under the Localism Act 2011, relating to items on this agenda. The nature as well as the existence of any such interest must be declared, and the agenda item(s) to which it relates must be stated.

A Member who declares a DPI in relation to any item will need to leave the meeting for that item (unless a relevant Dispensation has been granted).

(b) **Other Significant Interests (OSI)** under the Kent Code of Conduct as adopted by the Council on 19 July 2012, relating to items on this agenda. The nature as well as the existence of any such interest must be declared, and the agenda item(s) to which it relates must be stated.

A Member who declares an OSI in relation to any item will need to leave the meeting before the debate and vote on that item (unless a relevant Dispensation has been granted). However, prior to leaving, the Member may address the Committee in the same way that a member of the public may do so.

(c) **Voluntary Announcements of Other Interests** not required to be disclosed under (a) and (b), i.e. announcements made for transparency reasons alone, such as:

- Membership of outside bodies that have made representations on agenda items, or
- Where a Member knows a person involved, but does not have a close association with that person, or
- Where an item would affect the well-being of a Member, relative, close associate, employer, etc. but not his/her financial position.

[Note: an effect on the financial position of a Member, relative, close associate, employer, etc; OR an application made by a Member, relative, close associate, employer, etc, would both probably constitute either an OSI or in some cases a DPI].

Advice to Members on Declarations of Interest:

(a) Government Guidance on DPI is available in DCLG's Guide for Councillors, at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/240134/Openness_and_transparency_on_personal_interests.pdf

(b) The Kent Code of Conduct was adopted by the Full Council on 19 July 2012, with revisions adopted on 17.10.13, and a copy can be found in the Constitution at http://www.ashford.gov.uk/part-5---codes-and-protocols

(c) If any Councillor has any doubt about the existence or nature of any DPI or OSI which he/she may have in any item on this agenda, he/she should seek advice from the Head of Legal and Democratic Services and Monitoring Officer or from other Solicitors in Legal and Democratic Services as early as possible, and in advance of the Meeting.

Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the **22nd April 2015.**

Present:

Councillor Michael Claughton – Chairman – Cabinet Member, ABC;
Navin Kumta – Vice-Chairman – Clinical Lead Ashford CCG;
Tracey Kerly – Head of Communities and Housing, ABC;
Philip Segurola –Director Specialist Children's Services, KCC;
Paula Parker – KCC Social Services;
Faiza Khan – Public Health, KCC;
Sheila Davison – Head of Health, Parking & Community Safety, ABC;
Simon Perks – Accountable Officer, CCG;
Neil Fisher – Head of Strategy and Planning, CCG;
Caroline Harris – HealthWatch Representative;
Martin Harvey – Patient Participation Representative (Lay Member for the CCG);
Tracy Dighton – Voluntary Sector Representative;
Mark Lemon – Policy and Strategic Partnerships, KCC;
Stephen Bell – Local Children's Trust;
Christina Fuller – Cultural Projects Manager, ABC.
Emma Hanson – Head of Strategic Commissioning and Community Support, KCC;
Keith Fearon – Member Services and Scrutiny Manager, ABC;
Belinda King – Management Assistant, ABC;
Renu Sherchan – Environmental Health, ABC.

Also Present:

Councillor Paul Clokie

Apology:

Diane Aslett – Age UK.

1 Notes of the Meeting of the Board held on the 21st January 2015

1.1 Tracy Dighton referred to paragraph 4.12 and advised that her suggestion that the Chief Executive of Kent and Medway NHS and Social Care Partnership Trust be invited to a future meeting was supported by the Board.

Subject to the above comment, the Board agreed that the notes were a correct record.

2 Chairman's Report – Overview of Opportunities and Activity during the Year

2.1 The Chairman explained that his report represented a review of the past 12 months' activity. He believed it presented a positive view of the work

undertaken by the Board and recognised its importance in terms of improving services for the residents of Ashford. He considered that the profile of Health and Wellbeing Boards would increase and play a more strategic role following the General Election and he believed that this Board was travelling in the right direction.

The Board supported the Chairman's report.

3 Focus on Independent Living and Self-Management

3.1 Included with the Agenda papers was an introduction and covering report which set out details of the presentations the Board would receive and included recommendations for consideration.

(a) Building Community Capacity

3.2 Emma Hanson, Head of Strategic Commissioning and Community Support, KCC gave the above presentation. The presentation covered the Community Capacity Building Programme which explored the role that Community Support played in preventing or delaying the need for statutory services. It would support KCC in developing a commissioning approach for building community capacity including a core offer or menu of services to support wellbeing, social inclusion and independence across the County. The presentation also explained the work KCC were undertaking with the community of Wye which was a project about testing new models of care and support that were more commonly focused and accountable through working with local residents to co-design alternative models of care and support.

3.3 During the presentation Emma Hanson had mentioned that KCC currently commissioned services in Wye that supported 28 residents of Wye. Tracey Kerly asked what outcomes were expected if these funds were subsequently transferred to be allocated locally. Emma Hanson said that there were would be a reduction in costs and any surplus would be ploughed back in to the community allowing further work to be undertaken. She hoped that the initiative would reduce the number of emergency admissions to hospital and as part of the work, she would be working with both General Practitioners and the hospital on this initiative. Funding was available for one year for the pilot study. Paula Parker advised that KCC were utilising community wardens in enabling them to fulfil their community role in this area. The establishment of community agents would also allow them to work within the community and there was currently one of them for each CCG area.

3.4 In response to a question, Emma Hanson said that the funding for the services commissioned to support these residents had not been given to Wye but the discussions with them were talking about how this could be used in a different way to be of a mutual benefit to the community and also to KCC. KCC would not be looking for Parish Councils or the Borough Council to meet a shortfall in any provision and she emphasised it was about making sure that the services met the needs. Emma Hanson explained that if people at risk were identified at an earlier stage it would allow steps to be taken to put solutions in place prior to it reaching a point where it had to be treated as an emergency and an admission to hospital.

3.5 Emma Hanson provided details of the STAMP Programme which was supported by KCC, Public Health and the CCGs with a remit to help Kent Charities and social enterprises, manage the transition from grants/funding to commercial contracts. This organisation would work with partners in a different way and would feed in to the overall community strategy.

3.6 Emma Hanson made reference to the Community Wardens and a desire to increase their focus on health and social care. Sheila Davison emphasised that their community safety work already contributed significantly to health and welfare and therefore this needed to be treated with caution. Tracey Kerly explained that the sheltered housing scheme in Wye could be involved in developing this initiative and the Chairman suggested that this be taken forward outside of the meeting.

3.7 As part of the establishment of a Strategic Partnership Group, Emma Hanson said that she would welcome the appointment of an Ashford Borough Council representative on the Group.

3.8 Tracy Dighton referred to the difficulties, for example, of Managers in Children's Centres in drawing down additional funds to provide extra services. Emma Hanson explained that under the proposed model the Partnership would be tasked with sorting out the desired outcomes. They would work with other agencies to deal with the issue. In terms of courses run by STAMP, she advised that they did levy a charge for attendance at their events as it was considered preferable to charge a nominal amount rather than offer free spaces as this resulted in more people actually attending the events.

3.9 In terms of the pilot exercise, Emma Hanson considered that the work undertaken in Newington, Thanet could have relevance to Ashford's urban wards.

(b) Age UK Integrated Care Programme

3.10 Paula Parker, KCC Social Services gave a presentation on behalf of Diane Aslett of Age UK. The covering report explained that the purpose of the Age UK Integrated Care Programme was to co-develop with local partners new and innovative services that aimed to reduce the risk of and prevent vulnerable old people being admitted to hospital. The services would focus on maximising the independence and self-reliance of older people using a range of approaches including promoting self-management, peer support, building and maintaining social networks and practical support alongside existing health and social care interventions. Paula Parker drew attention to the link to a video set out within the presentation and encouraged members of the Board to view it outside of the meeting.

3.11 Caroline Harris said she had concerns in that there were less and less volunteers available and for those that did volunteer, their time was becoming stretched. She asked what could be done to help support the voluntary sector. Emma Hanson said that they were currently looking at the establishment of "spice credits" which could be earned and be used for example in gyms or for local attractions. She explained that she would

arrange for invitations to the launch of the Spice Credit Scheme to be sent to members of the Board. Councillor Clokie commented that if the credits were used to gain access to Local Authority run swimming pools then the Local Authority was subsidising the programme. Emma Hanson accepted this point but said that generally the credits could be used off peak and the other benefits from the use of the swimming pool were for example on the sales of food or beverages by that visitor. Emma Hanson encouraged all to come to the presentation and said that there was a strong evidence base that such a credit scheme would help in terms of supporting volunteers.

3.12 Tracy Dighton said she was aware of a pilot scheme entitled "Rother St Mary's" and she agreed to forward the details to Emma Hanson.

3.13 In terms of the recommendations, Councillor Clokie referred to (d) and advised there had been concern expressed in Tenterden that the development at Danemore could involve three storeys. He therefore suggested an amendment to the wording of recommendation (d).

The Board recommended that:

(a) the detailed briefings on the projects be noted.

(b) consideration be given to how the projects can be supported by stakeholders and commissioners especially through the life of the projects.

(c) the update and outcomes be brought to future meetings.

(d) details of the redevelopment of the sheltered scheme at Danemore, Tenterden are yet to be confirmed and an update be brought to a future meeting.

(e) Ashford Borough Council be invited to appoint a representative to join the Strategic Partnership in Wye.

(f) more information be provided to the Ashford North Network.

(g) an invite be issued to Board members to the launch of the Spice Credit Scheme.

4 Planning for Tomorrow, Delivering Today – Strategic Commissioning Plan 2014-2019

4.1 Included within the Agenda papers was a summary of the above document, together with a copy of the full document. Neil Fisher explained that last year the Board had received a report on the five year Commissioning Plan which included the first two years' Operation Plan. He said that the document before the Board was a refresh of year 2 and involved no strategic changes. He referred to certain targets and in particular to the fact that the target of 66.7% for Dementia diagnosis had not been achieved and was in the region of 52%.

4.2 In response to a question, Neil Fisher explained that the targets were not included within the document as the figures were not available to show the full year's performance. He said for the most part, the targets missed were not by a huge amount.

4.3 Simon Perks said he thought it would be useful for the Board to consider at a future meeting a report on the Constitutional Standards within which the CCG worked and which also identified the timescales when national targets had to be achieved. In terms of the target for patients being admitted, transferred or discharged within four hours from the arrival at the A & E Department, Simon Perks explained that the target was 95%, however, the current performance was around 90%. He said there was no one single answer as to why performance was at this level and advised that it had been included in the Hospital Trust's published improvement plan.

4.4 With reference to Dementia diagnosis, Simon Perks explained that the Canterbury CCG had achieved the target therefore further work was needed to be undertaken with Ashford's GP's to improve on performance. In terms of the William Harvey Hospital, Simon Perks explained that the CQC would return in July to undertake an assessment of improvements stemming from the Trust's improvement plan and at that time it may become clear as to whether the Hospital would be taken out of special measures. A new temporary Chief Executive was in post who wished to move beyond the current improvement plan and improve further. The Board agreed that it would be appropriate to invite the Chief Executive of the Trust to a future meeting of the Board.

The Board recommended that:

(a) the Strategic Commissioning Plan 2014-2019 be supported.

(b) a report be submitted to a future meeting of the Board on the CCGs Constitutional Standards.

(c) the Chief Executive of the East Kent Hospitals University NHS Foundation Trust be invited to the meeting of the Board to be held in October 2015.

5 Ashford Local Performance Plan

5.1 The report explained that the Ashford Local Performance Plan was a live document which illustrated the range of activities and programmes delivered in the Ashford Clinical Commissioning Group area, organised under the five Kent Health and Wellbeing Strategy outcomes. Faiza Khan took the Board through the report and asked whether the Board wished to concentrate on fewer of the outcomes rather than all of them.

5.2 Sheila Davison said that the Board would be refreshing its own priorities at its meeting in October 2015 and advised that currently the Board had five priorities it was currently working on.

5.3 Mark Lemon explained that the County Council had organised an event to be held on the 17th June 2015 at the County Showground to undertake a stocktake of the work undertaken to date on the health and wellbeing strategy and he asked that any members of the Board who wished to attend to let him know and he would arrange for an invitation to be sent.

The Board recommended that:

(a) the contents of the Ashford Local Performance Plan be noted.

(b) it be agreed that the Ashford Lead Officers Group raise any specific concerns and/or good practice that arise from the plan to the Ashford Health and Wellbeing Board.

(c) a number of key priority activities be identified and regular updates and reports be received on the progress of these activities.

(d) the plan be endorsed as an information resource to update the Kent Health and Wellbeing Board on Ashford's local achievements in relation to the Kent Health and Wellbeing Strategy priorities and outcomes.

(e) Board members be invited to contact Mark Lemon direct for invitations to the KCC Joint Health and Wellbeing Strategy event on the 17th June 2015 at 10am the County Showground, Maidstone.

6 Kent Health and Wellbeing Board Meeting and Strategy Update

6.1 Set out on the cover of the Agenda was a link to the Agendas and Minutes of the Kent Board.

6.2 Navin Kumta said that the most important item dealt with by the Kent Board was the Commissioning Plan of the CCG and the plan for Public Health. He also explained that a report on the Better Care Fund would be submitted to the next meeting of the main Kent Board.

The Board noted the report.

7 Partner Updates

7.1 Included with the Agenda were A4 templates submitted by Partners:-

(a) Clinical Commissioning Group (CCG)

Simon Perks said that in terms of A & E there were a number of initiatives in progress to improve the performance.

(b) Kent County Council (Social Services)

Noted.

(c) Kent County Council (Public Health)

Faiza Khan drew attention to the report and in particular to the initiatives involving smoke free parks and play spaces; the Alcohol Strategy; tobacco control; CAMHS; and breast feeding. She also explained that the contract would shortly be awarded to provide sexual health services for East Kent and that this will be the subject of a consultation process to determine location of services.

(**d) Ashford Borough Council**

Tracey Kerly gave an update and explained that the Little Hill Extra Care Scheme was on target, however, the project at Farrow Court was delayed with the first phase now due for initial completion by early July 2015 and the second phase by early 2017. It was also noted that the previous week the Council had supported the acquisition of the Park Mall shopping centre and Wilko store premises. She also explained that she had attended the launch of the Smoke Free Play Spaces scheme and she advised that the play spaces were being well used.

(e) Ashford Children and Young Persons Health and Wellbeing Committee

Stephen Bell explained that in terms of mental health, the provision for these services for young people should involve only a six week maximum wait. With reference to NEETS he advised that in terms of school leavers his organisation was unaware of what 12% of them were currently doing.

(f) Case Kent/Voluntary Sector Representative

Tracy Dighton explained that at the next Community Network meeting in Ashford, Neil Fisher from the CCG had agreed to speak and furthermore a representative from Kent County Council had agreed to attend to talk about the issue of contracting.

With reference to the Charing Gardening Club, the Chairman explained that at a recent Grants Gateway Panel £7,000 had been awarded to the organisation. He explained that at the Grants Panel Meeting it had been suggested that the Club undertake a disabled audit and he was pleased to report that this had now been done and the recommendations had been acted upon. The Chairman also said he was pleased that the organisations which had to be relocated from International House had all now successfully moved to new premises.

(g) HealthWatch Kent

Caroline Harris explained that their report on support received from GP’s by mental health patients had been published on their website.

8 Forward Plan

8.1 The Board noted the Forward Plan of subsequent meetings of the Board.

9 Next Meeting

9.1 The next meeting would be held on the 22nd July 2015.

9.2 The Chairman explained that this was his last meeting of the Board and said he wished to thank everybody who had been involved with its work for their support. The Chairman also said that he was concerned about the future of the Board and advised that he had met with the Leader of the Council and the Chief Executive to discuss this issue. If it was not possible to identify another Chairman for the Board from the partners, it was possible that an independent Chairman could be appointed. He said that he would be willing to take on this role if asked.

9.3 Sheila Davison also said that the Board wished to give thanks to Councillor Claughton as Chairman for all his work.

(KRF/AEH)

MINS: Ashford Health & Wellbeing Board - 22.04.15

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Focus on Sustainable Development

Introduction

The priority theme for today's meeting is Sustainable Health provision. Three presentations are being given.

The Health Infrastructure Working Group has been meeting over the past year to discuss issues relating to sustainable health provision particularly given the growth in Ashford. The group includes NHS England, NHS Property Services, CCG (Canterbury and Coastal) and KCC Strategic Commissioning.

Presentation 1

Preparing for Growth - *Simon Cole, Policy Manager, Planning and Development, Ashford Borough Council*

Simon will outline the timeline for the development of the new Local Plan and supporting Infrastructure Schedule which will be effective up to 2030. He will explain the importance of such planning to inform decisions where development should be located. The need to understand the flexibility of existing health and community buildings and potential demand for new development is key.

Presentation 2

The Next Five Years – *Simon Perks, NHS Ashford CCG's Accountable Officer*

Simon will present an overview of how services for the Ashford area may look in the next five years following the implementation of the CCG's Five Year Forward View. This will include changes in how services are provided, by who and what the impact of Community Networks maybe.

Presentation 3

Planning for the Future - *Stephen Ingram, Head of Primary Care, NHS England South (South East)*

This presentation reports on the direction of travel for NHS England South and how they are helping to identify future service and asset requirements given demographic trends and the need for an integrated approach to health service provision.

The AHWB is asked to:

a) **Note the need for the partners to provide policy direction and infrastructure detail to support the drafting of the Local Plan; and**

b) **Agree for the Health Infrastructure Working Group to consider the draft on behalf of the Ashford Health and Wellbeing Board.**

Preparing for Growth

Simon Cole, Policy Manager, Ashford Borough Council

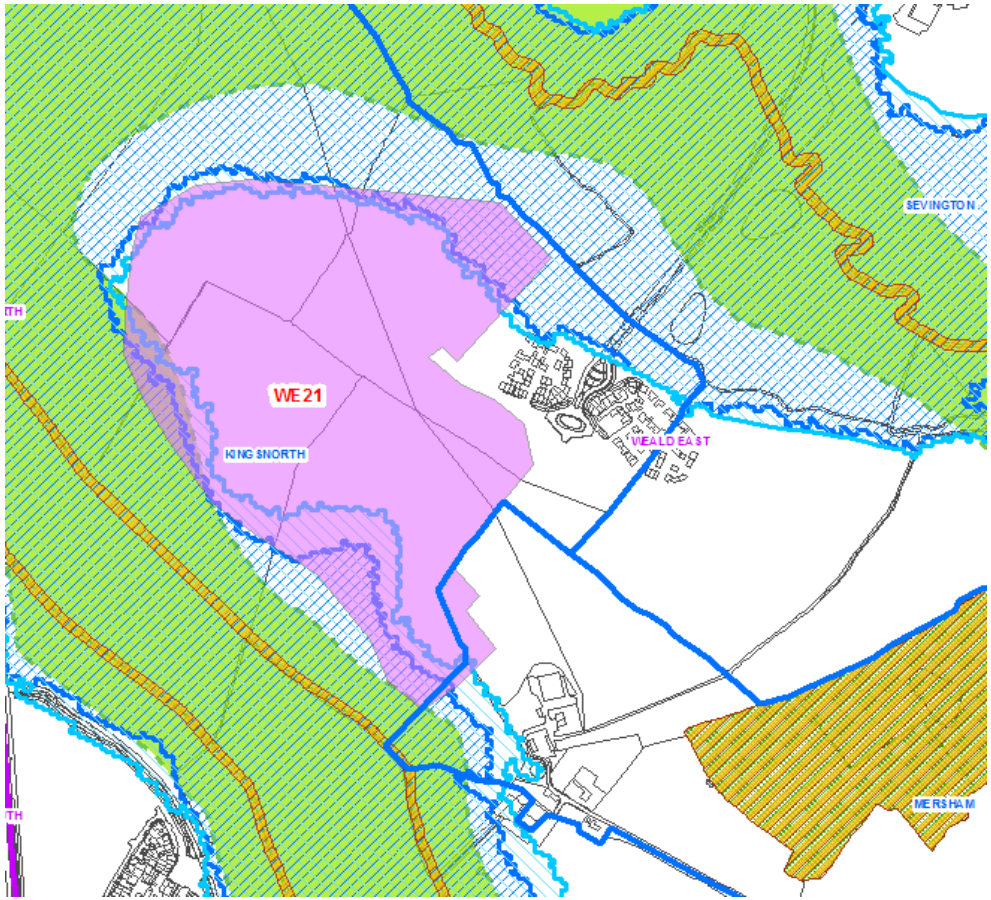
Introduction

- The Local Plan – why it's important to health service providers
- Identifying infrastructure needs
- Planning for delivery – Section 106 and the Community Infrastructure Levy (CIL)
- Working together

The Local Plan

- ABC now preparing a new Local Plan to replace the 2008 Core Strategy.
- Will look ahead 15 years from now.
- Proposing c. 14,000 new dwellings and c. 12,000 new jobs in the borough.
- Large majority of new development expected to be in and around Ashford

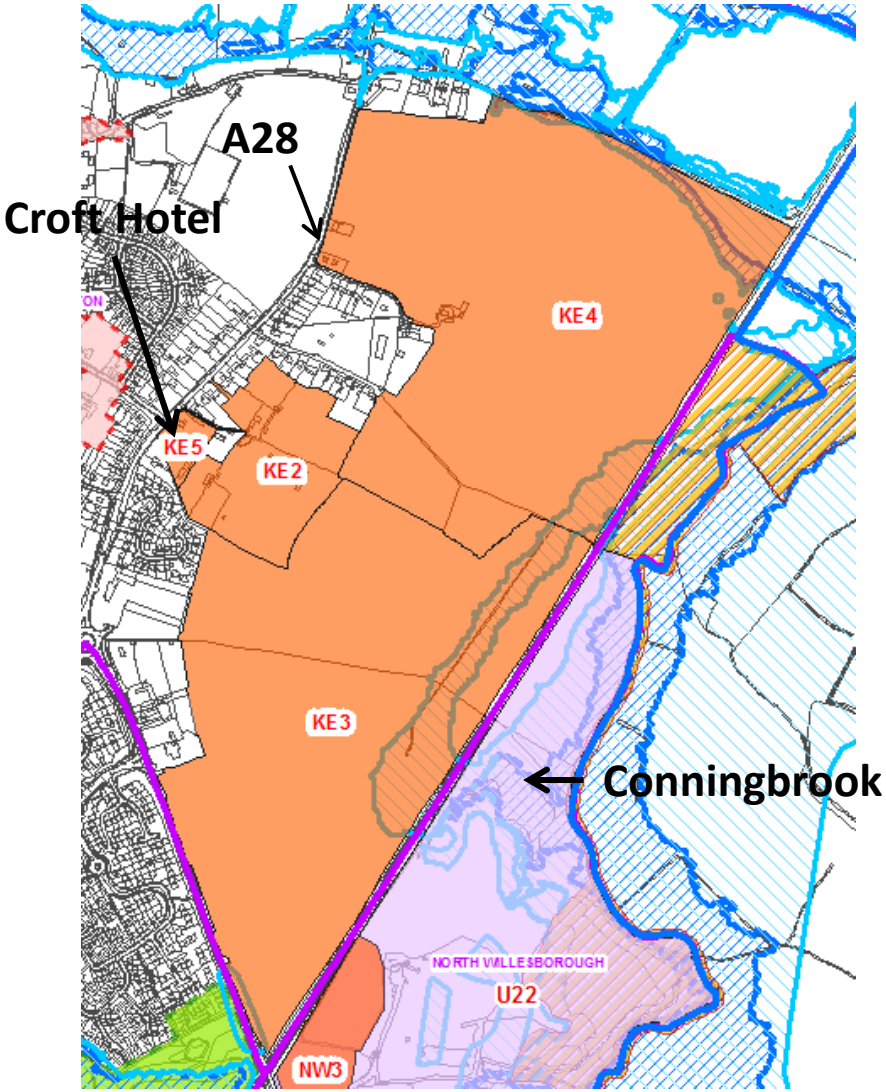
Cheeseman's Green



WE21 - West of Finberry Phase 1

Proposing 420 homes plus community, leisure and employment

Kennington



- **KE5 Croft Hotel**

Proposed for redevelopment of hotel and additional housing

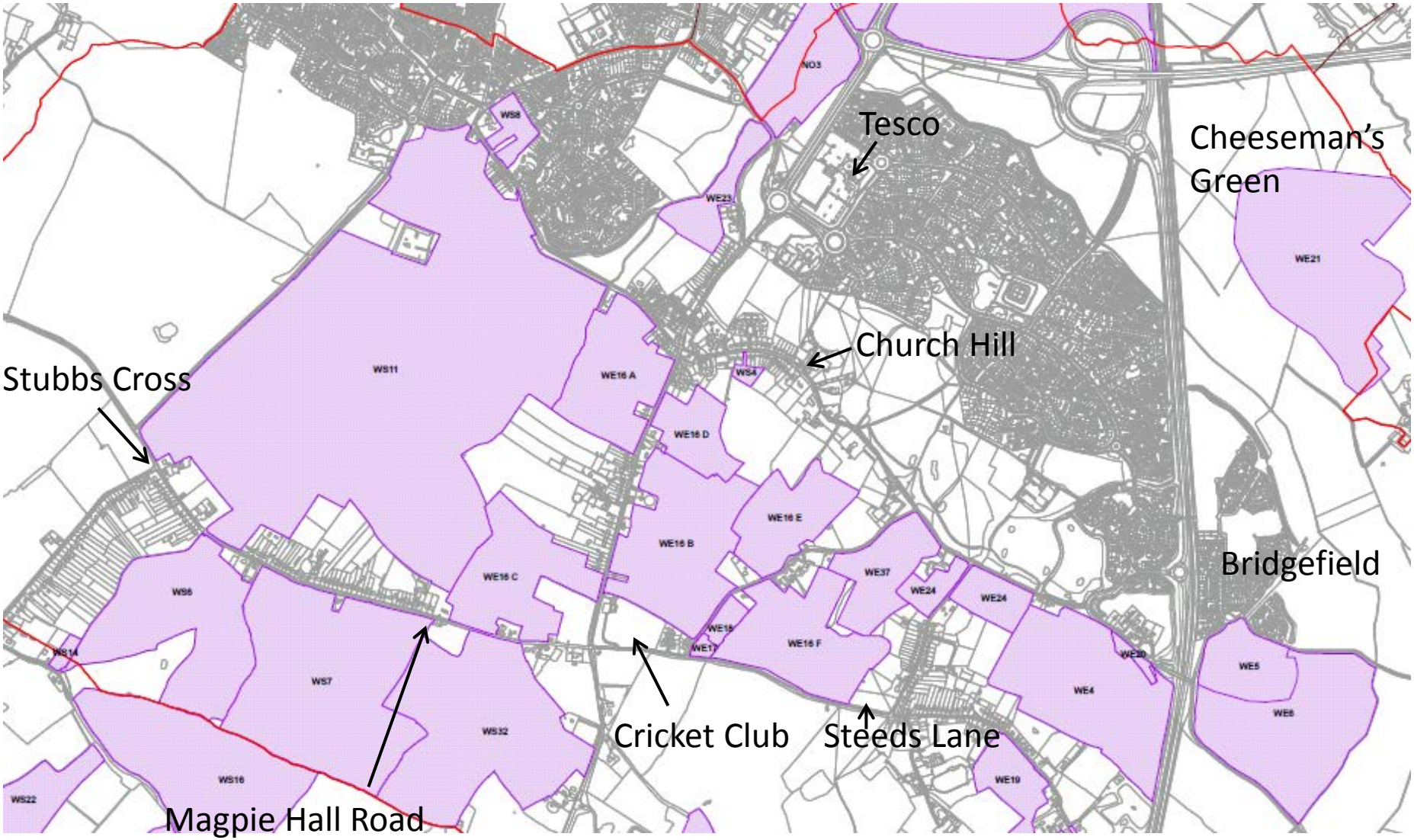
- **KE2 Orchard Farm**

Proposed for housing

- **KE3 & KE4**

Proposed 1000 homes on each

South of Kingsnorth



Infrastructure

- We need to work with health service providers to influence location of new development (para. 171 of the NPPF).
- You need to be proactive in identifying any new infrastructure requirements.
- We must show that either existing or new infrastructure can support new development.
- An Infrastructure Delivery Schedule needs to accompany the Local Plan.

Delivery

- CIL Regulations have changed the game
- Much less scope for use of S106 for strategic infrastructure – no ‘tariff’ based contributions
- CIL will generally deliver less funding than S106 – likely to be a long list of calls on CIL
- Need to be precise in identifying needs – where do they arise from ? what is needed to mitigate them ?

Working Together

- Integration of health service planning and development planning.
- Future roles of Hospital and GP services.
- Ensuring good public access to parks, sports, walking and cycling opportunities.
- What will be the role of this Board ?
- How can we increase the profile of the Health Infrastructure Group ?

The time is…now

- New draft Local Plan in 6 months time.
- Draft CIL Charging schedule in 6 months time.
- Decisions on proposed new site allocations before Christmas.
- Finalising the Infrastructure Delivery Schedule before Christmas.

Future Planning

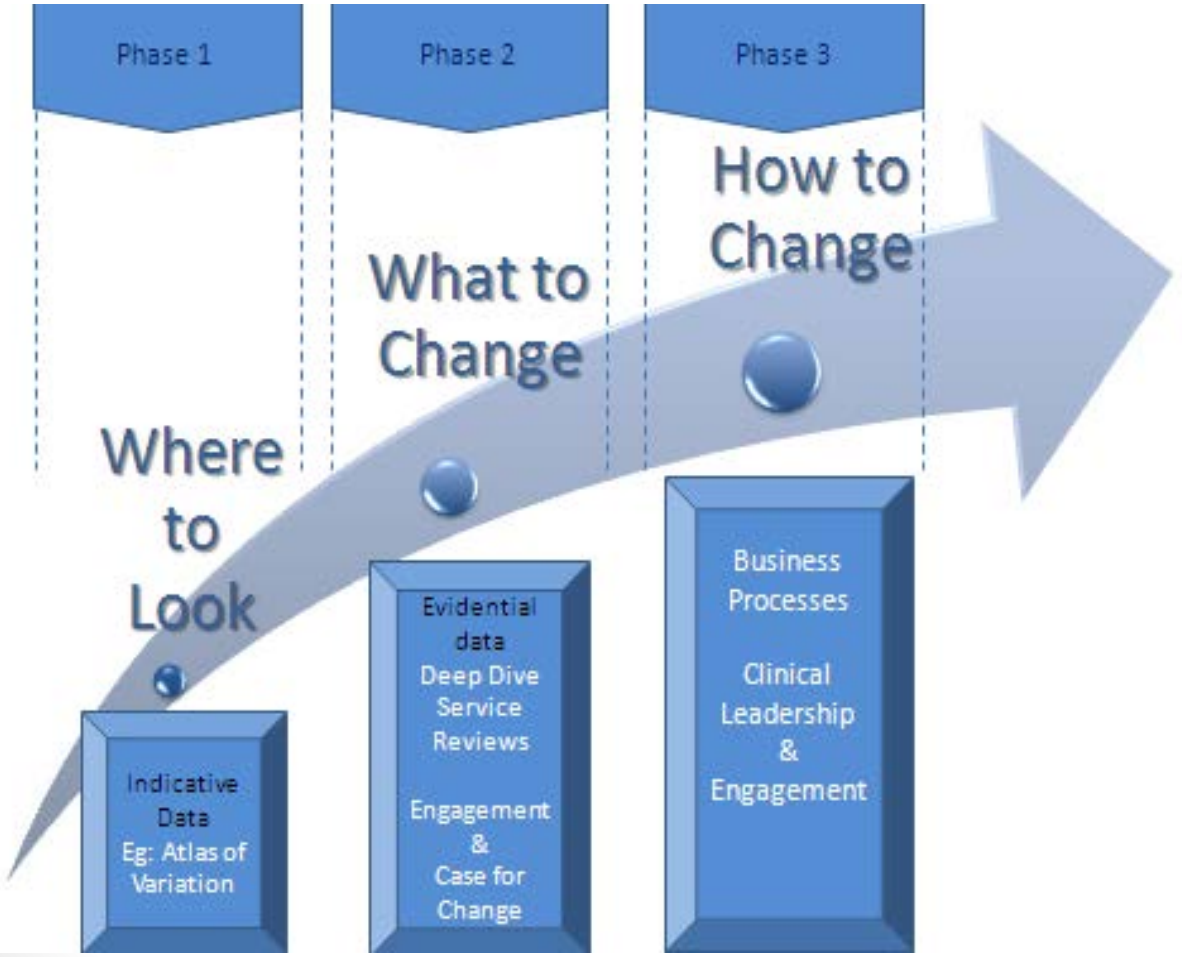
Neil Fisher
Head of Strategy and Planning
NHS Ashford CCG

NHS Ashford Clinical Commissioning Group

Achievements 2014/15

- **Long Term Conditions**
  - Community Networks have been set up
  - Increased our dementia diagnosis rates
  - Our care homes projects have led to a reduction in urgent care attendances and admissions
- **Mental Health**
  - Primary Care base mental health workers are now in place
  - Significant progress in increasing recovery rates with our IAPT services whilst also reducing waiting times.
- **Urgent Care**
  - New integrated discharge teams
  - Local Referral Units to maximise potential of community services (building an urgent care network)
  - Reduced delays in having care packages in place for timely discharge following inpatient care
  - Pilot 7 day Primary Care
  - Local Referral Unit ensures that patients are offered support within their own homes
- **Planned Care**
  - Glaucoma (access issue),
  - Orthopaedic Triage (addressing access standard failure through improved demand and system management)
- **Financial Duties**

Year Two: Commissioning for Value



Five Key Ingredients:

1. **Clinical Leadership**
2. **Indicative Data**
3. **Clinical Engagement**
4. **Evidential Data**
5. **Effective processes**

2015/16 Projects

- **Priority Projects**
  - Musculoskeletal (MSK) Programme – Programme Lead: Sue Luff
    - MSK Triage – Project Lead: Paula Smith
    - Spinal Surgery/Pain Pathway – Project Lead: Sue Luff
  - Dermatology – Project Lead: Laura Counter
  - Discharge to Assess – Project Lead: Ruth Davoll
  - Improved Access to Psychological Therapies – Project Lead: Lisa Barclay
  - Cardiology Diagnostics and Referral Pathway – Project Lead: Laura Counter
  - Elective/Demand Management Programme – Programme Lead: Lisa Barclay
- **Other Ongoing Projects**
  - A/E Recovery - Project Lead : Alistair Martin
  - Age UK PID – Project Lead: Clare White
  - OOH/111 – Project Lead: Thariea Whisker
  - Over 75 Admissions – Project Lead: Sue Luff
  - Dementia – Project Lead: Carol Boorman
  - Prescribing Scheme – Project Lead: Sheila Brown
  - Diabetes – Project Lead: Sue Luff
  - WAMD - Project Lead: Paula Smith

Project Updates – July 2015

- **Red – Risk to Delivery**
  - Elective/Demand Management Programme
    - Additional resource required
  - A/E Recovery
    - Significantly off trajectory for achievement of NHS Constitutional Standard
  - Discharge to Assess
    - Funding remains unidentified
- **Amber – Not Progressing As Plan**
  - Dermatology
  - Musculoskeletal (MSK) Programme
- **Green – Progressing as Plan**
  - Improved Access to Psychological Therapies
  - Cardiology Diagnostics and Referral Pathway
  - Age UK PID
  - OOH/111
  - Diabetes
  - WAMD
  - Dementia
  - Over 75 Admissions
  - Prescribing Scheme

National Drivers

- Increasing demands on services
  - Growing, ageing population
  - More complex needs.
- Tight financial envelope
- Increasing, yet often under-reported, prevalence of long term conditions.
- Overall satisfaction with primary care services remains high
- Growing challenges in relation to patient experience of access.
- Inequity in distribution of workforce, and recruitment.
- Retention and retirement issues are facing GPs and practice nurses in particular.
- Recognition that integrated models of health and social care should be more clinically and cost effective
- National drive to move care closer to home (FYFV).

Five Year Forward View

- Represents the shared view of the NHS national leadership
- Reflects an emerging consensus among patient groups, clinicians, local communities and frontline NHS leaders.
- Sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.
- Identifies that, in order to meet patients' needs and expectations, we need to develop a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care.
- As a result there is now quite wide consensus on the direction that the NHS should taking:
  - Increasingly we need to manage systems – networks of care – not just organisations.
  - Out-of-hospital care needs to become a much larger part of what the NHS does.
  - Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them.
  - Patients with mental illness need their physical health addressed at the same time.

Local Drivers

- 2014 approval to build 5,750 homes at Chilmington Green with 3,350 by 2021;
- Potential of 13,800 new residents (increase of 12% from 2011 census);
- Average life expectancy in Ashford is 83.4 years for women and 80.7 years for men;
- Long Term Conditions increasing
  - 25%+ population have LTC
  - 12% have 3+ conditions;
- By 2019 Ashford 0ver 65's will grow by 10% and comprise 20% of the population
- Proposed development at Tenterden – 500 houses by 2021

Five Year Plan Aspirations

Priority One: Community Networks

- We want our patients to recognise that the local NHS is sited within their own community and not around specific estate or hospitals. We want these networks to offer the largest possible range of services meeting the largest possible range of needs and that most aspects of any patient journey, through the health and social care system, is local to them.

Priority Two: Primary Care

- We will see practices working together in collaboration with each other and secondary care, embedding integrated community health and social care teams within day to day practice, offering improved access, and acting as the central hub for a wider range of services while maintaining the values and continuity of traditional GP services.

Priority Three: Urgent Care/Long Term Conditions

- We want care that crosses the boundaries between primary, community, hospital and social care.

Priority Four: Planned Care/Long Term Conditions

- We will ensure appropriate referral to the right clinician, according to patient choice in line with national access standards. Patients will see the correct person first time, will investigations carried out on the same day reducing the number of attendances.

Priority Five: Achieving “Parity of Esteem”

- We will improve the life expectancy and the physical health of those with severe mental illness, and improve the recognition of mental health needs in the treatment of all those with physical conditions and disabilities

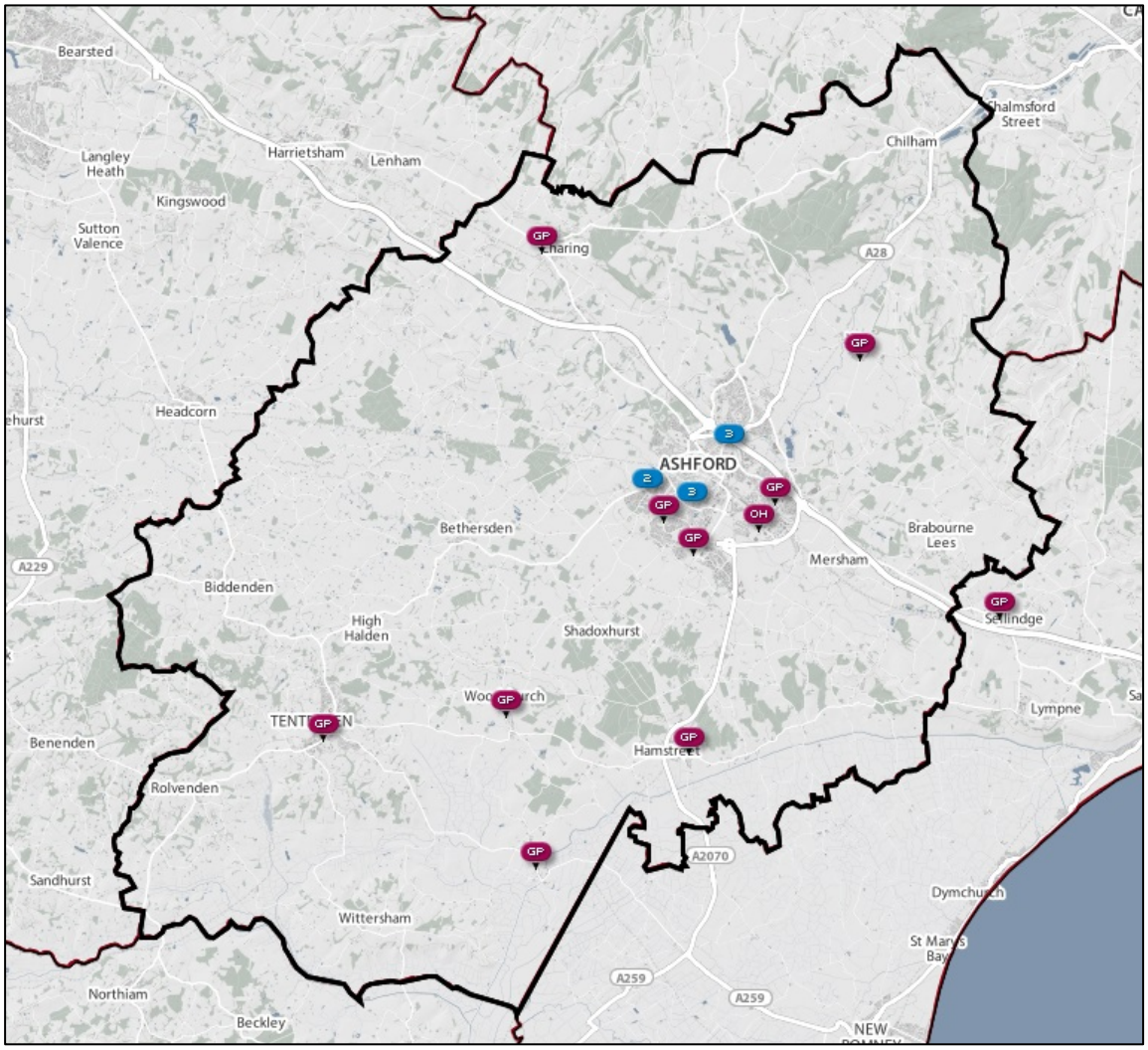
Priority Six: Children and Young People

- We will ensure that vertical and horizontal integration of all paediatric services, including health, social and voluntary sectors, to reduce inequalities in care, narrow the gaps, avoid duplication and reduce clinical variation

Impact of Our Vision

- Short term
  - Expansion in the provision of referral triage, outpatient clinics, diagnostics, screening, physical and psychological therapies all as one stop services closer to home (Network)
  - Reduction in hospital admissions by horizontal collaboration with EKHUFT to become a vanguard in “acute care”
  - Roll out the weekend service currently running in the rural Hub
  - Ramp up this service to cope with additional demand during peak winter pressures.
  - Facilitate re-ablement of patients to their own homes wherever possible
  - Introduce a ‘virtual ward’ where patients in the community at risk of hospital admission can be discussed by MDT’s
  - Repatriate community/specialist nurses and health visitors back to the practice
- Longer term
  - Form a “Multidisciplinary Community Provider” (MCP) holding its own unified budget for the provision of all local health and social care
  - Smaller “hotter” acute hospitals trust.

Current Location of Ashford Surgeries



New Models of Care

- A broad consensus on what a better future should be
- Radical upgrade in prevention and public health
- NHS will take decisive steps to break down the barriers in how care is provided
- England is too diverse for a one size sits all. Nor is the answer to let a thousand flowers bloom.
- Multispecialty Community Provider (MCP)
- Primary and Acute Care Systems (PACS)
- Redesign of Urgent and Emergency Care services to obtain integration.
- Smaller hospitals
- List based primary care

Multispecialty Community Provider (MCP)

- Groups of GPs to combine with nurses, community health services, hospital specialists, mental health, social care
- Integrated out-of hospital care
- A clear and robust governance structure
- Extend beyond primary care at scale
- Core primary medical care
- Community-based NHS services
  - District Nursing
  - Health visiting
  - Pharmacy
  - Step-down beds
  - Domiciliary Care
- Social care

An essential building block

- Lists of registered patients
- Minimum population of approx. 100k
- Joined up electronic records
- New types of contract
- Use risk stratification and population data to identify patients who will most benefit from intensive support
- Run expanded multi-disciplinary community based teams including for example pharmacists, social workers and nurse leaders
- Strong Voluntary Sector input
- Incorporate some specialists [employment or partnership]
  - Consultant Geriatricians
  - Psychiatrists
  - Paediatricians
  - “Generalist” consultants

Primary and Acute Care Systems (PACS)

- Integrated hospital and primary care provider
- Combining general practice and hospital services
- Similar in many ways to MCPs
- But…
  - It is an approach to full “vertical” integration
  - Incorporate all core hospital services
- NOT supported by Ashford GPs

Learning from MSK Triage Pilot

- Joined up working with CCG/EKHUFT has released savings in first 6 months of pilot
- Patients are being seen quicker and closer to home
- Surgeons only consult with surgical cases. De-pressurised hospital outpatients for the benefit of all East Kent residents.
- GP referrers have peer to peer education and feedback
- Increased trust and collaboration between practices.
- Increased confidence for commissioners to think “outside the box” by utilising local skills and expertise.

Major Risks

- **Strategy**
  - Balancing localism and strategic direction across CCGs and providers
  - Alignment of CCG networks to national models (size)
  - KCHFT community services – desire to change operating model enabling greater integration with primary, secondary and social care
  - EKHUFT proposed Clinical Strategy – sustainable acute hospitals, hotter and smaller
  - KCC Strategy – Social Care Transformation Programme and Accommodation Strategy
- **Engagement**
  - Significant engagement of patients, public and voluntary sector in design of local services
  - Clinical Engagement – increasing emphasis on new models of care
  - May require “brave” de/re-commissioning of services
- **Delivery**
  - Financial Recovery Plan
  - A&E Constitutional Standard achievement
- **Resources**
  - System wide commissioner capacity
  - Failure of other operational target on management capacity
  - Reduction of beds capacity within the Trust;
  - Implications of revised GP contract to be released

NHS Ashford Clinical Commissioning Group

Any questions?

Neil Fisher
Head of Strategy and Planning
NHS Ashford CCG & NHS Canterbury and Coastal CCG
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NHS England

Commissioning of Primary Care Services

NHS England: Commissioning responsibilities for primary care

- Responsibility sits principally with NHS England
- Primary care spans 4 separate contractor areas - Primary medical, primary dental, community pharmacy, and optometry
- The market entry rules differ for each contractor group
- Development of co-commissioning is realigning responsibilities for the future commissioning of primary medical services.

General practice

- Is currently facing significant challenge
- An increasing and ageing population, patient and public expectations of the service, workforce changes, infrastructure issues and regulatory requirements are driving the need for change
- The 5 Year Forward View sets out new models for primary care in the future – PACS and MCPs
- Funding and political agreement to support this – pilots and targeted investment in workforce and infrastructure
- New Deal for General Practice

General Practice – Local Solutions

- GP contracts provide flexibility for change and expansion
- Commissioning leverage is marginal as many existing contracts run in-perpetuity
- We anticipate that most change will be bottom-up and that general practice will evolve to the challenges facing it
- Testing new ways of working and new approaches
- Need to remain focussed on finding solutions that deliver good outcomes, safe services, positive experience and are sustainable

What might the future look like across Ashford?

- Fewer providers of services delivering GP services at scale from multiple sites
- Formation of new entities to provide GP and out-of-hospital services
- Larger multi-disciplinary teams, more varied roles – not simply more GPs and more GP practices
- Integrated services and care networks
- Greater focus on health promotion and prevention
- A changing role for the GP

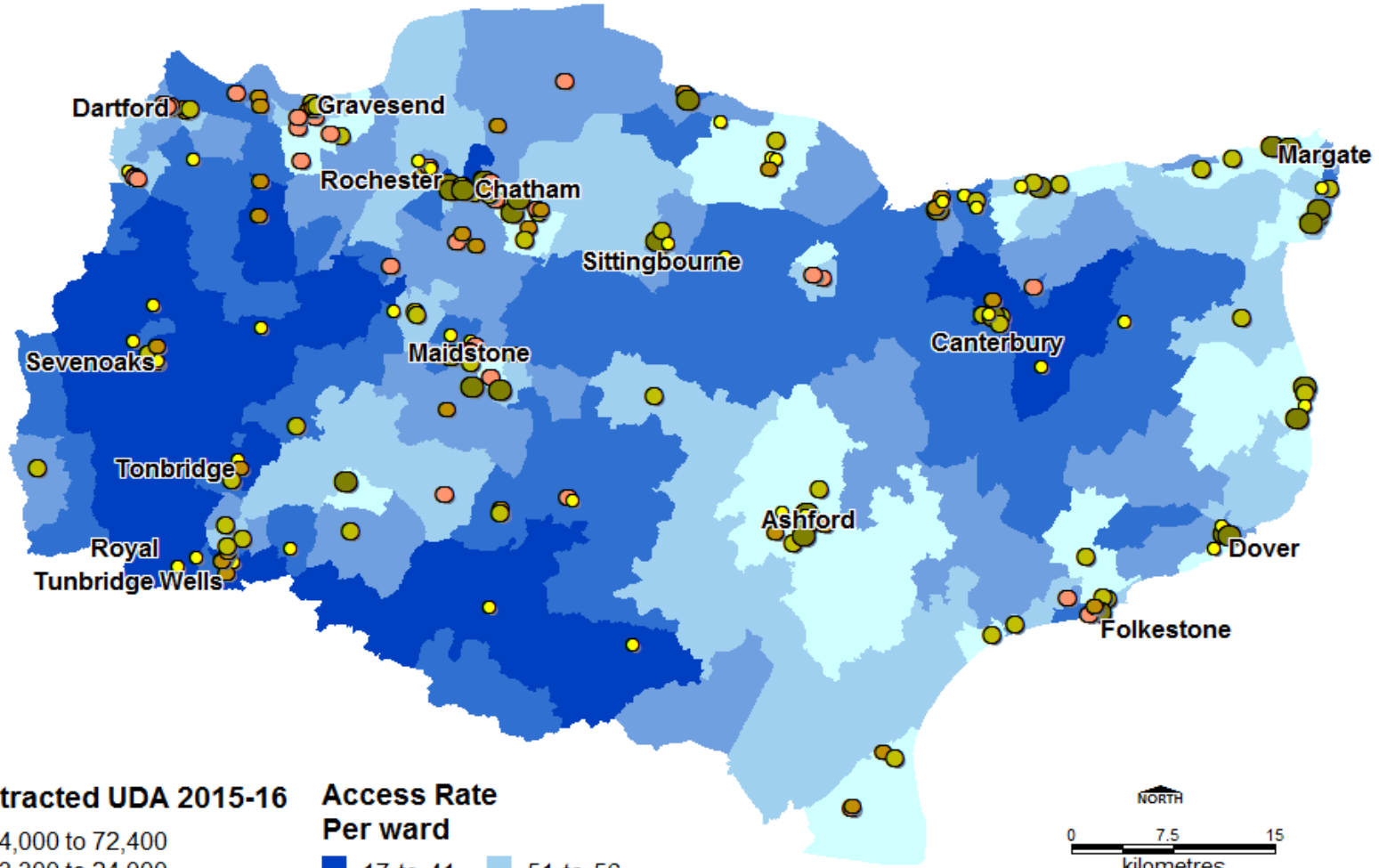
Ashford– specific communities

- Chilmington Green – New community hub primary care facility; modular build.
- Cheeseman's Green – expect existing providers to absorb population growth
- Tenterden – Ivy Court and East Cross Clinic
- New Hayesbank – Planned expansion of existing premises supported through Primary Care Infrastructure Fund

Dental Services

- Issues relate to the state of dental public health and access to NHS dental care
- Dental health across the Ashford area is relatively good compared with other areas across NHS South (South East)
- Access to primary dental services is measured by number of individual patients accessing NHS dental care every 2 years and by the amount of activity contracted for and delivered.
- Access in the Ashford area is relatively good
- Consequently investment priorities sit elsewhere

NHS England



Contracted UDA 2015-16

- 24,000 to 72,400
- 13,300 to 24,000
- 7,500 to 13,300
- 3,200 to 7,500
- 0 to 3,200

Access Rate Per ward

- 17 to 41
- 41 to 47
- 47 to 51
- 51 to 56
- 56 to 75

NORTH

0 7.5 15

kilometres

NHS Business Services Authority

An Update on General Practice from NHS England South (South East)

Briefing for a meeting of the Kent Health Overview and Scrutiny Committee for discussion at a meeting on Friday 17 July 2015.

1. Background

At a meeting with Kent County Council Health Overview and Scrutiny Committee (HOSC) on 05 September 2014 a detailed briefing was provided by NHS England (Kent and Medway Area Team) with regards to issues and challenges facing general practice both nationally and across Kent. The Committee requested a further update from NHS England with regards to the actions it was taking both nationally and locally regarding this.

This summary paper and its enclosures seek to update the Committee on:

- The development of national strategy and policy since last autumn,
- How this national strategy is being implemented at a local level
- Changes to general practice provision across Kent

Members are asked to refer back to the Committee papers provided by NHS England (Kent and Medway Area Team) for the 05 September 2014 meeting of the HOSC for information about the issues and challenges currently facing general practice.

In addition to this background context the following additional information may also be useful for Committee members.

- ***Nuffield Institute – "Is General Practice in Crisis" (04 November 2014)***

http://www.nuffieldtrust.org.uk/publications/general-practice-crisis

- ***House of Commons Library – Briefing Paper - Genera Practice in England (22 June 2015)***

http://researchbriefings.files.parliament.uk/documents/CBP-7194/CBP-7194.pdf

2. The development of a national strategy and an agreed budget to support implementation.

A significant number of national strategy and policy developments as well as local implementation actions and issues have occurred since the autumn. These include:

2.1 National Strategy: The Publication of the "Five Year Forward View"

The Five Year Forward View was published on 23 October 2014 by NHS England and sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health

England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

The Five Year Forward View highlights that the traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. Increasingly we need to manage systems – networks of care – not just organisations. In particular the NHS of the future needs to be characterised by:

- Out-of-hospital care that is a much larger part of what the NHS does.
- Services which are integrated around the needs of patients. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- Applying rapid learning from the best examples, not just from within the UK but internationally.
- Evaluation of the new care models to establish which produces the best experience for patients and the best value for money.

With specific reference to general practice, the Five Year Forward View sets out the following steps with regards to investment:

- Stabilising core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.
- Giving GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.
- Providing new funding through schemes such as the Prime Minsters Challenge Fund to support new ways of working and improved access to services.

- Expanding as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.
- Expanding funding to upgrade primary care infrastructure and scope of services.
- Working with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
- Building the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or *A&E visit.*

The Five Year Forward View also points towards two new additional models of primary care provision over and above the status quo that NHS England will be promoting over the next 5 years. These are **Multispecialty Community Providers** and **Primary and Acute Care Systems providers**.

Multispecialty Community Providers (MCPs)

Although it is expected that many smaller independent GP practices will continue in their current form it is recognised that primary care is entering the next stage of its evolution.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form - either as federations, networks or single organisations. These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.

- As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.
- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.
- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.
- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.

- They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.
- These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

Primary and Acute Care Systems (PACS)

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures. NHS England will permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kickstart the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.
- In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.
- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

PACS models are more complex in their nature than MCPs. They will take time and technical expertise to implement. As with any new model there are also potential unintended side effects that will need to be managed. The intention therefore is to pilot these in a small number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

2.2 Agreed Investment Plan for general practice to support Delivery of the Five Year Forward View

NHS England will be investing an extra £1billion into general practice over a four year period commencing 2015/16. This will be in the form of £250M a year, every year over a four year period and is known as the GP Infrastructure Fund.

This funding will deliver on the promise of a new deal for primary care. The first tranche of £250M will improve premises, help practices to harness technology and give practices the space to offer more appointments and improved care for the frail elderly – essential in supporting the reduction of hospital admissions.

GP practices were invited to submit their bids in January 2015, either through making improvements to existing buildings or the creation of new ones. In the first year it is anticipated that the money will predominantly accelerate schemes that were already in the pipeline, bringing benefits to patients more quickly. Practices were asked to set out proposals that would provide them with more capacity to do more; provide value for money; and improve access and services for the frail and elderly.

This new funding will accelerate investment in increasing infrastructure, accelerate better use of technology and in the short term, will be used to address immediate capacity and access issues, as well as lay the foundations for more integrated care to be delivered in community settings.

Across NHS South (South East) a number of the proposals submitted by GP practices will be supported through the GP Infrastructure Fund in 2015/16. The detail underpinning these individual schemes is currently being examined further and confirmation of final support will be issued shortly to the successful practices.

2.3 Other Premises Developments and testing new approaches

In addition to the above investment plan a range of premises developments have also been agreed at a local level through the allocation of improvement grants to practices. In 2014/15 a number of important schemes were supported enabling practices to expand and/or improve the fabric of their existing surgeries.

An example of a scheme supported with Improvement Grant funding is the extensive work undertaken at the Northumberland Court surgery in Maidstone.

2.4 Prime Minsters Challenge Fund (PMCF)

There have been two waves of the PMCF which has tested out new ways of delivering general practice service to local communities.

Across NHS South (South East) the following schemes have been supported.

Wave 1:

Integrated South Kent Coast Pilot delivered by Invicta Health CIC

Extended Primary Integrated Care (EPIC) delivered by Brighton Integrated Care Service (BICS)

Wave 2:

Step Change towards Multispecialty Community Providers delivered by GP Health Partners Ltd in Epsom, Surrey

Worthing & Adur Multispecialty Community Provider pilot delivered by Innovations in Primary Care Limited.

The Integrated South Kent Coast Pilot brings together 17 practices in both Folkestone and Dover to provide extended and more flexible access to services for 110,000 patients by creating a network of primary care with a hub facility based at two local community hospitals. Patients registered at the Folkestone practices have been able to book appointments from 8am to 8pm, seven days a week from 1 October 2014, and the Dover practices have been able to do since March 2015.

This pilot continues to receive positive patient feedback regarding the paramedic practitioner (PP) visiting service. The PPs work with the practices and NHS111 to visit acutely ill patients at home. They have access to GP clinical records and can see and treat patients in collaboration with the patient's GP to avoid admissions or a transfer to A&E. All 17 pilot practices refer patients for urgent visits Monday to Friday.

For patients with urgent mental health needs, this pilot is also introducing a new rapid assessment service delivered by a primary care mental health specialist, either at a patient's home, at their GP practice or one of the two community hospital hubs.

2.5 New Care Models - Vanguard Sites

Three GP practices across Whitstable and Canterbury were successful in applying to be one of only 29 sites within the first wave of Vanguard sites to form a Multi-speciality Community Provider service. The Vanguard scheme for Whitstable in Kent is made up of the Whitstable Medical Practice, Northgate Medical Practice and the Saddleton Road & Seasalter Surgeries.

Whitstable's Multispecialty Community Provider will cover a population of 53,382 local people currently registered with these GP practices. They will be working in partnership with local health, care and support organisations including Canterbury & Coastal CCG, Kent County Council, East Kent Hospital University Foundation Trust, Kent Community Health Trust, Kent Partnership Trust and AgeUK.

Patients, such as an elderly person with dementia living in residential care, for example, will see the benefits of the new model of care through better trained care workers looking after them each day. These care workers will have learnt in a new setting, alongside colleagues from other disciplines and with access to new technology. This will result in a team looking after the patient that has better insight into dementia and from specialist input from a geriatrician with expert knowledge of the condition. The patient and their family will feel fully involved in all decisions about their care plan, and will be able to set goals and outcomes for their care and support that are important to them personally.

2.6 "Building the Workforce – The New Deal for General Practice" ("GP Workforce 10 Point Plan")

NHS England, Health Education England (HEE), The Royal College of General Practice, and the British Medical Association GP Committee are all working together to ensure that we have a skilled, trained and motivated workforce in general practice. This is a 10 point action plan across three broad areas of action – recruitment, retention and returners.

All four organisations have jointly developed a new GP workforce action plan which sets out a range of initiatives to expand the general practice workforce:

- **To recruit newly trained doctors into general practice** in areas that are struggling to recruit. We will incentivise them to become GPs by offering a further year of training in a related clinical specialty of interest such as paediatrics, psychiatry, dermatology, emergency medicine and public health. This work will be underpinned by a national marketing campaign aimed at graduate doctors to highlight the opportunities and benefits of a career in general practice. Alongside this pilot training hubs based in GP practices will be established in areas with the greatest workforce needs to encourage doctors to train as GPs in these areas. They will also enable nurses and other primary care staff to gain new skills.
- **To retain GPs** the plan includes establishing a new scheme to encourage GPs who may be considering a career break or retirement, to remain working on a part-time basis. It will enable practices to offer GPs the opportunity to work with a modified workload and will be piloted in areas which have found it more difficult to recruit. There will also be a wider review of existing 'retainee' schemes.
- **To encourage doctors to return to general practice** HEE and NHS England will publish a new induction and returner scheme, recognising the different needs of those returning from work overseas or from a career break. There will also be targeted investment to encourage GPs to return to work in areas of greatest need which will help with the costs of returning and the cost of employing these staff.

NHS England is investing £10million of funding to kick start the initiatives in the plan, which will complement work that is already underway to strengthen the GP workforce. The plan is part of the Five Year Forward View which set out a specific commitment to tackle workforce issues.

Across Kent Surrey and Sussex Community Education Providers Networks (CEPNs) have been established across in each of the 20 CCGs. The purpose of CEPNs is to facilitate educational networks between GP practices with GP and primary care workforce tutors offering support in education, training and workforce planning. The establishment of CEPNs across each of the CCGs provides an important foundation through which to address the workforce challenges facing general practice through a partnership involving HEE, NHS England, CCGs, practices and various professions.

2.7 Clinical Pharmacists in General Practice

NHS England launched a £15 million programme on 07 July 2015 by inviting GP practices to submit their bids for engaging clinical pharmacists in the delivery of GP practice services. This initiative is part of delivering the GP Workforce 10 Point Plan and is about exploring opportunities to support general practice by piloting innovative workforce initiatives.

This pilot builds on the experiences of general practices, which already have clinical pharmacists in patient facing roles, and in some cases this extends to positions as partners. The pilot will be evaluated so that successes and learning are identified and reported.

The intention is to invest at least £15 million over the next three years to test out this new patient-facing role in which clinical pharmacists have extended responsibility over and above many current ways of working. Practices have already suggested that this extended role could include the management of care for people with self-limiting illnesses and those with long term conditions and have asked that the new team members have the ability to independently prescribe.

The pilot will be funded for three years with an expectation that practices will continue with the role into year four and beyond. It is anticipated that in the region of 250 clinical pharmacists will be involved over this period with the ambition of supporting over 1 million patients.

Practices are being strongly encouraged to work together to assemble joint bids involving pharmacists across a number of sites. Applications to participate in the pilot will need to demonstrate a case of need in relation to workforce challenges and clinical demands. It is anticipated that clinical pharmacists will be in post early in 2016.

Details of the pilot can be accessed below:
http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/07/clinical-pharm-gp-pilot.pdf

2.8 Organisational Change and the Development of Co-Commissioning

NHS England's Organisational Alignment and Capability Program was concluded in April 2015. This internal restructure resulted in a shift from 27 Area Teams to 12 Sub Regions with a further reduction in management costs.

The functions of primary care commissioning and contracting are still largely undertaken by NHS England. At a local level the team supporting this is part of NHS South (South East) which covers the Kent Surrey and Sussex area.

Alongside this internal restructuring has been the roll-out and development of co-commissioning. This follows the publication of "Next Steps towards Primary Care Co-Commissioning" by NHs England in November 2014.

The introduction of co-commissioning is an essential step towards expanding and strengthening primary medical care. Co-commissioning is recognition that CCGs are harnessing clinical insight and energy to drive changes in their local health systems that have not been achievable before now but are hindered from taking an holistic and integrated approach to improving healthcare for their local populations, due to their lack of say over the commissioning of both primary care. Co-commissioning will be a key enabler in developing integrated out-of-hospital services based around the needs of local communities. It will also drive the development of new models of care such as MCPS and PACS.

Across NHS South (South East) 2 of the 20 CCGs have delegated responsibility for the commissioning of primary medical services. The two CCGs concerned are Eastbourne, Hailsham and Seaford CCG and High Weald, Lewes, Havens CCG. The remaining CCGs have been invited to submit their proposals for either entering into Joint Commissioning arrangements or to take on delegated responsibility by early October 2015. Should their applications be supported then these would take effect from 1st April 2016. CCGs that either do not submit proposals to change their status or whose proposals are not supported will retain their existing advisory role with regards to the commissioning of primary medical services.

2.9 Amendments to the existing national GP contract (General Medical Services contract for 2015/16)

A number of important changes to the GMS contract have been agreed between NHS Employers (acting on behalf of the Department of Health and NHS England) and the General Practitioners Committee (acting on behalf of the BMA) which will take effect from 2015/16. These include the following:

- a named, accountable GP for all patients (including children) who will take lead responsibility for the co-ordination of all appropriate services required under the contract
- the patient participation enhanced service will end and associated funding will be reinvested into global sum. From 1 April 2015, it will be a contractual requirement for all practices to have a patient participation group (PPG) and to make reasonable efforts for this to be representative of the practice population
- the alcohol enhanced service will end and associated funding will be reinvested into global sum. From 1 April 2015 it will be a contractual requirement for all practices to identify newly registered patients aged 16 or over who are drinking alcohol at increased or higher risk levels
- assurance on out of hours provision has been agreed to ensure that all service providers are delivering out of hours care in line with the National Quality Requirements (or any successor quality standards)
- improved maternity/paternity arrangements have been agreed, to cover both external locums and cover provided by existing GPs within the practice who do not already work full time

- further commitment to expand and improve the provision of online services for patients, including extending online access to medical records and the availability of online appointments
- publication of GP net earnings - practices will publish average net earnings (to include contractor and salaried GPs) relating to 2014/15, as well as the number of full and part time GPs associated with the published figure
- assurance on out of hours provision has been agreed to ensure that all service providers are delivering out of hours care in line with the National Quality Requirements (or any successor quality standards)
- improved maternity/paternity arrangements have been agreed, to cover both external locums and cover provided by existing GPs within the practice who do not already work full time
- NHS England and GPC will re-examine the way in which GP practices are funded for their patient lists with the aim of adapting the formula to better reflect deprivation

2.10 Outcome of the General Election and formation of a majority government.

The outcome of the general election should mean that there is consistency in the direction of policy regarding the NHS. The Secretary of State for Health made a speech on 19 June 2015 reaffirming the direction of travel for general practice in policy terms. A copy of the speech, entitled “A New Deal for General Practice” can be accessed below.

https://www.gov.uk/government/speeches/new-deal-for-general-practice

3. Changes to general practice provision across Kent and NHS South (South East) since last autumn

There are a number of changes to the provision of general practice services to update the Committee on. These include:

3.1 Contract Resignations and Practice Closures

The closure of Dover Medical Centre (30 November 2014) following the cessation of the APMS contract formally held by Concordia Health. Patients were supported in finding an alternative practice with which to re-register. Many of these patients chose to re-register with Pencester Health who provide GP services under a permanent GMS contract from within the same building.

The closure of Broadstairs Medical Practice (31 March 2015) following the cessation of the APMS contract formally held by Concordia Health. Patients were supported in finding an alternative practice with which to re-register. Many of these patients chose to re-register with the Albion Road practice who provide GP services under a permanent GMS contract from within the same building.

NHS South (South East) has also recently been served with contract resignation notices by two further GP contractors. The practices concerned are Cecil Square in Margate (where the PMS Agreement will cease on 30 September 2015) and Sterling House in Luton, Medway (where the APMS contract will cease on 30 September 2015). A procurement decision about both patient lists will need to be taken shortly following a period of consultation with patients and stakeholders.

3.2 Termination of two GP contracts in Medway (January 2015) and Hove (June 2015)

NHS England, in the form of the previous Kent and Medway Area Team and as NHS South (South East) served notice to terminate two separate GMS contracts in the interests of patient safety. In both cases temporary APMS contracts have been agreed with neighbouring practices to ensure that patients can continue to access GP services. A procurement decision about the future management of both practices (the Green Suite surgery in Rochester and the former Goodwood Court Surgery in Hove) and patient lists will need to be taken in due course by NHS England South (South East).

3.3 Practice Mergers

A number of practices have recently come together in order to become more resilient and efficient. NHS England is supportive of such changes from GP contractors where this is in the patient and public interest. The following practices across Kent have recently merged:

- Albion Place Medical Practice in Maidstone was created following the merger of Marsham Street and Holland Road practice's on 23 October 2014. The practice will shortly be moving into new premises.
- Faversham Medical Practice – The Cross Lane practice and Dr Logan's practice merged on 1st April 2015.
- Sittingbourne – The Memorial Medical Centre and Dr Venkat's practice at 31 London Road, Sittingbourne merged on 1st July 2015.

3.4 Multiple Contract Holders

There has been a slow but emerging pattern of smaller practices going into partnership with partners and organisations that already hold multiple GP contracts. Sometimes the originating partner(s) remain(s) on the contract and sometimes they simply choose to hand their contract on and leave the practice. The Regulations and Directions that underpin GP contracts allow for these variations to take place so long as they comply with the requirements of the Regulations and Directions.

- **Malling Health and the Directors of Malling Health:** Manage GP contracts at Iwade Health Centre, Staplehurst Health Centre, Ivy Bower Surgery in Greenhithe, West Kingsdown Medical Centre and at Parkwood, Nelson Road & Rainham Healthy Living Centre (Blue Suite) in Medway. Malling Health also manage a large number of contracts for GP services across other parts of England and now form part of the umbrella company Integrated Medical Health (IMH).

- **Minster Medical Group and Directors of Minster Medical Group:** Manage contracts for GP services at Minster Medical Centre on the Isle of Sheppey, at Lakeside in Sittingbourne, and from Parkwood in Rainham.
- **Sydenham House Medical Group:** Manage GP services at Sydenham House Medical Centre, Ashford Kent, Musgrove Park Medical Centre, South Ashford as well as High Glades Medical Centre, St Leonards, East Sussex, Gun Lane Medical Centre, Strood, Rochester and have a share in the partnership at Tunbury Avenue Surgery in Walderslade, Medway.

4. What action is NHS South (South East) taking to ensure high quality GP services are provided and made available to local communities?

NHS England has provided a range of support and leadership to enable the following examples of developmental change to take place over recent months. Examples include:

- Working in close collaboration with our CCGs and LMCs to develop local primary care strategies and implementation plans.
- GP practice workforce baseline undertaken by GP practices for Health Education England in conjunction with NHS England South (South East).
- Providing significant investment to enable numerous GP premises to be improved and expanded.
- Taking tactical opportunities to support existing GP practices to significantly expand their patient lists and develop their infrastructure (e.g.: in Dover, Broadstairs, Hove and Medway)
- Awarding a 10 year APMS contract at Dymchurch Medical Centre (01 April 2015) with the option to extend this for up to a further 7 years following a tender procurement after the previous contract holder had resigned their contract.
- Additional funding allocated to the Wave 1 Prime Minsters Challenge Fund in Folkestone and Dover to enable Invicta Health to extend the pilot to 31 March 2016 (from October 2015).
- Funding to support the North Canterbury Vanguard pilot
- Piloting the role of GP Urgent Care Clinical Fellow with a number of practices in Dartford, Gravesham and Swanley CCG in collaboration with the CCG and HEE.

5. Summary

General practice continues to operate under considerable pressure. Workforce issues, increased demand and expectations on the service, the requirements of regulation, registration and accountability as well as infrastructure constraints pose significant challenges to existing GP contractors and those staff working on the front-line.

These challenges are however recognised and understood. A clear national strategy for the future of the NHS has been set-out and a plan for addressing the principal areas of concern has been and continues to be developed. Action is being taken to address workforce and infrastructure issues. Important changes to the national GP contract have also been made. Implementation of The New Deal for General Practice will require commitment from a

number of parties – the NHS (both NHS England and CCGs), local authorities, from GP contractors and the wider profession as well as from patients and the public.

Most change will be led and shaped locally by GP practices themselves in conjunction with their CCGs and in dialogue with their communities and partners. NHS England will play a key role in shaping and enabling this change to take place but sustainable change will need to be clinical led and locally owned. During this period of change maintaining business continuity is of critical importance such that change is introduced in a planned and managed way such that this minimises inconvenience and anxiety for patients whilst bringing about a system of care that produces good outcomes, high quality care and resilience.

Within Kent a number of changes have taken place as the service evolves and action taken to ensure all patients continue to have access to local GP services. New ways of working are being tested and piloted and new investment is being made into the service both in overall terms as well as being targeted at specific communities, groups of practices and individual contractors where appropriate. However there remains a great deal to do.

We anticipate that the pace and scale of evolution and change of GP services will increase in the coming months and that this will span several years. It is not possible to outline what the final blueprint and disposition of services will look like; however it is almost certain that this will look and feel very different with regards to who provides services, how services are delivered and from which locations. In this respect the place of care through which primary medical care services are provided in the future will not simply be from GP surgery buildings but through a range of ways of engaging and treating patients which harnesses technology, makes full use of new workforce roles and delivers care in a networked way across health and social care. This will mean that the role and function of the GP will also change. What will remain a constant is that the future service will need to deliver safe, high quality care that yields both good outcomes and a positive patient experience.

Stephen Ingram, Head of Primary Care

NHS England – South (South East)
7 July 2015

Ashford Health & Wellbeing Board (AHWB)

AGENDA ITEM – Lead Officer Group (LOG) Report

Performance Progress Plan and Theme Setting

1. The Board will recall at its last meeting in April that the Local Performance Progress Plan was presented by Public Health on behalf of the LOG. The document provides a live information resource on Ashford's local achievements in relation to the Kent Health and Wellbeing Strategy priorities and outcomes. It will be updated at key points in the year and any issues that arise will be brought to the Board's attention.

2. The LOG has set a meeting on 3rd August to review the plan using key agency data that can best inform our progress. At this meeting we will start to consider what the next year's themes for the Board should be in light of what Ashford's health profile is telling us alongside the views and experience of practitioners.

3. The LOG is aiming to recommend to the Board at its October meeting what should be considered as its key priorities so closer and more detailed joint inspection can be programmed in over the coming year.

4. The LOG also wishes to recommend that the October meeting includes an update from the Voluntary Sector as a theme for the presentations.

'Must do' Project Progress

5. Below is a summary update of the 'must do' projects from the lead partners.

a) Community Networks (lead CCG – Neil Fisher)

Ashford has three community networks – Ashford South, Rural and Ashford North. Each of the localities will have completed the third round of meetings by the end of July. The groups will use the opportunity to review the priorities from the original stakeholder meetings to ensure that the proposed projects meet the needs of the population. The groups have all discussed how they ensure that the wider community are part of the process.

Ashford Rural - The group discussed the proposed revision to the Intermediate Care Beds specification within West View which will support the ability for primary care to access beds as an alternative to transfer to secondary care and will support increased access to therapies. The group are in the process of exploring provision of outpatient services within the town to reduce the need for patients to travel. The group discussed the communication plan and links to communications within the locality.

Ashford North - The group wish to explore ways to promote wellbeing across all ages and are in the process of identifying the current provision across all providers. This will support the ability to identify service gaps**.** The group will also review provision for carers and performance against the current contracts.

Ashford South - The group are exploring how they can support children and young families through access to local services and greater integration across health and social care. The group will work with a local charity to support young families to manage their children as an alternative to visiting A/E.

b) Farrow Court (lead ABC – Richard Robinson)

Building work continues on site with 33 dwellings in phase 1 due for completion by late August 2015 including communal facilities. Once phase 1 is complete phases 2 and 3 will commence with anticipated completion of these in late 2016/early 2017. Detailed discussions continue with ABC, Social Services and Age UK about the arrangements for making the Day Centre at the new Farrow Court facility a centre of excellence. The discussions include aiming to deliver services seven days a week with a specific focus on dementia clients at weekends. Joint working discussions are continuing although it is likely that Age UK will want to 'bed in' to the new facility before expanding dementia services.

c) ***Rough Sleeping*** (lead ABC – Sharon Williams)

Porchlight have been appointed and are working with local rough sleepers. A group has been set up to coordinate action across various agencies involved. Meeting being organised with the CCG in July to pursue a joint commissioning proposal. Porchlight to compile data of relevance to future commissioning decision including outcomes from this type of intervention.

d) ***Dementia Day Care*** (Lead Dementia Alliance - Lisa Barclay (CCG))

The new Dementia Alliance has recently agreed 3 key areas of work in addition to looking at extending dementia day care. These include consulting local people living with dementia on what service they need, promoting the dementia helpline, and holding an awareness raising event. Further discussion on an additional dementia day centre is required but opportunities to undertake further dementia work at the new care scheme at The Warren will be pursued.

e) ***Healthy Weight -*** (Lead ABC - Simon Harris)

Local projects are under review and a new emphasis on this work has been agreed on a geographical basis i.e Stanhope. A new project being supported through the South Ashford Community Network has been agreed. This project called 'Aspirations Health Living Zone' includes scoping the local health offer, signposting and increasing provision as required. Key local partners engaged in project development including KCC Public Health, Ashford BC, Ashford Supporting Families and CCG. Funding secured for a pilot period of an initial six months. This pilot period includes the need for a project coordinator who should be in place by September 2015.

d) Infrastructure Working Group (Lead ABC)

Please refer to presentations for progress on the Local Plan.

A number of infrastructure projects have been discussed including the need to work in an integrated way for the Chilmington Community Hub and supporting discussions between Ivy Court Surgery and NHS England regarding development plans in Tenterden.

Update on Strategy's and Action Plans

Ashford Alcohol Plan (Lead – Public Health)

Ashford will prepare an Alcohol Action plan from the Kent Alcohol Strategy which will be delivered, with partners, through the Community Safety Partnership strategy (Substance Misuse group). The draft action plan will be shared with the Ashford Health and Wellbeing Board for agreement prior to implementation.

Homelessness Strategy and Action Plan (Lead – Sharon Williams)

Ashford Homelessness Review has been completed. A draft Homelessness Strategy is being finalised and once completed it will be added to the Council's consultation portal. See attached review.

ASHFORD
BOROUGH COUNCIL

Ashford Homelessness Review

2015

Contents

Introduction

Under the Homelessness Act 2002 it is a requirement to formulate a Homelessness Strategy by carrying out a homelessness review for the borough. The review should consider a wide population of households who are homeless or at risk of homelessness, not just those who are unintentionally homeless and have a priority need. The review informs the Homelessness Strategy and should establish the extent of homelessness in the borough, assess its likely extent in the future, identify what is being done and by whom and what resources are available to prevent and tackle homelessness.

Having undertaken the review it can then be determined if current activities are adequate and appropriate to meet aims of preventing and reducing homelessness and whether any changes or additional provision are necessary..

This review uses statistical data and consultation outcomes to assess current and emerging homeless needs and trends. The review process has been guided using information from the National Practitioner Support Service (NPSS)[1] developing homelessness strategies toolkit. Engagement with a range of partners has increased understanding around local pressures and how services could work together to prevent and reduce homelessness.

The Ministerial statement 'Making Every Contact Count: A Joint Approach to the Prevention of Homelessness'[2] set out the 10 local challenges and these have been used as the basis for consultation and the subsequent development of the Homelessness Strategy action plan.

The 10 local challenges are:

1 Adopt a corporate commitment to prevent homelessness which has buy in across all local authority services.

2 Actively work in partnership with voluntary sector and other local partners to address support, education and training needs.

3 Offer a housing options prevention service, including written advice, to all clients.

4 Adopt a No Second Night Out model or an effective local alternative.

5 Have housing pathways agreed or in development with each key partner and client group that includes appropriate accommodation and support.

6 Develop a suitable private rented sector offer for all client groups, including advice and support to both clients and landlords.

7 Actively engage in preventing mortgage repossessions including through the Mortgage Rescue Scheme.

8 Have a homelessness strategy which sets out a proactive approach to preventing homelessness and is reviewed annually so that it is responsive to emerging needs.

[1] http://www.practitionersupport.org/
[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7597/2200459.pdf

9 Not place any young person aged 16 or 17 in bed and breakfast accommodation.

10 Not place any families in bed and breakfast accommodation unless in an emergency and then for no longer than 6 weeks.

Consultation

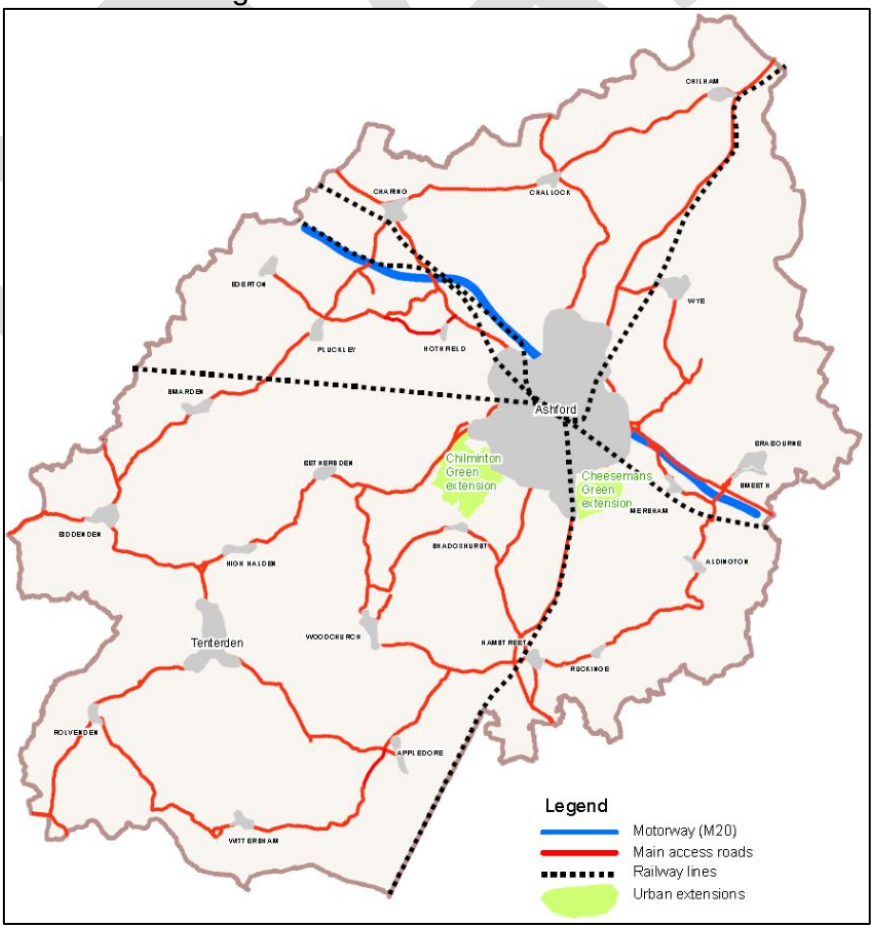
A stakeholder consultation event was held in November 2014. A range of agencies and organisations attended and a summary of the event is included from page 32. This included considering the relevance of the 10 local challenges to local circumstances and any amendments needed to reflect specific local pressures.

11 telephone interviews were undertaken in May 2015 with service users a summary of the key points is included from page 35.

General information

The borough covers an area of over 58,000 hectares with a population of 117,956 living in 47,787 households (Census 2011). There are 2 urban areas, Ashford and Tenterden, each surrounded by a large rural hinterland. As a 'growth area' the borough has planned expansion for housing, retail and commercial uses. The urban extensions of Cheesemans Green and Chilmington Green will deliver in the region of 7,000 homes over the next 20 years.

Figure1: Map of Ashford Borough



Housing costs

To buy

Approximately 68% of households in the Borough own their property, either with or without a mortgage. The table below from the Strategic Housing Market Assessment (SHMA)[3] 2012 gives the mean house price for areas of the borough

Figure 2: Mean House Prices by Sub Area and Type (2012)

	Detached	Semi-detached	Terraced	Flats	Overall
Ashford Rural North	£431,500	£280,600	£264,300	£130,500	£350,200
Ashford Rural West	£424,400	£233,500	£160,200	£171,400	£331,600
Ashford Rural South	£426,800	£209,900	£241,200	£229,800	£332,900
Ashford Rural East	£380,200	£262,700	£192,000	-	£317,900
Ashford town	£252,700	£185,400	£156,300	£103,900	£183,000

To rent

The private rented market is currently buoyant with prices rising. A search of private rented properties[4] (27/04/2015) within a 1 mile radius of Ashford town centre identified 120 self contained properties (1 bed to 4 bed) to rent. Of these only 6 were below the Ashford local housing allowance rate set for April 2015 but 3 of these states they are not available to people in receipt of benefits.

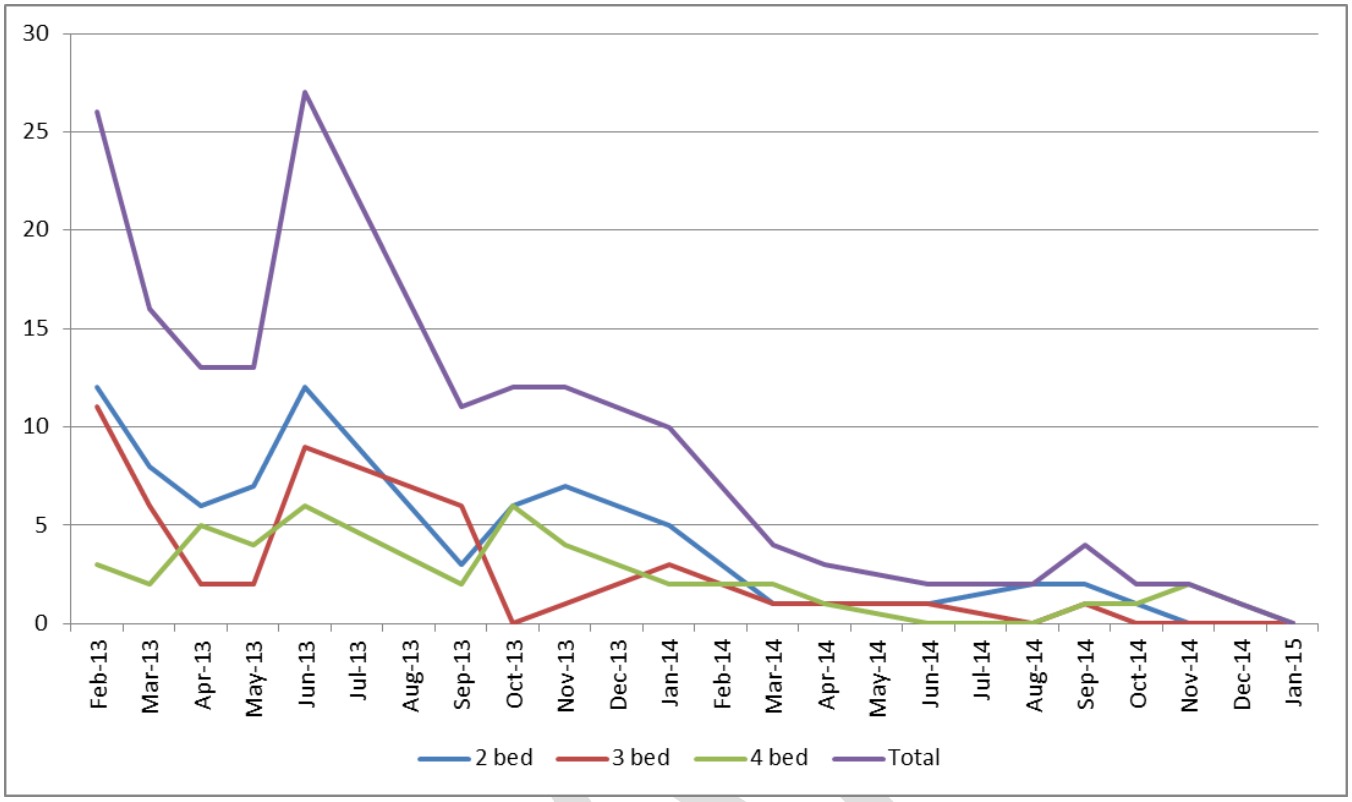
Figure 3: Summary of prices of private property to rent

Rooms for rent in shared houses varied in cost from £295 - £550 pcm. None of the 62 rooms advertised on www.houseshare.com were below the LHA 2015 rate for shared rooms of £291.57 Many of the advertisements state available for single professional people only.

The following graph highlights that there are fluctuation in the number of private rented sector homes below the local housing allowance rate and indicates a sharp decline during 2014.

[3] http://www.ashford.gov.uk/local-plan-2030-evidence-base
[4] www.rightmove.co.uk

Figure 4: Number of private rented properties with rental under the local housing allowance



Incomes

The SHMA 2012 compares the incomes of full-time employed Ashford residents with those of people working in jobs located in the borough. At around £23,700 the median income of Ashford "workers" is about £3,500 lower than the median income of Ashford "residents" £27,220. The fact that the earnings of those who live in Ashford are greater than those that work there does however mean that there is some risk of those in local employment (and thus contributing to the local economy) being marginalised from the housing market as they are less able to afford local properties. Higher earnings from those commuting out of the borough are somewhat distorting property prices in relation to local wage levels.

Incomes required to afford different tenures are show in the table below. The calculations are based on 3.5 times household income for house purchase and 30% of income to be spent on housing for rented properties. The figures for house purchase are based on a 100% mortgage for the purposes of comparing the different types of housing.

Figure 5: Indicative Income Required to Purchase/Rent without Additional Subsidy

Area	Lower quartile purchase price	Lower quartile private rent	Affordable rent	Lower quartile social rent
Ashford Town	£40,900	£25,000	£20,000	£14,200
Rural North	£76,000	£27,800	£22,200	£14,200
Rural West	£82,900	£30,000	£24,000	£14,200
Rural East	£72,000	£29,000	£23,200	£14,200
Rural South	£68,000	£29,000	£23,200	£14,200

Employment and Earnings

The percentage of economically active people aged 16-64 who are unemployed stood at 5.3% in June 2014[5], the lowest unemployment rate since October 2008. In comparison Canterbury and Shepway currently have higher unemployment rates at 6.4% and 6.9% respectively with Maidstone seeing 5.2% unemployment. The unemployment rate for the south east is 5% and nationally 6.8%.

Median weekly earnings (gross) for employees living in the borough were £506.30 in 2014. This income has fluctuated over the last 5 years as shown in Table 2

Figure 6: Median weekly earnings (gross) for residents living in the area, all full time workers

	2014	2013	2012	2011	2010
Ashford	506.30	512.50	496.60	507.90	470.00
Canterbury	574.40	577.50	545.60	559.70	510.90
Maidstone	515.40	500.90	542.90	538.30	558.40
Shepway	481.40	500.50	474.90	491.00	480.80

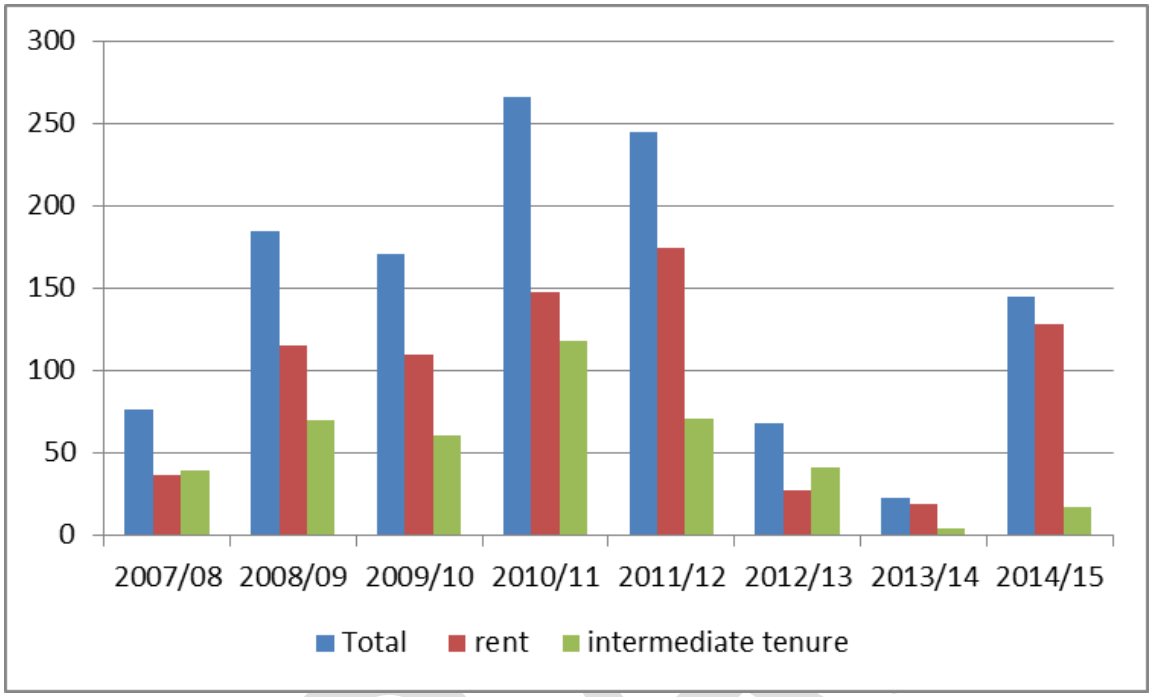
Source: ONS annual survey of hours and earnings - resident analysis

[5] https://www.nomisweb.co.uk/reports/lmp/la/1946157311/subreports/ea_time_series/report.aspx?

Affordable housing delivery

The SHMA 2012 concludes that there is a need for 368 affordable homes to be built each year. The Chart x below illustrates that affordable housing delivery has fallen below the level needed each year.

Figure 7: Affordable housing built per year



Population

The population of the borough is predicted to continue growing from its level of 117, 956 recorded by the Census 2011.

Figure 8: Predicted population growth to 2031

Year	Population
2016	133,700
2021	149,700
2026	165,600
2031	170,100

Source: KCC District Profile version September 2014

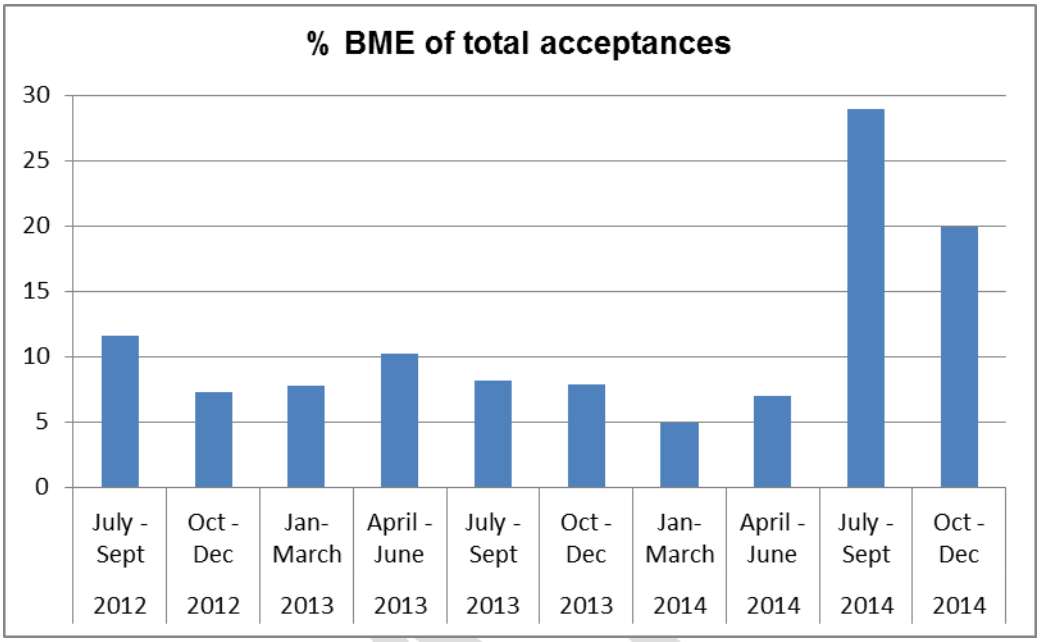
The majority of the population is white, 93.7% with 6.3% of the population formed by black and minority ethnic groups (BME)[6]. The BME population of Ashford is slightly lower than that of the south east or nationally at 13% and 18% respectively.

It is useful to compare homelessness acceptances from BME groups to identify whether homelessness is disproportionally higher or lower than the population profile. The chart

[6] Census 2011

below shows the percentage of homeless acceptances (eligible, unintentionally homeless and priority need) from applicants from a Black or minority ethnic origin. A further breakdown of acceptances by BME groups is shown in Figure 24.

Figure 8: Percentage of homelessness acceptances by BME groups of total acceptances



Source: http://opendatacommunities.org/data/homelessness/homelessness-acceptances/ethnicity

Deprivation

In the current indices' of deprivation (2010)[7] Ashford has an average rank of 198 (out of 326). In 2007 Ashford ranked 227 out of 354 authorities, equivalent to a drop in one place in the average rank of local authorities. In neighbouring authorities, Maidstone shows less deprivation with a rank of 217, whilst Canterbury and Shepway have greater levels of average deprivation with a rank of 166 and 97 respectively in 2010.

In comparison with other Kent authorities Ashford ranks 8th out of 12 (with 1 being most deprived).[8]

The overall indices of multiple deprivation is made up of seven domains each weighted according to their perceived importance: Income (22.5%); Employment (22.5%); Health deprivation and disability (13.5%); Education and skills (13.5%); Barriers to housing and services (9.3%); Crime (9.3%); Living environment (9.3%).

Each domain is scored at Lower Super Output Area (LSOA) and there are on average 3 -4 LSOAs per ward. Deprivation data is not available at ward level. The pattern of deprivation can vary considerable within a district. KCC has recorded the 20 most deprived LSOA's in Kent for each domain. Two Ashford LSOAs are recorded as falling within the most deprived 20 in Kent for education and skills (4th and 20th) and four LSOA's for barriers to housing and services (4th, 10th, 14th and 15th). These four LSOAs fall with the wards of Isle of Oxney, Downs North, Saxon Shore and Downs west.

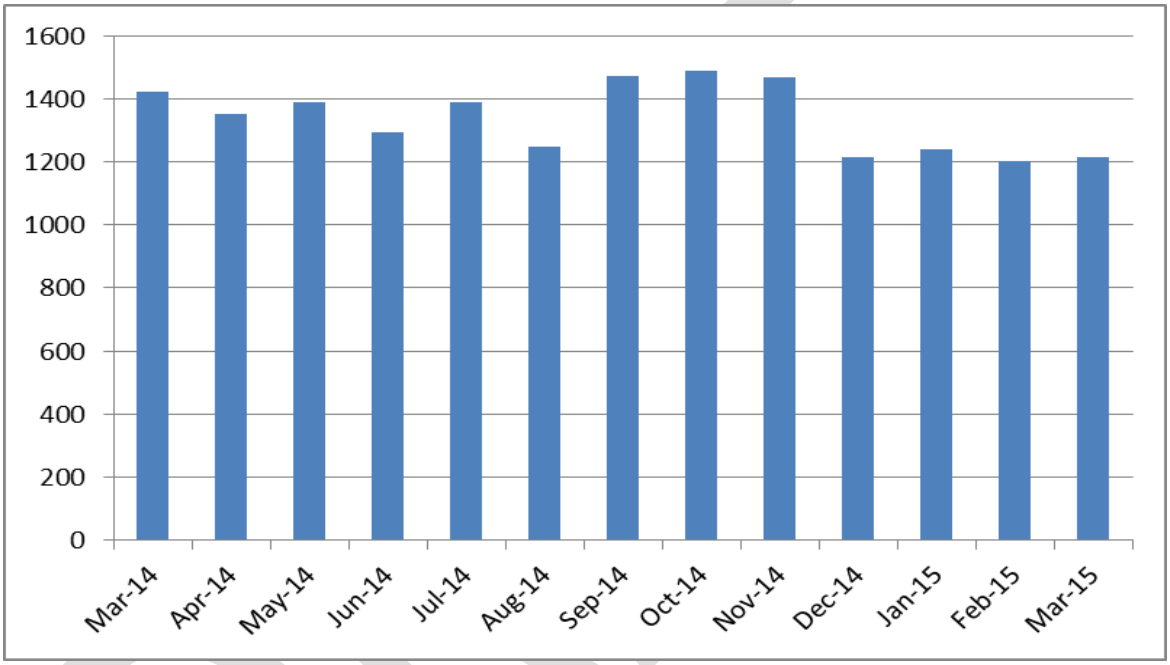
[7] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010
[8] KCC indices of deprivation 2010 detailed findings

The indicators used to create the domain barriers to housing and services are; household overcrowding, homelessness, housing affordability, distances to GP surgery, food shop, primary school, post office. Housing affordability and distance to services will be of higher significance in rural areas.

Housing Register

The number of applicants on the Ashford housing register each month is shown in the graph below.

Figure 9: Number of applicants on Ashford Housing Register



Numbers on the housing register vary due to undertaking annual reviews and the number of people housed, which could decrease at anyone point due to new affordable housing becoming available.

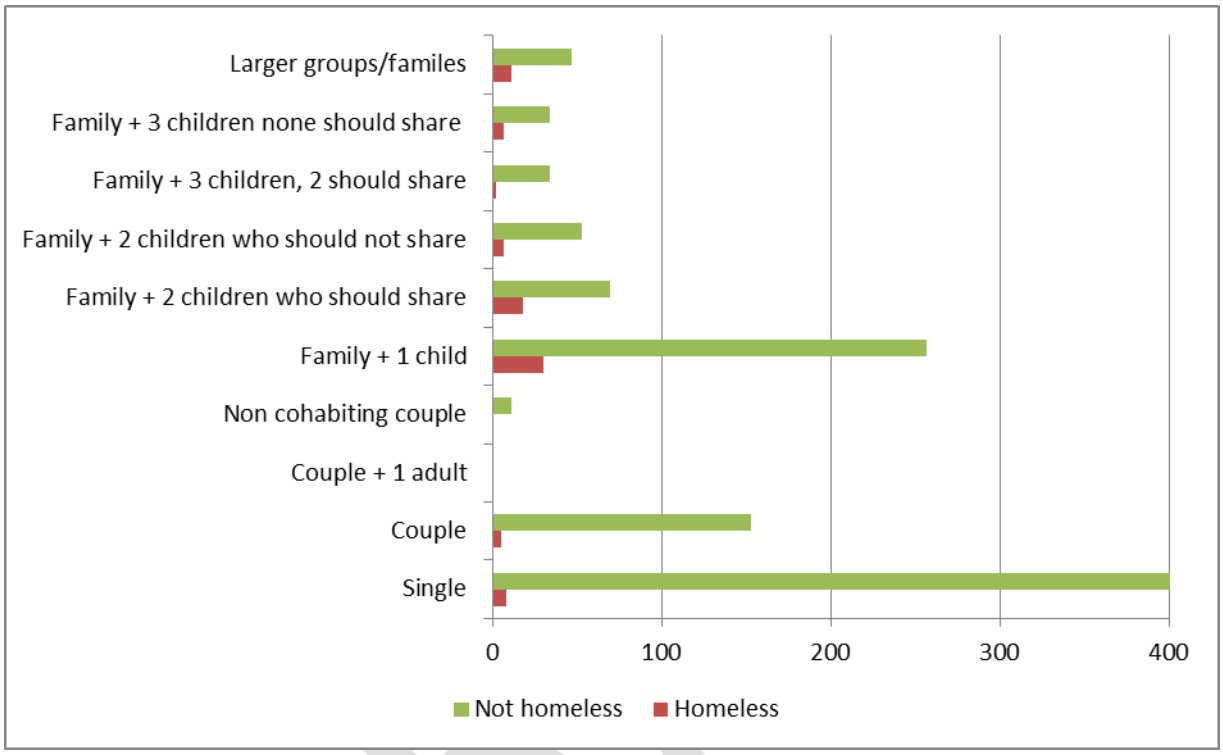
In February 2015 the greatest numbers of applicants on the housing register were single people, couples and families with 1 child, indicating a need for shared housing, 1 and 2 bedroom accommodation. Applicants on the housing register are allocated a band dependent on their assessed housing needs. Band A is for those with the most urgent housing needs. Figure 10 details each and the number of applicants that fall within each band and of those the number that are homeless.

Figure10: Housing register applicants in each band

Band	Total number of applicants	Number registered as homeless
A	39	3
B	63	0
C	1028	83
D	107	1
E	4	1

Of the applicants on the register, 88 applicants are homeless. The majority, 75 households, are families with children and larger families, requiring 2 bedroom, 3 bedroom and larger accommodation. The highest number of homeless households are accommodated in private sector leasing property (56), Bed and Breakfast (15) and in the private rented sector (12).

Figure 11: Household composition of housing register applicants, February 2015



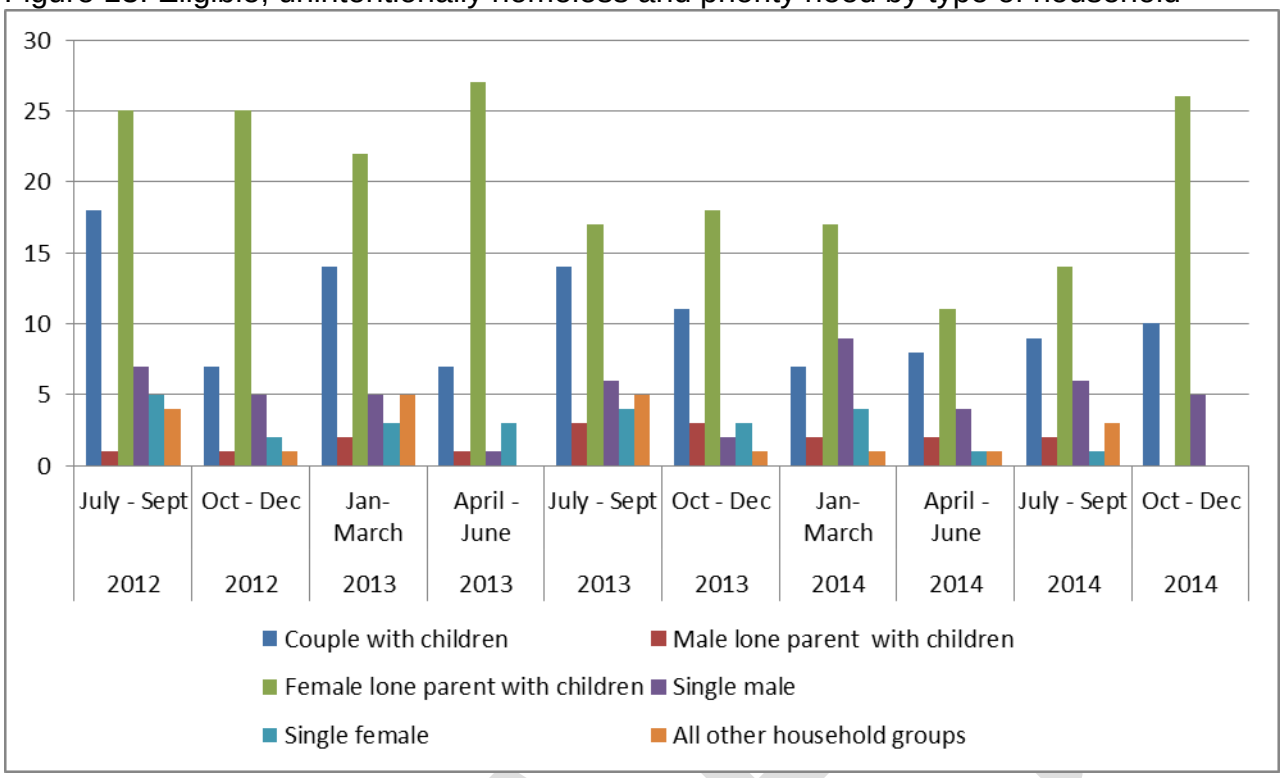
Similarly during 2013/14 there were 167 homeless acceptances. The composition of these households is predominantly with children and the highest requirement is for 2 bedroom accommodation.

Figure 12: Household composition of homeless acceptances 2013/14

Household	Number of acceptances
pregnant no other children	12
1 child	63
2 children	29
3 or more children	23
single people	40

The trend of the composition of homeless households over a period of time is shown in figure 13, confirming that majority of eligible, unintentional and priority need households are families.

Figure 13: Eligible, unintentionally homeless and priority need by type of household



Source : P1e data

Empty Homes

The total number of vacant properties[9] at 6th October 2014, was 1007 an increase from the previous years total of 997 but lower than 2012 and 2011 totals of 1163 and 1221 vacant properties respectively. Within this total the number of long term empty homes (vacant for more than 6 months) at October 2014 were 250 properties, a decrease from the previous 3 years of 307, 449 and 504.

In all social housing 34 properties were vacant at 1st April 2014. With only 1 long term empty property held by a registered provider. This is a decrease on the total of vacant social housing in 2013 of 88 where 46 properties were defined as long term vacant. These could be accounted for in sites waiting redevelopment such as Ashdown Court. Within the council's own stock there were 26 vacant properties at 1st April 2014 a decrease on the previous two years of 34 and 49 properties. Similarly a decrease in vacant properties owned by registered providers is seen with 8 properties in 2014, 54 in 2013 and 61 in 2012.

[9] DCLG live tables 615

Court possessions

Figure 14: Number of claims and possessions over the last 3 years

	2011/12	2012/13	2013/14	2014/15 (April – Dec 14
Mortgage claims	131	120	97	58
Mortgage possessions	37	34	37	4
Private landlord claims	45	40	53	25
Private landlord possessions	3	12	12	10
Social landlord claims	117	173	174	95
Social landlord possessions	21	22	32	10
Accelerated landlord possessions	7	17	26	17
Total possessions	68	85	107	41

Source: KCC mortgage and landlord possession statistics in Kent, at quarter 3, 2014
And https://www.gov.uk/government/statistics/mortgage-and-landlord-possession-statistics-october-to-december-2014

A mortgage or landlord possession action starts when a mortgage lender or landlord completes and submits a 'claim' to the courts to repossess a property. The most common reason for repossession is arrears of mortgage or rent.

Landlords can sometimes evict tenants using 'accelerated possession'. This is quicker than a normal eviction and doesn't usually need a court hearing
The landlord can only do this if the tenants has:

- an assured shorthold tenancy or a statutory periodic tenancy
- a written tenancy agreement
- been given you the required written notice (a minimum of 2 months) in the right form
- hasn't been asked to leave before the end of a fixed-term tenancy

For accepted homeless cases the reasons for the approach have been recorded as given in Figure 15. A private landlord does not always state why the S21 has been served. There are few homelessness acceptances from social housing as anyone evicted from social tenancies tend to be found intentionally homeless. In addition the eviction panel will work to consider ways of preventing an eviction from council owned housing, whereby before an area manager applies for a warrant of eviction it is considered by the serious arrears officer and the senior housing options officer if there is any additional advice or support that could help the household to prevent their homelessness. Help can only be given where tenants are willing to engage with staff.

Figure 15: Reasons for approach for accepted homelessness cases

	2011/12	2012/13	2013/14	2014/15 (April – Sept 14
Mortgage arrears	3	5	7	3
Private landlord arrears	0	2	1	1
Private landlords termination S21	43	54	66	22
Social landlord arrears	0	1	0	0

Homeless acceptances

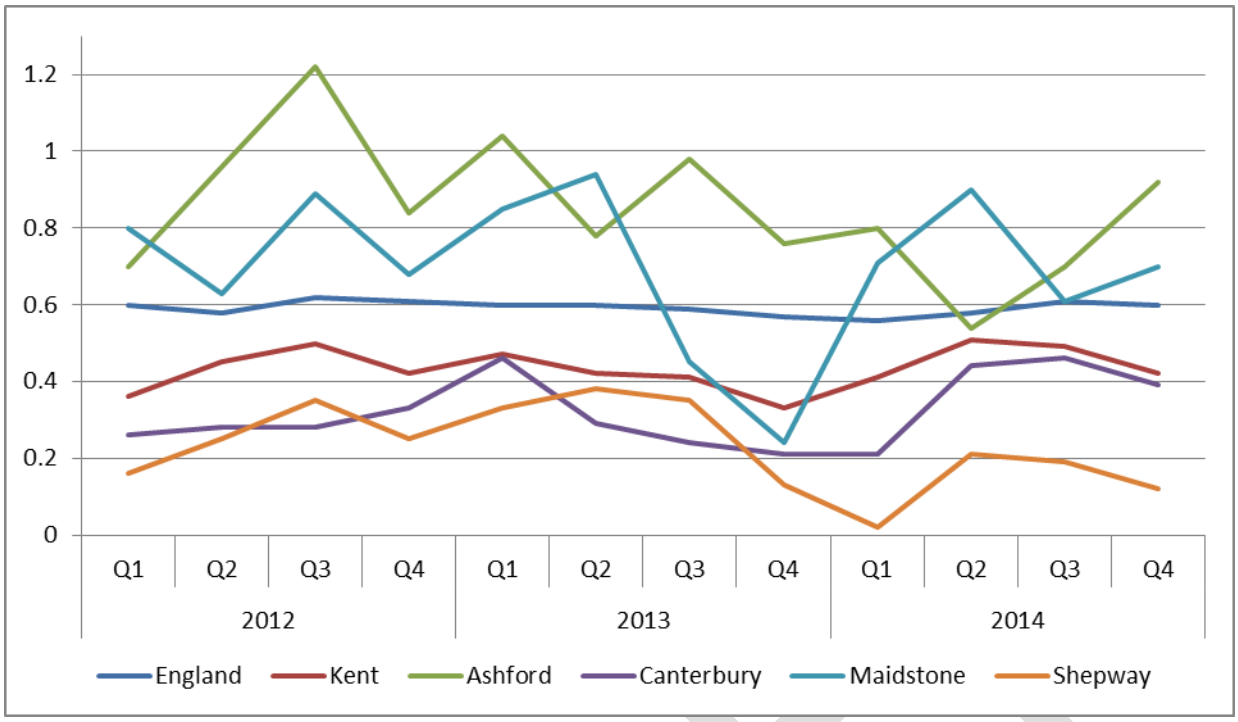
Over the last 5 years the average number of homelessness acceptances has been 175 per year. The number per year is shown in figure 16 below.

Figure 16: Numbers accepted as homeless and being in priority need

To compare with neighbouring authorities and nationally the number of acceptances per 1000 households is used. Ashford consistently has a higher number of acceptances per 1000 households than the national average except for a dip in quarter 2 of 2014.

Following an external review of the Housing Options Service, a range of measures has been implemented to improve the service. This includes a training programme for officers, the appointment of two new Landlord Liaison Officers together with conducting more robust investigations, reviewing all of our processes, restructuring the team and being more pro-active has resulted in a fall in the number of acceptances being noted. However, landlords selling properties are not considering homelessness prevention; in addition, many landlords will no longer take the Homeless Prevention Bond and with market rents higher than the LHA rate, private rented properties are largely unaffordable to anyone claiming full benefits, especially single persons.

Figure17: Homelessness acceptances per 1000 households



Source: KCC homelessness bulletin 2014 qtr4

Reasons for loss of last settled home

In Ashford there have been reductions in homelessness acceptances where parents or relatives/friends were no longer willing to accommodate and in non violent relationship breakdown over the last two years. This reduction is attributable to a review of working practices to, wherever possible, keep people at home, especially young people. Home visits are undertaken to every client at risk of homelessness so both the client and the person evicting them can be spoken with to assess the circumstances. With regard to young people there is a lead housing options officer who works closely with Social Services to conduct a joint assessment with them and the young person to decide if the young person should be a Child In Care (following the Southwark judgement in 2009).

The recent changes at KCC social services has seen the introduction of an Early Help and Prevention Service. These services are designed to respond early to tackle problems emerging for children, young people and families, who without early help would be at greater risk of developing more serious problems and having poorer outcomes. Adequate housing and prevention of homelessness is a critical factor in providing a stable environment for children and young people.

A rise in homelessness acceptances has been seen in loss of rented or tied accommodation due to a termination of an assured shorthold tenancy, violent relationship breakdown and loss of rented accommodation for other reasons.

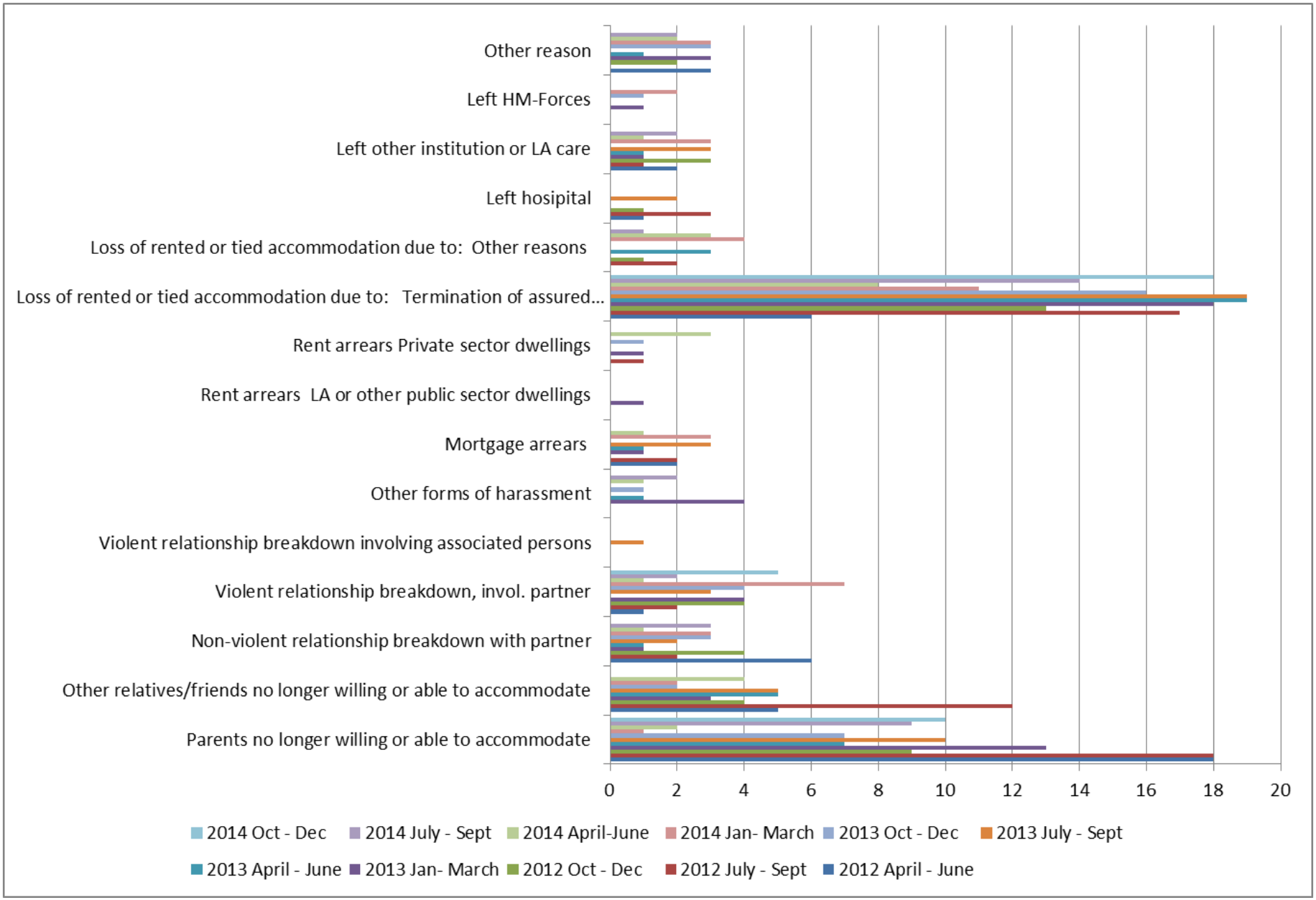
Some landlords are now selling their properties and no longer wish to rent them out. To monitor the reasons for loss of private rented accommodation the reasons for serving a S21 notice, where known, will be recorded, although this is not a requirement.

The rise in acceptances due to violent relationships could be due to having a named housing options officer as a point of contact for domestic violence, who attends MARAC (multi-agency risk assessment conference)and co-ordinates the SAFE referrals, plus there is a one stop shop which is held every week at the Willow Centre, enabling more victims of domestic violence to come forward to seek housing advice.

There were no recorded acceptances for the following reasons

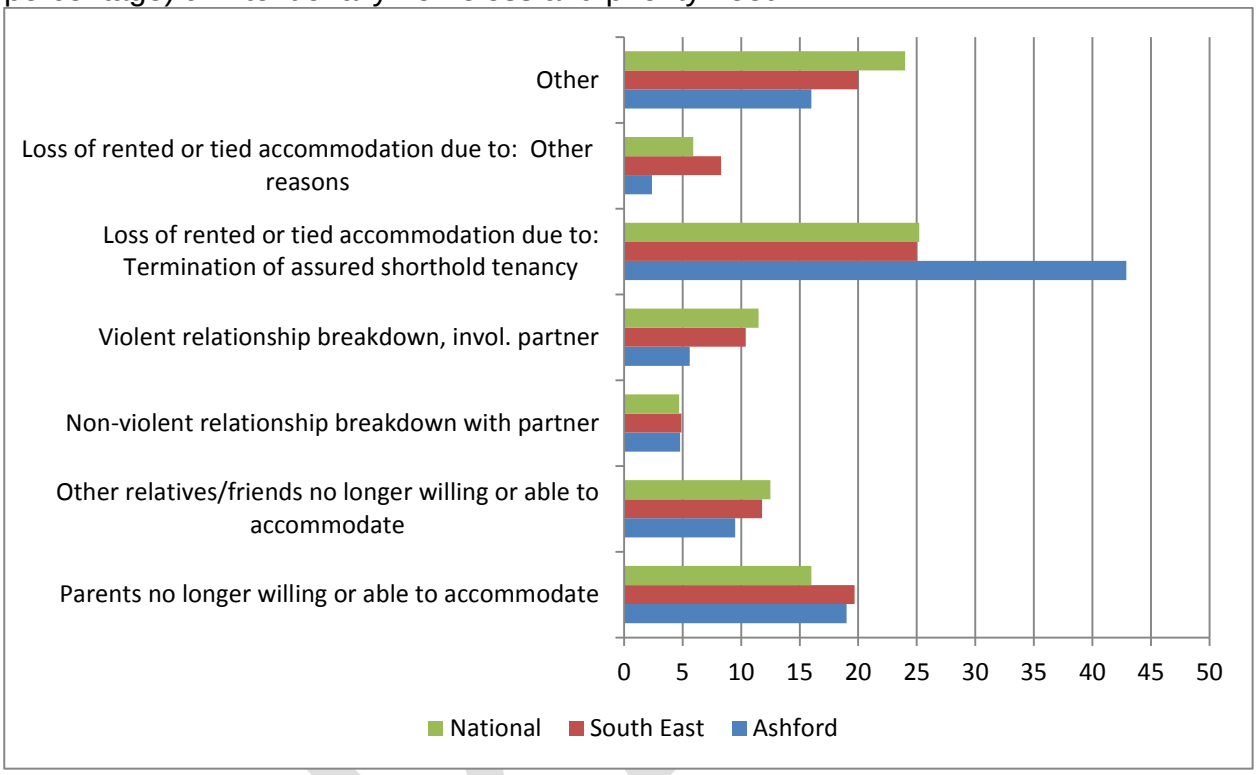
- Racially motivated violence
- Other forms of violence
- Racially motivated harassment
- Rent arrears registered social landlord/other housing association dwellings
- Required to leave National Asylum Support Service accommodation

Figure 18: Reason for loss of accommodation


Other reason
Left HM-Forces
Left other institution or LA care
Left hosipital
Loss of rented or tied accommodation due to: Other reasons
Loss of rented or tied accommodation due to: Termination of assured...
Rent arrears Private sector dwellings
Rent arrears LA or other public sector dwellings
Mortgage arrears
Other forms of harassment
Violent relationship breakdown involving associated persons
Violent relationship breakdown, invol. partner
Non-violent relationship breakdown with partner
Other relatives/friends no longer willing or able to accommodate
Parents no longer willing or able to accommodate
0
2
4
6
8
10
12
14
16
18
20
2014 Oct - Dec
2014 July - Sept
2014 April-June
2014 Jan- March
2013 Oct - Dec
2013 July - Sept
2013 April - June
2013 Jan- March
2012 Oct - Dec
2012 July - Sept
2012 April - June

Using a percentage of homeless acceptances (unintentionally and priority need) to compare local to regional and national figures for 2013/14. This highlights that the loss of rented accommodation due to termination of assured shorthold tenancy is creating higher proportion of numbers of homelessness cases locally

Figure 19: Local, national and regional comparison for homeless acceptances 2013/14 (by percentage) unintentionally homeless and priority need



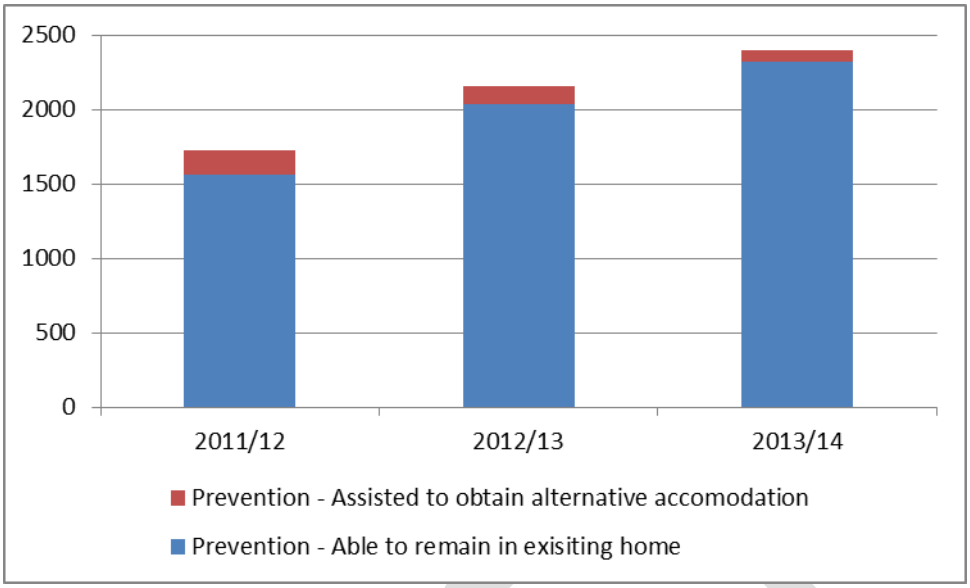
Source: From P1e via practioners support statistical compiler

Prevention and relief of homelessness

Homelessness prevention involves providing people with the ways and means to address their housing and other needs to avoid homelessness. This is done by either assisting them to obtain alternative accommodation or enabling them to remain in their existing home. Prevention work is occasionally done in conjunction with partner agencies such as CAB, Floating Support etc.

Homelessness relief occurs when an authority has made a negative homeless decision i.e. that a household is either intentionally homeless or is non priority as defined within part VII of the Housing Act 1996 (amended 2002), but helps someone to secure alternative accommodation, even though it is under no statutory obligation to do so.

Figure 20: Prevention, number of cases where homelessness has been prevented in Ashford



Homelessness prevention is always the preferred option and a range of options will be explored to determine if the households can remain in their existing accommodation or assisted to find alternative settled accommodation.

In 2013/14 the rate per 1000 households of homelessness prevention in Ashford was 48.98 This is significantly higher than the overall rate per 1000 households for England which was 9.28.

Figure 21: Measures used to prevent homelessness by percentage of total preventions

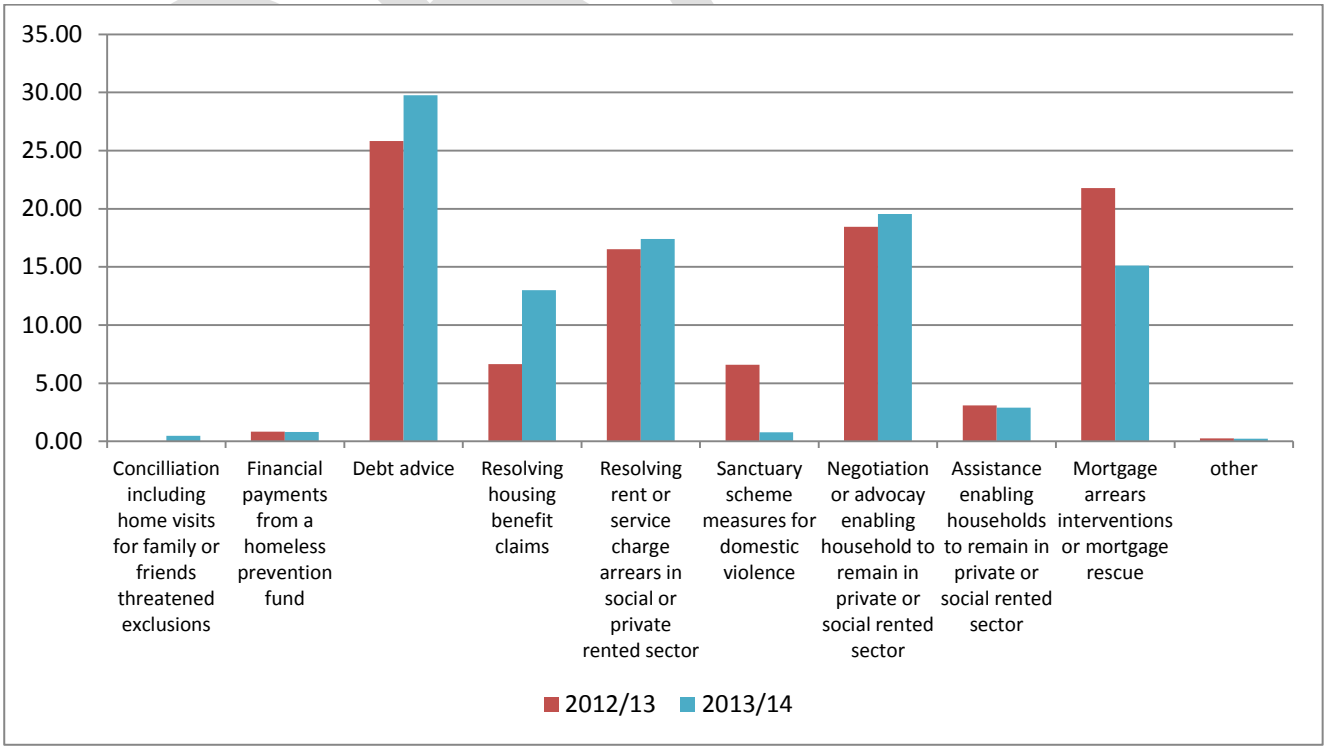


Figure 22: Number of negative decisions (not homeless, non priority, intentionally homeless)

	Not homeless	Non priority	Intentionally homeless
2012/13	105	19	19
2013/14	141	30	28

The housing option available to relive homelessness is into the private rented sector where procuring properties is difficult. Since the recruitment of the 2 Landlord Liaison Officers you can see numbers where positive action has been successful in reliving homelessness have increased.

Figure 23: Number of cases where positive action was successful in relieving homelessness

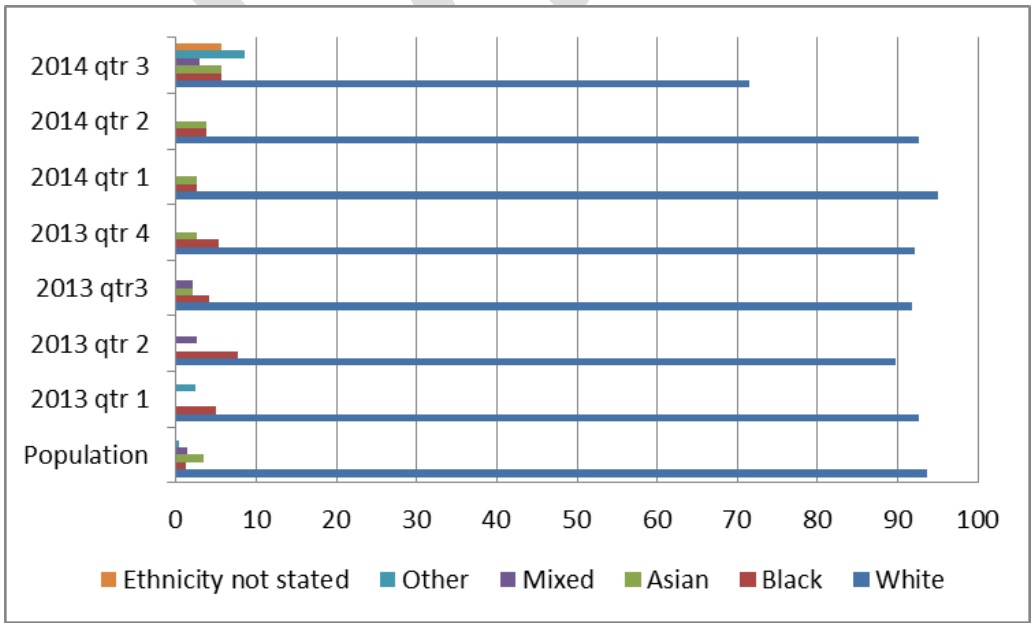
	2011/12	2012/13	2013/14
Ashford	1	2	4

Acceptances by ethnic origin

The population of Ashford is predominately white making up 93.7% of the total population. The percentage of the Ashford population from BME groups from the 2011 census is: Black 1.2% , Asian 3.4%, Mixed 1.4%, Other 0.4.

It is important to compare ethnic minority acceptances against the population profile to determine if there is any disproportionate representation of any group.

Figure 24: Ashford: Eligible, unintentionally homeless and priority need by ethnic origin as percentage of total acceptances.



Homelessness decisions

The number of homeless decisions for Ashford over the last 7 quarters up to December 2014 is shown in Figure 25.

Figure 25: Homelessness decisions

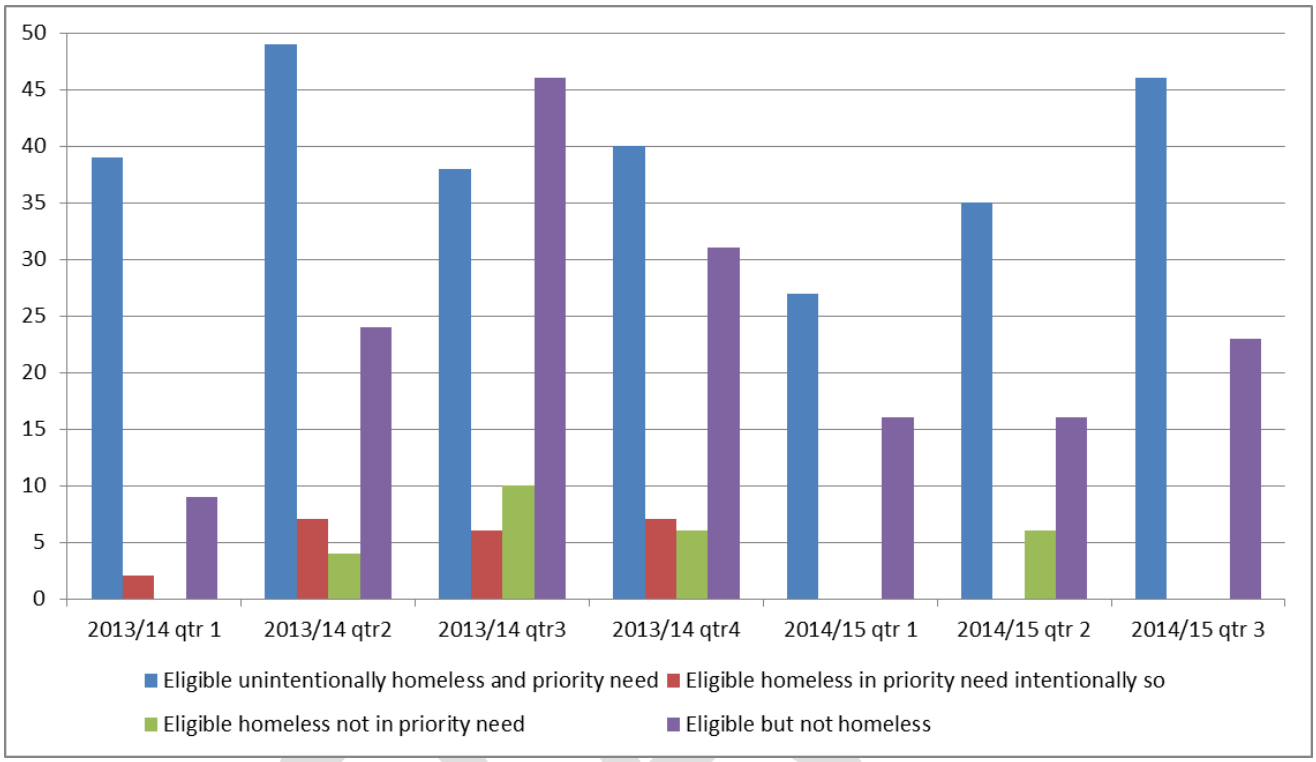
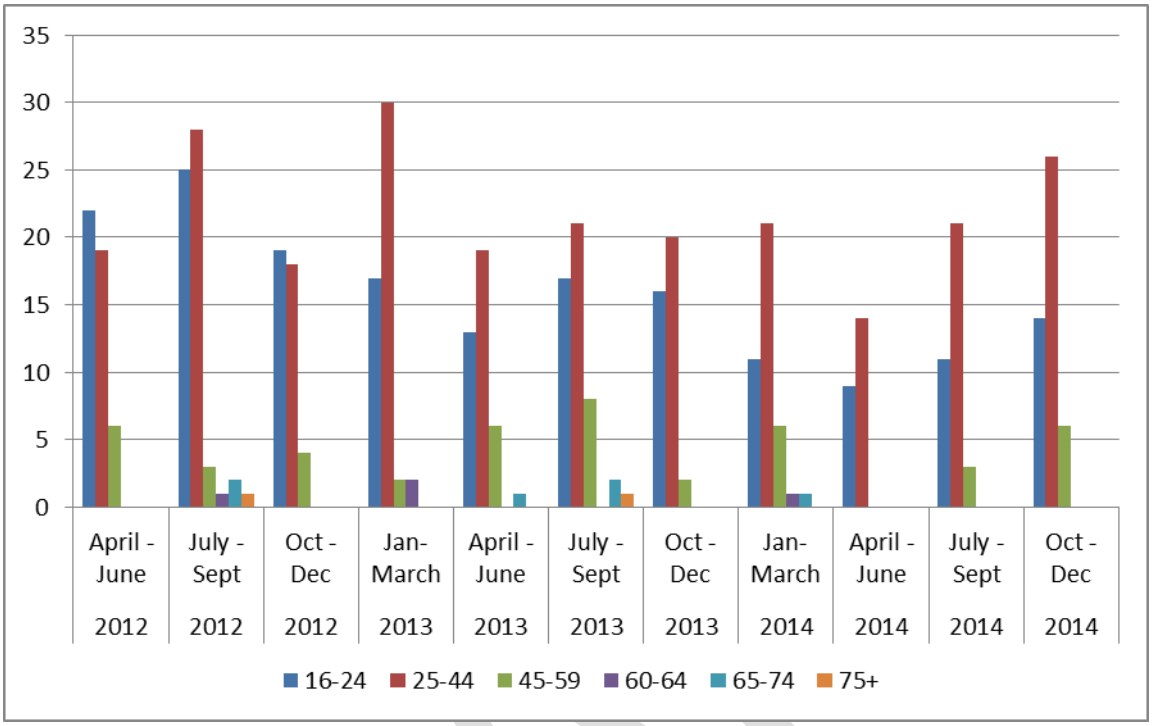


Figure 26: Comparison to the national averages for homelessness decision for the year 2013/14.

	% of all decisions Ashford 2013/14	% of all decisions England 2013/14
Eligible unintentionally homeless and priority need	52	47
Eligible homeless in priority need intentionally so	7	8
Eligible homeless not in priority need	6	19
Eligible but not homeless	35	27

Understanding the age range, in addition to the household composition, of homeless applicants will help inform what services need to be provided. As can be seen from Figure 27, the majority of homeless households fall within the age ranges 16-24 and 25 – 44.

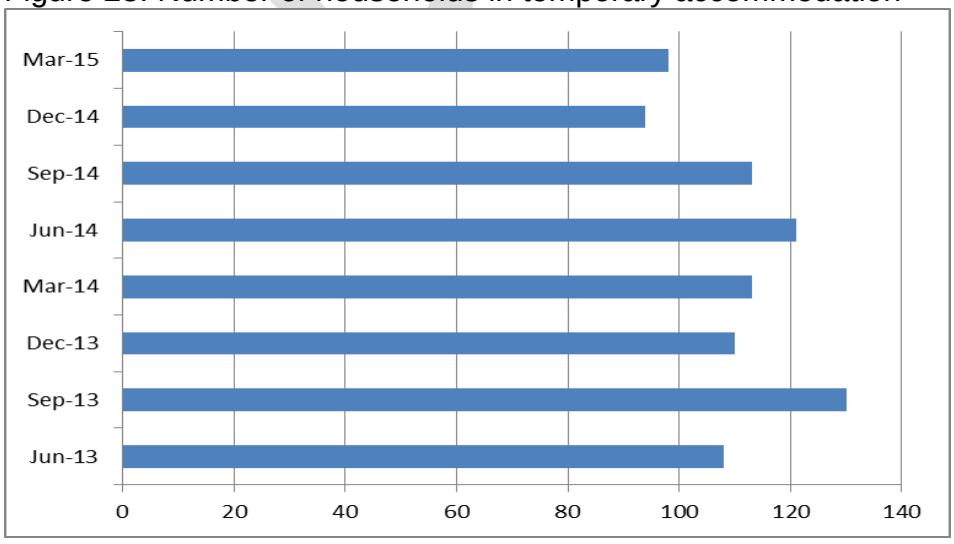
Figure 27: Ashford: eligible, unintentionally homeless and priority need by age of applicant



Applicant households' accommodation (temporary accommodation)

In Ashford the total a number of households in temporary accommodation is over 100 at the end of each quarter as shown in Figure 28. Between 60 and 70 households are accommodated in private sector leased properties at any one time. Other temporary accommodation available includes Christchurch House, Bed and Breakfast and self contained properties within Ashford Borough Council's own stock.

Figure 28: Number of households in temporary accommodation



The numbers accommodated in temporary accommodation remains stable due to maintaining a constant supply of PSL properties, which provides longer term, better quality, temporary accommodation.

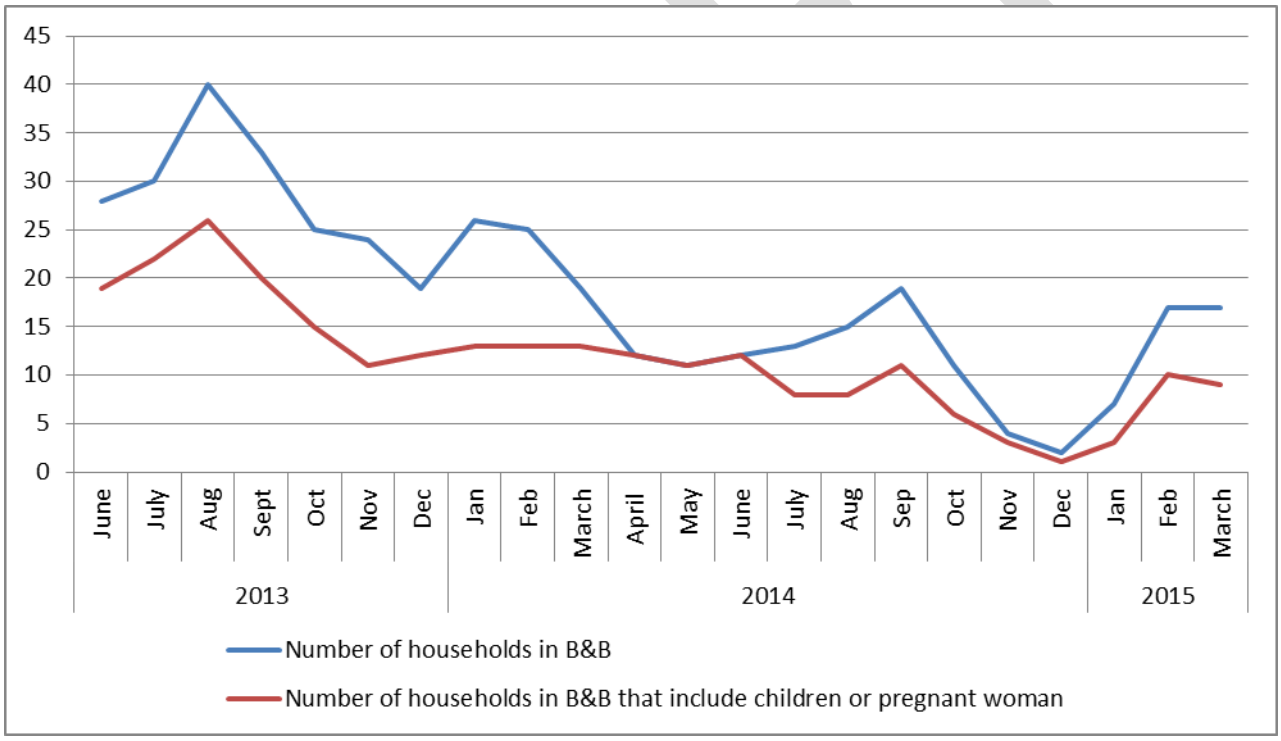
The length of time spent in temporary accommodation varies. Moving on to settled accommodation is either into social housing through bidding on Kent HomeChoice or into the private rented sector.

It is very unusual for a household to be placed out of the area, and then would only be for specific reason.

Bed &Breakfast accommodation use

The use of bed and breakfast accommodation in 2014 is declining as can be seen in Figure 29. This illustrates both the total number of households in B&B and within that total the number of households with children or a pregnant woman.

Figure 29: Households in B&B accommodation



The reduction in the numbers of households in bed and breakfast accommodation is attributable to the review and a restructuring of the housing options team and its working practices.

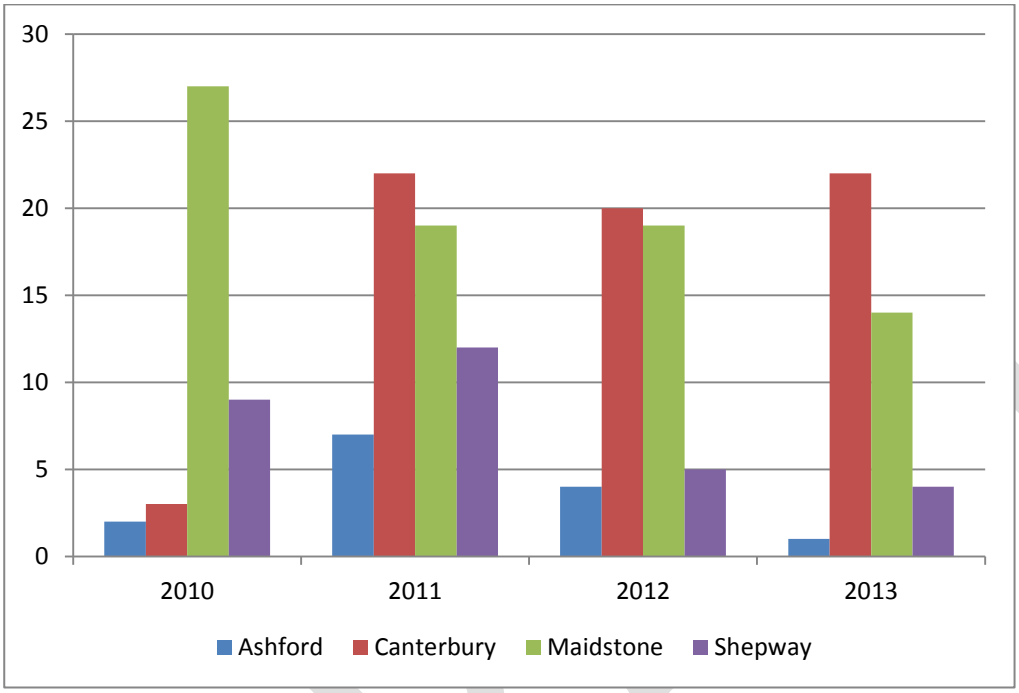
The length of time spent in bed and breakfast accommodation should be as short as is possible. Figures collected at the end of each year show a snapshot of the number of homeless households in bed and breakfast accommodation for longer than the six week legal limit as: 2010/11 = 9, 2011/12 = 3, 2012/13 = 6, 2013/14 = 8

Rough sleeping

The number of rough sleepers is estimated annually in each local authority area.

The figure 30 compares the number of estimated rough sleepers in neighbouring local aauthorities. Ashford, historically has the lowest number of rough sleepers, in the 2014 estimate this has increased to 5 rough sleepers.

Figure 30: Number of Rough Sleepers (estimate)



Ashford historically has a lower number of rough sleepers that the neighbouring authorities. Although there has been a rise to an estimated 5 rough sleepers at the count in 2014. This rise could be due to difficulties in securing accommodation in the private rented sector due to the LHA rates and the cut in housing benefit for under 35s (reduced to single room rate rather than the one room rate). In addition, funding for the Porchlight outreach service has been reduced so they are unable to offer the same level of pro-active work.

Demand on Housing Options Service

Figure 31: Approaches for housing advice

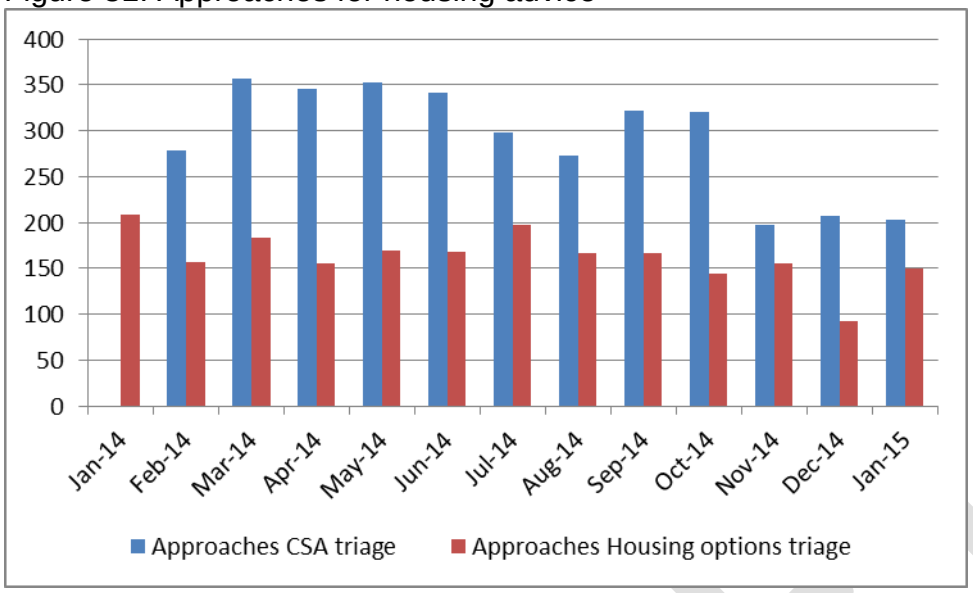
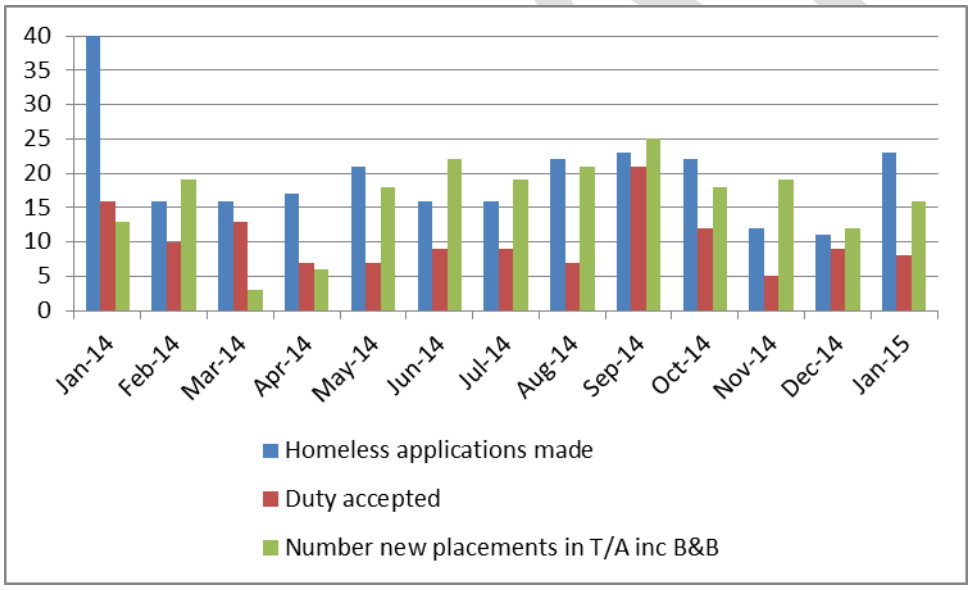


Figure 31: Number of applications and outcomes



The above charts demonstrate that whilst numbers approaching the service are high the number of applications and cases accepted shows that prevention work carried out is being effective.

Alongside statistical evidence a homelessness review also needs to consider current practice in preventing and dealing with homelessness, existing services and accommodation provision. It also seeks to identify where services may need to be strengthened or developed to have the most positive effect in preventing and reducing homelessness.

Corporate approach

Homelessness is one of 5 key priorities of the Ashford Health and Wellbeing Board. The Board looks at the way the health and wellbeing of Ashford's residents is observed and measured and how to improve their health and wellbeing, through joined up commissioning across the National Health Service, social care, borough council, public health and other services that are directly related to health and wellbeing. Unsuitable housing and homelessness can have a negative impact on a person's health and wellbeing. Reducing negative housing factors can therfore contribute to easing pressures on health and social care services.

The Councils corporate plan, Focus 2013-15 does not have a specific priority to tackle homelessness but is committed to providing quality homes and places to live.

The Ashford Housing Strategy has a specific priority to:

Prevent and reduce homelessness and increase access to settled accommodation for homeless households and those at risk of homelessness

With an action to:

Implement the homelessness strategy with focus on:
Preventing homelessness wherever possible
Providing quality housing services and suitable accommodation for homeless people.

The Council's Tenancy Strategy introduced fixed term tenancies from 1st October 2012. This enables reviews of tenants' circumstances and facilitates using housing stock in the most appropriate way for those in greatest housing need. The Lettings Policy was updated in January 2015 and at an operational level the housing register is reviewed every 6 months.

The Council works collaboratively with other local authorities and agencies, often under the auspices of the Kent Housing Group and the Kent Joint Policy and Planning Board (Housing) where greater benefit is derived from a joined up approach and sharing of good practice.

The Kent Housing Group's primary aim is to encourage discussion around best practice in housing amongst Chief Housing Officers of Local Authorities and Chief Executives of Housing Associations working in Kent. The groups remit includes:

- Providing strategic leadership - shaping and setting the housing agenda;
- Building relationships and influence decisions for the benefit of Kent;
- Drawing in resources from both traditional and alternative sources.
- Working together to improve the supply and quality of affordable homes.
- Creating sustainable communities in Kent.

Along with being tasked with the delivery of the Kent Forum Housing Strategy[10] This strategy recognises that each authority will have its own homelessness strategy. The strategy acknowledges the pressures and challenges of the recent economic downturn, welfare reform and increased demand for private rented properties could affect homelessness and this will be monitored.

The Kent Joint Policy and Planning Board for Housing is a strategic partnership between health, housing and social care. The JPPB provides the forum where strategic issues

[10] https://shareweb.kent.gov.uk/Documents/community-and-living/Regeneration/KFHS%20Refresh%20FINAL.pdf

requiring joint working between health, housing and social care, can be raised and measures to address them, developed.

A policy for the discharge of homelessness duty into the private rented sector is in place having been developed jointly with 5 other Kent authorities and adopted by Ashford Borough Council. By working jointly it is anticipated that this will ensure a consistent approach to implementing the power across the County. This is one example of joint working across the county that is led by the Kent Housing Options Group, a sub group of KHG.

The Housing Options Team

The structure of the Housing Options Team is shown in Appendix 1. The Team was reconfigured in 2013 to provide a more streamlined service after customers were experiencing long waiting times at the Gateway and further delay for follow up appointments if necessary. A telephone triage service now operates between 9am and 4pm and an appointment made for a Housing Option Officer to return the call the same day, for more complex cases a home visit can be made within 72 hours of the initial call. Home visits are arranged to ensure time is available for officers to complete their case work. All services are geared towards prevention of homelessness. This includes clients being advised of all their housing options, an income and expenditure assessment to assess affordability together with a 'whole needs' assessment to see what other support maybe needed and can be referred or signposted to. Outside of normal hours a Housing Options Officer is on call to respond to emergencies that come via the Council's monitoring centre.

Each of the 4 housing options officers work generically with a specific responsibility for a particular client group; mental health, young people, ex-offenders and domestic abuse. This enables close working relationships to be formed with a range of agencies and personnel as well as the wider Housing Options Team to look proactively for suitable options within the private rented sector. The specific officer approach has been well received by agencies as they now have a recognised name contact to get in touch with when they are working with a client who needs housing assistance. This has resulted in a reduction in the number of "homeless tonight" cases approaching from these areas.

The Whole Needs Assessment tool enables Housing Options Officers to refer and signpost customers to other organisations that can assist with specific problems. This recognises that difficulty accessing or maintaining housing can be interrelated with other issues, such as debt, benefits, health and support. The tool is currently under review with new partner agencies being added.

Each customer has a named Housing Option Officer to liaise with and once housed an officer relevant to the tenure will continue to offer support to them whether in social housing stock or the private rented sector.

An independent review of the Housing Options Service was undertaken in 2014. This identified a number of strengths and that the team is working effectively.

Accessing suitable accommodation and helping tenants to maintain tenancies in the private rented sector is imperative to reducing and preventing homelessness. The council has landlord liaison officers who can communicate between landlord and tenants, where

there have been problems with a tenancy. These problems may include; damage to property, anti-social behaviour, rent arrears, or failure on the part of the landlord to fulfil their obligations. The landlord liaison officers will investigate and negotiate to if possible to resolve any issues to the satisfaction of both parties.

Under the private sector leasing scheme, the Council leases properties from landlords for a fixed period. This provides suitable temporary accommodation for homeless households. In March 2015 there were 60 households accommodated through the private sector leasing scheme

Also operating is the Council's social lettings agency, A Better Choice Lettings (ABC Lettings) which operates in a similar way to a high street lettings agency to broker tenancies between tenants and landlords, but with a focus to provide access to accommodation for tenants normally seen as a higher risk by high street agencies and landlords. The stark difference is that the main aim is not to make a profit from running such a service but to enable access to accommodation for those who would not normally be able to use a high street lettings agency. This tends to be a large percentage of those who present to the Council as homeless.

Protocols are used to ensure good practice is adhered to from all agencies especially when dealing with vulnerable client group. A number of protocols have been developed on a county wide basis under the guidance of the Joint Policy and Planning Board (housing) together with a reconnection policy which aims to promote equal access to supported accommodation but to enable reconnection to an area when the supported service is no longer required. The JPPB (Housing) is currently reviewing the protocols to ensure the restructure at social services is reflected, which may mean changes to existing practices.

To improve homelessness services across Kent, Ashford has with other local authorities signed up to the Gold Standard[11] programme, designed to help local authorities deliver more efficient and cost effective homelessness prevention services. The challenge follows a 10 step continuous improvement approach that starts with a pledge for local authorities aspiring to 'strive for continuous improvement in front line housing services' and culminates in an application for the Gold Standard Challenge. This review has been developed with reference to the gold standard programme.

Communications

The stakeholder consultation event identified that there are misconceptions around homelessness and lack of knowledge about services that are offered and options available to prevent and relieve homelessness.

The council does not have a communication plans for homelessness and currently raises awareness of the issues through officer contact with a range of organisations and agencies. Individual agencies working with homeless people undertake their own publicity campaigns and awareness raising.

The Council's Landlord Liaison Officers promote the work they do to both high street letting agents and private landlords and emphasize that early intervention in key in preventing homelessness. They hold a Landlord's Focus Groups bi-monthly and a Landlord Forum annually. To engage with more landlords to encourage them to use the

[11] http://home.practitionersupport.org/

social lettings agency a shop front was rented in the high street, which proved successful, with at least 30 new contacts that may lead to procuring additional properties.

Accessing Housing Options Information

There are a number of ways information about housing options can be accessed by the public.

Face to face with a customer service advisor (CSA) at the Gateways in Ashford and Tenterden. CSA will provide basic advice and signposting and refer more complex cases to a housing options officer.

Personal presentations to the Ashford Gateway for the 12 months prior to the end of September 2014 show that Choice Based Lettings is the most common topic, 4135 enquiries, followed by housing advice (2659 enquiries) and then enquires relating to council stock such as repairs and maintenance, rent and mutual exchange.

Telephone advice from customer service advisor or housing services team

Online information available on the Ashford Borough Council website.

Kiosk self help stations are available at the Ashford and Tenterden Gateways and 4 children's centres. In the 12 months prior to end of September 2014, housing was the most frequently chosen option from the kiosk. (The others being employment and benefits).

Within the housing information, the housing options section is most viewed, 1124 views. Within that section information about private renting and choice based lettings are the most frequently chosen. Of the homelessness prevention topics, the most popular were those associated with affordability. 149 visitors clicked directly on the 'I am going to be made homeless' option.

Accommodation and Services

Supported accommodation in the borough is detailed in the table below.

Accommodation (existing)	Client group	Number of units	Level of support	How funded (support)
Porchlight - Simon Mead House	Single homeless (18-65 yrs)	11 Individual bedrooms, shared facilities	Low level	KCC Supporting People
Homegroup - Stonham	Young single people (16-25 yrs)	Individual bedrooms, shared facilities	Low level	KCC Supporting People
Homegroup - Emergency Accommodation (based at Stonham)	Young single people (16-18)	3 Individual bedrooms, shared facilities	Low level	Ashford Borough Council

YMCA - Brookfield Court	Young Single People (16-25)	3 x 3 individual rooms, shared facilities	Low level	Ashford Borough Council
Circa - Womens Refuge	Women fleeing domestic violence	16 self contained units	Medium Level	KCC Supporting People
Christchurch House	Homeless families	8 Individual rooms, shared facilities	No support but superintendent on site daily	Ashford Borough Council

Accommodation being built	**Client group**	**Number of units**	**Level of support**	**How Funded**
St Stephens Walk – expected completion Sept 2015	Single Homeless	11 Self contained flats	High	Private Finance Initiative (PFI)
The Limes – expected completion Sept 2015	Young people (16-25 yrs)	8 Self contained flats and communal space	High	Supporting People

In addition to the above supported accommodation homeless households can be assisted to access private rented accommodation, either directly with a private landlord, or the Ashford Social Lettings agency (64 properties in Ashford on full management option March 2015). Using the Homeless Prevention Bond scheme is another way to assist households into the private rented sector.

Case Study: Christchurch House

Christchurch House in Ashford was a rundown, empty commercial property. It has been renovated and turned into a short-stay accommodation facility containing eight accommodation units (including a wheelchair-accessible unit and wheelchair-friendly kitchen facilities) along with washing facilities, a communal kitchen area, storage space and a pleasant courtyard. The property will be a temporary home to people whom the council has a homeless duty and whose homelessness cases are under review. Traditionally the majority of homeless applicants the council has a duty to house have been placed in bed and breakfast (B&B) accommodation. This project is expected to save the taxpayer around £75,000 per year and reduce the trauma faced by families in a B&B.

Temporary Accommodation

Temporary accommodation has been in transition since 2011 when the Government introduced LHA rates into the calculation of HB subsidy for temporary accommodation and capped the amount of subsidy payable in temporary accommodation cases. Claimants in temporary accommodation are also subject to the benefit cap. The treatment of temporary accommodation in Universal Credit is a further and final step in the journey of

transition for temporary accommodation. The Government expects LAs to provide suitable permanent accommodation for claimants who present as homeless rather than using over-expensive temporary accommodation to home such families[12].

Services and Support

A number of organisations offer a wide range of services to people which will assist with their housing situation. However it is not always known who provides what and any referral criteria. As part of improving communications greater awareness of services and support offered in the borough or can be accessed by residents would be useful.

These services include:

- Debt advice
- Tenancy training
- Benefit advice
- Employment advice
- Support for families and young people
- Support for homeless people
- Support for victims of domestic abuse

A 'Hub' has been set up in cooperation with the Department of Work and Pensions to offer wider advice to people seeking to return to work to reduce barriers to employment.

Case Study: Kent Advice Service for Single Homeless

The Kent Advice Service for Single Homeless (KASSH) is a service providing assistance to single homeless people across Kent and run by Riverside ECHG. The focus of the service is to help prevent homelessness among single men and women who are at risk of becoming homeless because they are facing eviction from a private rented property, or are sofa-surfing, or who have slept rough already. The KASSH team provide a single service offer which can include emergency accommodation, help with reconnecting to someone's family or home area or a range of other options to prevent single people becoming homeless.

Welfare Reform

A snapshot of claimants affected by the benefit cap on 16th September 2014 identified 49 households affected by the benefit cap, all are families with 3 or more children. 19 households are living in the private rented sector. These households present a higher risk of becoming homeless if they fall into rent arears than those in council or housing association homes and finding suitable alternative accommodation for larger families is very challenging.

The roll out of Universal Credit means households who previously would have had their rent paid directly to the landlord will now have to budget and be responsible for paying their own housing costs. This will need to be monitored to identify those households who maybe at risk of falling into arears.

[12] HB circular A9/2014

Consultation Outcomes

Stakeholder consultation – November 2014

The key points identified from the stakeholder consultation were

- Aligning polices and strategic aims.
- Prevention and early help/intervention are key.
- There are a number of projects/initiatives working in this area although some have specific criteria to be able to access them and concern about those people in housing difficulty who may not meet such criteria and potentially could become homeless.
- Awareness raising of what services are available both to professionals and public.
- Identifying first signs of homelessness to enable preventative work to commence.
- Could a directory / web based information portal help access information?
  Recognised difficulties of keeping information updated. How best to link to existing 'directories' such as Live It Well website.
- Helping people to 'self-help' through signposting to services.
- Importance of frontline staff giving a consistent message. How could this be better coordinated.
- Are services the right ones to offer. Are people engaging with them, do they know how to access services. More publicity?
- With regard to private rented sector.
  - More needed to be done to improve joint working with private landlords to encourage them to make LA aware when they are looking to evict a tenants so appropriate alternative accommodation can be found.
  - Need to raise awareness of both landlords and tenants of services that can assist, such as tenancy training, landlord liaison officers.
  - Support providers could help families going into PRS, but don't receive any referrals – possibility of including information about support services in tenants packs.
  - Need to address concerns of those who would rather wait for social housing than consider PRS – ABC lettings agency offers minimum 12 months tenancy to help address concerns about security of tenure.
  - If person under notice of eviction they are placed in Band C and housing options officers work with them to find other housing options.
  - Landlord liaison officers to forge closer links with letting agents.
  - To help prevent homelessness, Gravesham BC will give higher banding if household can find alternative accommodation e.g. stay with family.

Agreed that a twice yearly meeting to monitor the progress of the homelessness strategy would be useful.

Common themes emerging were:

- Joint commitment to the prevention of homelessness at a strategic level

- Joint working across all organisations

- Early intervention is key to homelessness prevention

- Improve communication
  - Between partners
  - Increased public awareness of homelessness and causes of homelessness
  - Where to go for help – easy to understand information

- Demand for accommodation for client groups with high support needs and those who do fit into priority need criteria

- Further develop relations with private landlords to increase availability of suitable accommodation for homeless households
  - Work to breakdown misconceptions of private rented sector with tenants
  - Work with tenants to understand responsibility of renting

Gaps
The stakeholder consultation sought to identify where there are gaps in local service provision or what additional services could make a positive contribution to the prevention and reduction of homelessness.

These were grouped under the 10 local challenges set in making every contact count, although some will be effective across several challenges.

1 Adopt a corporate commitment to prevent homelessness which has buy in across all local authority services.

- Joined up interagency approach to staff training in housing options to ensure consistent information/advice is given.
- Aligned priorities needed to prevent conflicting objectives – prevention to be key priority
- Increase commitment to raising awareness of homelessness

2 Actively work in partnership with voluntary sector and other local partners to address support, education, training and employment needs.

- Need to keep information updated – whole needs assessment tool
- Some criteria are inflexible restricting help being offered
- Need to raise public awareness/responsibility
- Training for partner organisations, managing expectations of what's available
- Finding out what services are needed from service users.

3 Offer a housing options prevention service, including written advice, to all clients.

- Awareness raising for - universal credit, budgeting, anti social behaviour act, providing information to the customers including how to reach those who cannot read or are not computer literate

- Early years education on realities of homelessness, money management etc.
- Increase joint working in voluntary sector
- Homelessness options needed for those who are not in priority need
- Private rented sector not affordable to people on benefits
- Develop more ‘must –do’ emphasis on tenants
- Closer liaison with housing providers when they are taking eviction action

4 Adopt a No Second Night Out model or an effective local alternative.

- Need for more supported accommodation and a hostel in Ashford
- No winter shelter in Ashford for rough sleepers
- Increase street pastor service

5 Have housing pathways agreed or in development with each key partner and client group that includes appropriate accommodation and support.

- Lack of accommodation for those with high support needs
- Need better links with mental health teams and support for people with low level mental health problems
- Increase landlord contacts and Involvement of landlords in the process, knowledge of floating support
- Difficulties contacting resettlement workers
- Avoid missed opportunities through customer/staff contact
- Recognising and dealing with financial issues

6 Develop a suitable private rented sector offer for all client groups, including advice and support to both clients and landlords.

- Support for vulnerable tenants
- Information sharing to sustain tenancies, awareness of potential issues and knowledge of support services available, early identification of problems and signposting to services
- Tenancy training/packs/accreditation
- Rent guarantee

7 Actively engage in preventing homelessness including loss of private sector accommodation and parental eviction.

- Increase public awareness/understanding of homelessness
- Improve links between private landlords and services and incentives with letting agents
- Financial literacy/information courses
- Mediation service to address parental eviction
- Joint agency working , specifically for hard to reach families
- Use of the housing register banding to encourage self help.

8 Have a homelessness strategy which sets out a proactive approach to preventing homelessness and is reviewed annually so that it is responsive to emerging needs.

- Raising public awareness
- Influencing policy and sharing policy with other authorities

- Sharing of statistics
- Political recognition of issues

9 Not place any young person aged 16 or 17 in bed and breakfast accommodation.

- Use of early help notification at point of 'risk' of homelessness i.e. prevention
- Affordable /safe offer of accommodation / supported lodging model for 16/17 / emergency accommodation for young people with babies
- Intensive support workers
- Family mediation services, keeping families together, holistic support, educating parents (parental responsibility), conflict resolution, relationship mediations
- Education through schools, youth groups etc
- Schools identifying quickly – referring to organisation
- Problems claiming benefits
- Impact of statutory school age on family income

10 Not place any families in bed and breakfast accommodation unless in an emergency and then for no longer than 6 weeks

- Maintaining support through from B&B to move –on
- Annexes to current B&B, self contained.
- Lack of temporary accommodation

Service User consultation outcomes – May 2015

Key points

- Accommodation before homelessness and circumstances leading to homelessness

Five respondents were living in private rented or renting from family, four respondents were living with family including family of ex-partners, one respondent was sofa surfing and one respondent was living in the refuge, due to fleeing domestic violence.

The most frequent reason for homelessness was being given notice from private rented or property to be sold (six respondents), family/relationship breakdown was given by three respondents and one respondent had fled domestic violence and another was asked to leave due to overcrowding, from living with ex-partners family.

- Employment and training

Two respondents were in employment/training and have been able to retain that.

- Support and advice

Eight respondents were in contact with services prior to their homelessness, with a mixed response to how helpful they were in regard to housing circumstances. Further to their homelessness the majority of respondents (seven) sought advice from Council or at the Gateway, two used the Citizens Advice Bureau.

With regard to accessing self help through a directory of services, six respondents indicated they would use such a resources, if knew where and how to access the information.

In terms of future accommodation, of those who specified, seven stated they would prefer Council /Housing Association property, and one would prefer the private rented sector. Nine respondents said they have considered looking for private rented accommodation, reason for not pursuing this tenure were given as; not secure, bad experiences with landlords , difficulty using computers to search, spent a long time looking.

Five respondents continued to receive support (mental Health Services, DV services, and family support services) and there was evidence of some signposting to other services.

There was limited response to what support would be useful but money management and tenancy skills were noted being helpful, along with where to access furniture.

- Public awareness

Four respondents thought that there was some public awareness of why people become homerless and four thought there was no public awareness. There was little idea of how to increase public understanding of homelessness.

Outcomes of the Homelessness Strategy 2012.

This section of the Review looks at the achievements of the Homelessness Strategy 201232 and where actions may not been fulfilled. This will highlight areas that need further consideration going forward with the development of the Homelessness Strategy 2015.

The Homelessness Strategy 2012 has 3 priority headings.

- Ashford wide commitment to preventing homelessness wherever possible
- Quality housing services and suitable accommodation for people for whom homelessness cannot be prevented
- Settled and sustainable homes, with access to housing support if needed

By reviewing progress towards achieving these will highlight what is working well and where there may need to be changes to address current homelessness needs to inform our action plan. This is set out in the table below.

- **Ashford wide commitment to preventing homelessness wherever possible**

An up-to-date understanding of homelessness in Ashford so that we are able to direct our resources appropriately.	
Work completed /ongoing	Future work identified
Housing Option Officers now have specialist areas to enable closer working relationship with other agencies, helping to foster a come to us early approach to identify causes of homelessness and utilise prevention measures whenever possible.	Need to continue to reach organisations to increase knowledge of tools available to prevent homelessness.

Ashford worked with other Kent Local Authorities to produce a policy for discharging homelessness duty in to the private rented sector. Data on homelessness is captured through the computer systems and used to inform future work.	Continue to contribute to Kent Housing Options Group meetings and develop ideas for performance monitoring and joint working Make better use of data to monitor trends and develop benchmarking against other Kent local authorities
A commitment from all agencies in Ashford to recognise homelessness triggers and to refer those at risk to appropriate services.	
A telephone triage service has been introduced and home visits follow where needed. Housing Option Officers work closely with landlord liaison officers to prevent homelessness. Regular forums with private sector landlords helps identify and address issues around access to accommodation and standards together with impact of welfare reform. Discretionary Housing Payment has been used to help with homelessness prevention and close working with the welfare reform officers who advise those affected by benefit reduction on how to maximise income and access employment.	Further work required to develop early intervention measures particularly for young people, those with mental health problems and private rented sector tenants. Housing Options Officers find many families they are working with they cannot refer to troubled families project as fail to meet the specific criteria to be accepted to the programme. Given the withdrawal for Mortgage rescue more work needed to promote the Mortgage Repossession Prevention Scheme
Readily available information and advice so that residents are able to meet their own housing needs as far as possible, and prevent homelessness.	
More information is available online, including housing register application form, change of circumstances and updating contact details. An interview and finance form is being developed to avoid duplicating work both for clients and officers in finance and housing. The whole needs assessment approach is being updated to ensure clients are referred to the most appropriate services for their needs, to help them maintain settled accommodation. With the closure of the Shelter office in Ashford, telephone advice continues to be available from them, with the Housing Legal Aid service is provided by Holden & Co.	Further work is needed to improve prevention of homelessness amongst young people. Particularly in light of the withdrawal of funding from the Porchlight schools programme. Information from the self help kiosks needs to be collected and analysis undertaken to determine who is using the facility and if better use could be made of them. Joint working needs to be undertaken to assist people with budgeting, opening bank accounts etc. to enable the receipt of benefits.

- **Quality housing services and suitable accommodation for people for whom homelessness cannot be prevented**

Quality homelessness services and temporary accommodation suitable for people with different needs.	
A supported housing scheme for young people is under construction that will contribute to preventing homelessness and, reducing the use of bed and breakfast. A further scheme of short term accommodation for homeless families is now operating and providing an alterative to bed and breakfast accommodation The Kent Advice Service for Single Homeless is running alongside other prevention measures in Ashford. Due to a cut in funding the Porchlight out-reach service for rough sleepers has been reduced.	Continued work on developing robust accommodation pathways for all client groups is required.
Clear pathways to settled housing, a better quality of life, health and wellbeing.	
A regular move–on meeting is held to facilitate planned pathways for clients and to make the best use of the supported accommodation available. Work is ongoing to improve communication with the hospital discharge team especially for people with mental health and substance misuse problems and offenders, who are particularly vulnerable if discharged with no accommodation arranged.	With organisational restructures it is necessary to keep updated with changes to personnel and roles to build relationships with key people to agree proactive, prevention measures are ongoing.

- **Settled and sustainable homes, with access to housing support if needed**

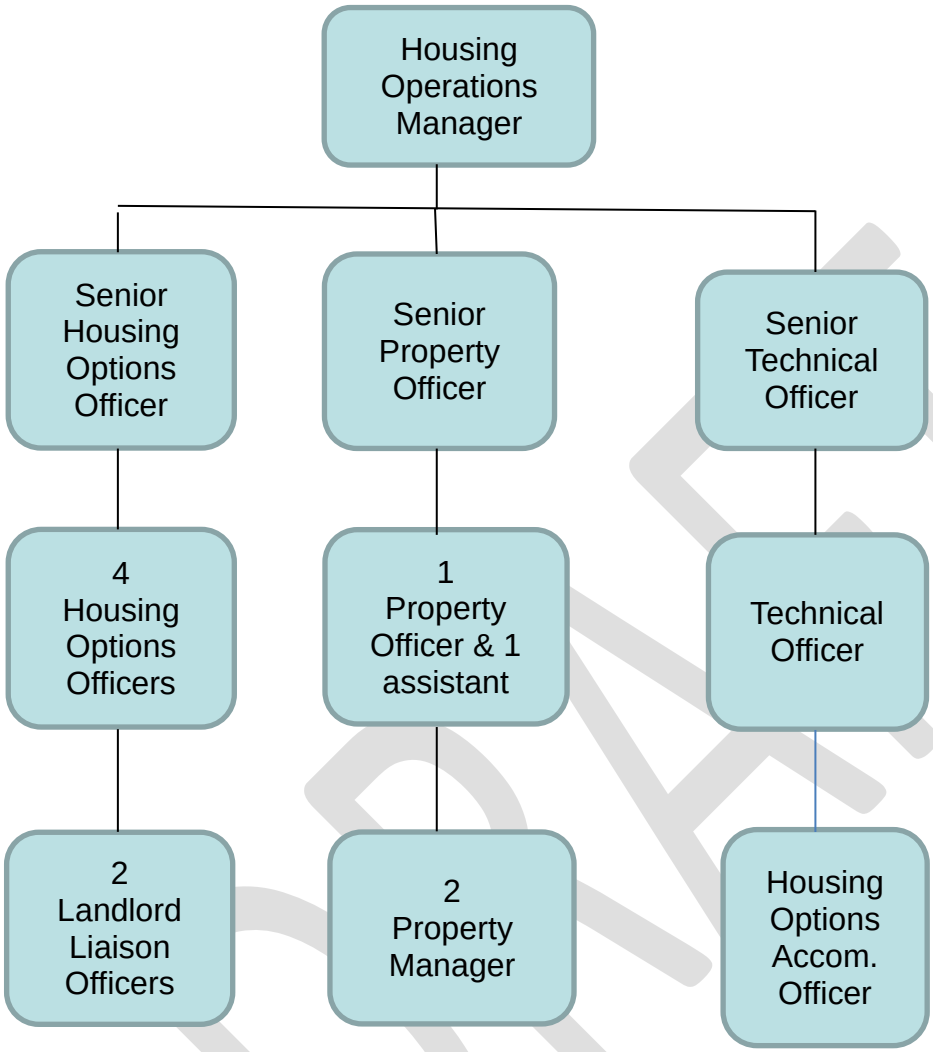
Suitable accommodation and support for people with health, care or support needs who are at risk of homelessness, or homeless.	
The Council contributed the review of the Supporting People Strategy and the Kent Accommodation Strategy to ensure the commissioning of support is meeting local needs. Homelessness is one of the key priorities of the Ashford Health and wellbeing Board, linking the impact of homelessness to increased prevalence of ill health and difficulties accessing services.	

Social and affordable housing is developed and managed effectively to meet housing needs and prevent homelessness.	
The area managers work closely with welfare reform officers to identify tenants who maybe at risk due to changes in benefit regime to assist them to retain existing accommodation or move to a more affordable home	Lack of affordable housing results in fewer opportunities to develop supported housing options for vulnerable people including those at risk of homelessness. With fixed term tenancies a procedure with Registered Providers needs to evolve to ensure timely notification of the ending of a tenancy. Housing Options Officers need training to increase understanding of cultural needs of gypsy and traveller communities to offer appropriate housing advice.
Improved access to suitable and good quality private rented homes, that are affordable and sustainable in the longer term.	
A range of initiatives to increase access to the private rented sector are in place: Landlords forum, accreditation scheme, social lettings agency, signposting to the Kent no use empty campaign, tenancy training	Work is needed to provide accommodation for single homeless people, developing a scheme with private sector landlords to provide shared accommodation either with the council or another agency to manage tenancies could assist those only eligible for shared room rate of housing benefit.

Case study: Welfare Reform Intervention

The Welfare Reform Officer assisted a lady who was struggling to pay her rent to source further part time work which enabled her to claim working tax credits. By meeting regularly to help understand how to budget, she now is managing 3 part time jobs and paying her rent and council tax without assistance. This type of intervention is crucial in preventing homelessness.

Appendix 1 - Housing Options Team structure



Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for the Clinical Commissioning Group – Quarter 1: April to June 2015

What's going on in our world	Annual Operating Plan submitted to NHS England as per deadline, outlining priority project for 2015/16 Annual Report published Action Plans in place to address underperformance against national constitution measures Unsuccessful bid against PM Challenge Fund bid for extended 7 day working Community Networks meeting continue
Success stories since last AHWB	Achieving IAPT national recovery rate Increased care plans, through IT system, available to all health providers Dementia diagnosis rate maintained over 50% but still behind planned trajectory Over 75 identifying frailty scheme that our membership has agreed to, this links in to the CQIN pathway work that our Community and Acute providers have been working on. This will support a reduction in falls, by identifying frailty before crisis.
What we are focusing on for the next quarter <u>specific to the key projects</u>	Continued development of community network to test model assumptions Implementing revised specification for Westview to support creating of capacity for GP beds and non-weight bearing patients
Anything else relevant to AHWB priorities NOT mentioned above	
Strategic challenges & risks including horizon scanning?	Ensuring that implementation of community networks is balanced with current demands of capacity
Any thing else the Board needs to know	
Signed & dated	

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for Kent County Council – Quarter 1: April to June 2015

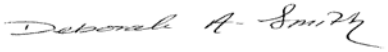
What's going on in our world	• KCC has a new commissioning framework, which is driving KCC's new strategic statement and supporting outcomes (replacing Bold Steps for Kent) to show how the strategic aims align to the organisation's aims. • Care Act One of KCC biggest challenges for 2015/16 is the implementation of part two of the Care Act. There is a lot of preparation being done in readiness for part two of the Care Act. KCC have already implemented part one of the Care Act, but recognising that it is still important to keep embedding the Act into practice every day. Some of the key changes in part two are around the cap on care costs and the increase to capital threshold. • Think local, act personal! The 'Making it Real' initiative sets out what people use services for and what carers expect to see and experience if support services are truly personalised. Over the next six months, there will be a series of events within some of the Clinical Commissioning Groups, to identify local priority areas that should be taken forward to develop better and more personalised community based care and support. Colleagues, service users and carers will be invited to participate in these events. One example of how we're already successfully working with partners is the new British Sign Language interpreting card, which helps health services support deaf patients at their appointments. • Shared lives Over the past few months KCC Shared lives service has been reviewing the current service to identify opportunities for individuals with a learning disability, to move from a residential setting, into a Shared Lives home. Shared Lives offers a person centred and bespoke service, in a family type setting from the Shared Lives host's own home and is an alternative to other residential type services. The service offers long term, transition, short breaks and day support to a wide range of people with Learning and Physical Disabilities, Mental Health issues, people on the Autistic Spectrum, Older People and people living with dementia. Shared Lives Hosts are recruited, vetted, trained, monitored and supported by the KCC Shared Lives team.

Success stories since last AHWB	• Independent advocacy • KCC have commissioned services for carer's assessments and advocacy, together with greater access to advice and information for customers through Kent.gov.uk.
What we are focusing on for the next quarter <u>specific to the key projects</u>	• Working with CCG to develop Community Networks • Our Place (Wye and Hixhill, supporting a community to be self-sufficient) • Integrated Care Pilot in Tenterden
Anything else relevant to AHWB priorities NOT mentioned above	KCC Transformation programme continues
Strategic challenges & risks including horizon scanning?	No
Any thing else the Board needs to know	No
Signed & dated	Paula Parker 03/07/15

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for Public Health – Quarter 1: April to June 2015

What's going on in our world	Smoke Free Parks and play spaces – The first Smokefree Park in Kent was launched in April at Kilndown Park in Stanhope. The pilot attracted considerable media attention resulting in public support for smokefree places where children play. The play parks are equipped with additional trail games to promote physical activity and mental wellbeing. There are plans to roll the pilot to other play parks in Ashford. Other District Authorities are also interested in adopting the same approach. Alcohol Strategy – Ashford will prepare an Alcohol Action plan from the Kent Alcohol Strategy which will be delivered, with partners, through the Community Safety Partnership strategy (Substance Misuse group). The draft action plan will be shared with the Ashford Health and Wellbeing Board for agreement prior to implementation.
Success stories since last AHWB	Health Profiles for Ashford Recent Health profile data for 2015 has been published by Area Public Health Observatory (APHO) in June 2015. The data set shows that Ashford is performing above the England average for many of the indicators but is performing Red (ie. Significantly worse than the England average), namely: Homelessness Violent crime (violence offences) – possibly due to recording methods Obese children (Year 6) Killed and seriously injured on roads. Other indicators where Ashford is at risk of becoming significantly worse than the England average are: Smoking prevalence Excess weight in adults Hip fractures in people aged 65+ Life Expectancy at birth (male and female) Smoking related deaths Further details can be accessed on the apho website: http://www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=A*
What we are focusing on for the next quarter specific to the key projects	Discussions with Ashford Borough Council Housing department on how to expand Smoke Free Homes initiatives into the rented sector. The pilot is a community based initiative co-designed with Kent residents and offers a free goody bag to support people making their homes smokefree. The programme rolled out across Kent is currently being delivered by Childrens Centres.

Anything else relevant to AHWB priorities NOT mentioned above	
Strategic challenges & risks including horizon scanning?	Government announcements to reduce public health budgets by £200m nationally within this financial year will affect Kent Public Health commissioning and preventative health services. Local Authorities are awaiting decisions on how the cuts will be devolved locally - the Kent allocation has not yet been confirmed. Along with continued local government cuts, there are likely to be considerable financial pressures on Kent Public Health services.
Any thing else the Board needs to know	
Signed & dated	 23/6/15

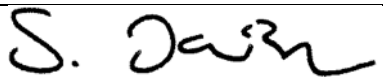
Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for the Ashford Borough Council – Quarter 1: April to June 2015

What's going on in our world	• **Park Mall** – Council exchanged contracts on the purchase of Park Mall bringing it into public ownership. Plans to rejuvenate the area over the coming months. Wilko store also recently purchased. • **M20 Junction10a –** Consultation on the proposed scheme is now expected to start in September. • **Jasmin Vardimon International Dance Academy** – Funding now in place for initial stage of the project. Council leading the business case and project viability assessment. Significant funding challenges. • **Elwick Place** plans progressing to mixed retail, leisure, office and residential (estimated 600 jobs). Proposals being developed for hotel, cinema, additional car parking and 153 dwelling. Planning application expected in next few months. Public realm works around International House begin underway and scheduled to complete in August. • **Designer Outlet Expansion** (phased extension to double floor space). Planning application submitted. Detailed plans, shop design, car parking, environmental strategy and retail implication information progressing. • **Ashford College** (£20m campus for 1,000 students) Construction process is proceeding as planned, with build start scheduled for September 2015. • **International Station spurs** (finding signalling solutions to enable future interoperability for all international service providers). Key to retaining Eurostar and other services in Ashford. Awaiting European Funding confirmation. • **Chilmington Green** (development based on Garden City principles (1000 jobs and 5,750 houses) resolution to grant planning permission given. Ongoing s106 discussions. • **Commercial Quarter (**55,000 sq m commercial office floor space plus 150 homes). Agent appointed & architects working on design and layout. • **TENT1 –** (additional 249 homes in Tenterden). Delays over section 106 discussions but final decision imminent. • **Conningbrook Lakes Country Park –** it is open. Over time the park will offer a range of leisure and water based activities while also providing a gateway for walkers and cyclists to explore the Stour Valley. • **Repton Park Community Centre.** Planning application submission anticipated in early autumn 2015. Design of the building, name for the centre and signage being finalized with key players. • **Willesborough Community Centre** - The conversion of St Marys Church Willesborough into a shared space serving both church and community will be complete in September. Volunteers at the church plan a range of services centred on a community café. These will be focused on the five areas of Wholeness & Wellbeing, Children, The Elderly, Life Skills & Management and The Wider World. It is expected that a debt centre serving the whole of Ashford will be established and run by the church.

	• **Create Festival -** Festival to take place on 26th July 2015 and celebrating its 20th anniversary. This event provides an excellent opportunity to engage with the public and there will be a multi agency community engagement area. Any partners interested to be involved please contact the Community Safety Unit email: csu@ashford.gov.uk. • **National Tourism Symposium** - Hosted in June by the Council & Visit Kent; attracted a national audience of several hundred leading industry professionals and keynote speakers – including the government Minister for Tourism and Sport.
Success stories since last AHWB	• **Self Harm Project** - Project review pointed to a new approach to any further work, focusing on one to one work with young people referred to the programme through partners. Further funding secured from the CCG for an extension to the project. Sk8side to be commissioned to deliver this work. Possibility of this being a major project for the South Ashford Community Network with potential to expand into the Ashford North Community Network. Progress being made but need to increase referral rates. • **Dementia** – Poster showing the council's dementia work was displayed during Dementia Awareness Week at the exhibition run by the Alzhelmer's Society within Ashford Town centre. Staff were on hand to answer questions and tell people about Farrow Court. In dementia awareness week a tea party followed a dementia friends awareness session at Cotton Hill House Sheltered scheme and included members of the local over 60s club. Dementia Friends training for elected members to be run in September. • **Domestic Abuse** – Freedom programme courses up and running. About to trial a recovery tool kit (i.e. a follow on from freedom to provide top up support). Additional funding obtained by the Domestic Abuse Forum for staff to be trained in use of the tool kit. • **Little Hill Extra Care Scheme –** this Council site was gifted to KCC in June last year as part of the Excellent Homes for All PFI project. When complete in April 2016 it will offer 41 extra care apartments at affordable rents. This Project will also deliver 12 units of move-on (short-term) accommodation at St. Stephens Walk in Ashford to help people acquire the skills to live independently. The scheme will be operational in September 2015. Although project is showing behind time at present, contractors are confident they will make this time up and comply with deadlines. • **New Build Affordable Homes** - Programme agreed to deliver the fifth phase of the programme which was the provision of 106 units of which 50 units were proposed for the redevelopment of an existing sheltered housing scheme at Danemore in Tenterden. Access the full programme at http://www.ashford.gov.uk/developments-coming-soon. A bid for funding for the Danemore scheme has been made through the Care and Support Specialised Housing Fund (CaSSH) phase 2. Outcome will be known in October. • **Chamberlain Manor extra care scheme (Housing and Care 21) -** will be opened officially on 17th July. 67 units for rented and shared ownership and communal facilities.

	• **Spearpoint sports facilities**. Sports Council funding secured and approval given to replace the Spearpoint pavilion with a new community building. Progressing and aim for construction to start in 2016. • **Singleton Village Hall** – Opened earlier this year. • **'Smoke Free' Play Spaces** – Pilot project to encourage an emotional response from local residents, discouraging them from smoking in public places and around children. Secured £15k from Kent Public Health and circa £4k from other sources including Moat Housing. Three key elements: entrance signage to play areas asking adults to not smoke, suite of pavement games which add play value to our play spaces but also promote key 'stop smoking' messages and community days & school sessions delivered by Sure Start and other key health partners to promote the campaign. Signs currently installed in the following play spaces; Stour Centre, Moat play spaces (x3) in Stanhope, , Newtown Green, The Limes, Cuckoo Park, Goat Lees, St Stephens Walk, with Bulleid Place & Repton Park (x3) to follow. Evaluation through consultation with primary school children and residents to take place in the autumn. • **Newtown Fun Day** - organised by the council's housing department. Around 750 people turned out to enjoy the sunshine and the activities designed to encourage fitness and wellbeing. • **Safety In Action** – Over 1,200 year six pupils participated in a practical workshop covering a wide range of safety issues including drug and alcohol awareness, water, rail, fire, internet and road safety.
What we are focusing on for the next quarter <u>specific to the key projects</u>	• **Refer LOG report on work for:** - **Dementia** Day Centre at the new Farrow Court facility; - **Healthy Weight,** group set up and a new project called 'Aspirational Health Zone' in Stanhope to start in September; - **Farrow Court** – building work continues on site; - **Rough Sleepers Project**, Porchlight commissioned, joint working started. - **Homelessness Strategy** – Being reviewed. If information required now contact sharon.williams@ashford.gov.uk.
Anything else relevant to AHWB priorities NOT mentioned above	• **Walk to School Project** - Need to identify funding to continue supporting the 'Walk to School' project. At present ABC is struggling to find resources to expand to additional schools. Awaiting feedback from KCC public health. • **Sexual Health in Ashford** - new integrated sexual health model contract starts on August 1st which includes dedicated outreach. Need to find a location in Tenterden for a weekly outreach clinic. Suggestions please to Wendy Jeffreys, KCC Public Health. Concern over scaling back of service in Stanhope. We desperately need to keep the provision in Stanhope as we know there is a high need, but it is also what draws girls into the hub and means we can then support their other needs too. • **Housing for Health** - new NHS Alliance website for strategic leads in general practice, primary care and clinical commissioning. It helps understanding and engagement with housing to create a wider 'community of care' in response to the NHS Five Year Forward View http://www.housingforhealth.net/.
Strategic	• **Council developing its corporate plan**. Discussions being informed by

challenges & risks including horizon scanning?	changing population demographics and desire to support healthy living.
Any thing else the Board needs to know	• **New psychoactive substances** - Progress towards legislation to ban sale • **Safety in Action for 2016** - We may need to find a venue, but discussions with Towers School continue. Any alternative suggestions? • **Active People Data from Sport England** – Ashford ranked 4th worst in Kent for 16+ participation and way below the Kent average and the South East average of people taking part in at least 30 mins sport each week. The Ashford average is 30.8% of people, Kent is 34.5% and the South East is 36.9%.
Signed & dated	 Sheila Davison - July 2015

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for Case Kent/Voluntary Sector – Quarter 1: April to June 2015

What's going on in our world	Local voluntary and community sector infrastructure body Case Kent is planning to merge with EKVAS during the next quarter. This will mean the new infrastructure body will cover the whole of East Kent. Many charities are working through the tendering process for the community and mental health service delivery contracts next year. Currently, potential delivery partners are meeting potential strategic partners.
Success stories since last AHWB	There are over 350 voluntary and community organisations in Ashford so here are a couple of examples as a flavour of what's happening in the sector overall. CASE Kent have supported eight small charities obtain funding totalling £42,500 over this period. Included in this was an Ashford Project, Wye Community Farm who will use the funding to run a Rural Skills Training project to provide training for offenders so that once they have completed their community service they will have enhanced their CV and improved their employment prospects. This will aim to reduce the chances of re-offending and improve future employment prospects. CASE Kent have run a series of workshops across East Kent since April bringing funders to open meetings with local organisations to make groups more aware of funding available to them. Ashford, Dover and Shepway have fewer relative applications to Funders like the Big Lottery than other areas of the country so we are working with these funders to redress this. CASE Kent are now working on Funding bids with 9 of those groups that attended potentially with more to follow.
What we are focusing on for the next quarter <u>specific to the key projects</u>	CASE Kent has secured Lottery funding to produce a 'State of the Sector' report on the Voluntary Sector. This will look at how 'cost-effective' the sector is, funding issues for the sector, sustainability and engagement with statutory bodies (including health and local CCGs). They have appointed a consultant, Barbara Beaton of Sandpiper Business Support, to help them produce the report. Work on this report began in May. We plan to present this information at the October Board meeting.
Anything else relevant to AHWB priorities NOT mentioned above	
Strategic challenges & risks including horizon	Michael attended one of the Healthwatch events, in Thanet as he couldn't make the Ashford one. This was concerned with

scanning?	engaging/consulting with health-related organisations around future changes to East Kent hospitals. It was quite a low turn out and apparently this was a pattern across the county. I was told I was one of the few representatives attending from the voluntary sector. One of the issues discussed was the uncertainty over the future of the Hospital Care Navigators who had been given a few months extended funding despite having a really positive impact since they've been in post since Summer. There was a feeling that relatively small projects like these would really benefit from some longer term funding (meaning 2-3 years not 5-10) .
Anything else the Board needs to know	The next sector network meeting will take place in early September. This will allow us to engage more of the sector before the Board meeting in October.
Signed & dated	Tracy Dighton, Michael James. 8th July 2015.

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for the Healthwatch – Quarter 1: April to June 2015

What's going on in our world	**Healthwatch Kent – Ashford focus** ➢ Enter & View visit planned to William Harvey A&E and Outpatients. These are return visits to check on improvements ➢ Fed into the CQC plans for their return inspection to EKUHFT. Inspection started on July 13th ➢ Just completed first stage of public engagement for EKUHFT's clinical strategy. Held 9 public events across East Kent and visited over 20 community groups to hear about people's experiences of the current services. Also distributed information to parents via schools. ➢ Published our Strategic Priorities for this year and our Annual report – both available on our website
Success stories since last AHWB	**Healthwatch Kent – Ashford focus** ➢ Healthwatch Big Bus Tour came to Ashford outside William Harvey. Visited all 12 districts in total over 7 days. Reached hundreds of people who would not otherwise be engaged in health or social care ➢ Persuaded the CQC to join Healthwatch's listening events in East Kent to talk to patients rather than duplicating and holding their own. ➢ Conducted an Enter & View visit to St Martins mental health unit in Canterbury ➢ 277,000 branded Healthwatch pharmacy bags distributed across Kent ➢ Secured verbal agreement on all of our recommendations for the CAMHS service
What we are focusing on for the next quarter specific to the key projects	**Healthwatch Kent – Ashford focus** ➢ Mental Health out of county beds ➢ KMPT CQC Action Plan (expecting CQC report to be published late July/early August) ➢ CQC Actions following return visit to EKUHFT ➢ Discharge – Healthwatch England publishing a Special Inquiry into unsafe discharge. Planning our own discharge project in North Kent ➢ Publishing our Enter & View reports for EKUHFT visits and mental health visits ➢ Improving public consultations ➢ Planning End of Life Care project
Anything else relevant to AHWB priorities NOT	**Healthwatch Kent – Ashford focus** • There is a Kent wide review of stroke & vascular services

mentioned above	(not being run by Healthwatch – lead by CCGs & NHS England). Very tight timings for public involvement
Strategic challenges & risks including horizon scanning?	**Healthwatch Kent – Ashford focus**
Anything else the Board needs to know	**Healthwatch Kent – Ashford focus**
Signed & dated	