Corporate Director (Law and Governance) and Monitoring Officer, T W Mortimer LLB Solicitor

ASHFORD HEALTH AND WELLBEING BOARD

ASHFORD BOROUGH COUNCIL

Notice of a meeting, to be held in Committee Room 1, Civic Centre, Tannery Lane, Ashford, Kent on Wednesday, 18th April, 2018 at 9.30 am.

The Members of the Ashford Health and Wellbeing Board are:-

Cllr Brad Bradford – Portfolio Holder for Health, Parking and Community Safety, Ashford Borough Council (Chairman)

Dr. Navin Kumta – Clinical Lead and Chair Ashford Clinical Commissioning Group (Vice-Chairman)

Deborah Smith – Public Health Specialist, Kent County Council

Cllr Peter Oakford – Deputy Leader and Cabinet Member for Strategic Commissioning and Public Health Kent County Council

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

Matthew Capper – Director of Performance and Delivery (NHS Ashford and Canterbury), Clinical Commissioning Group

Karen Cook – Policy Advisor, Kent County Council

John Bridle - HealthWatch representative

Chris Morley – Patient & Public Engagement (PPE) Ashford Clinical Commissioning Group

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

Helen Anderson – Ashford Local Children's Partnership Group

Mr R Isworth - KALC

Tracey Kerly – Chief Executive, Ashford Borough Council

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

Christina Fuller – Head of Culture, Ashford Borough Council.

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   a) Disclosable Pecuniary Interests (DPI)
   b) Other Significant Interests (OSI)
   c) Voluntary Announcements of Other Interests

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July 2018

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17th October 2018

KF
10 April 2018

Queries concerning this agenda? Please contact Keith Fearon 01233 330564, email keith.fearon@ashford.gov.uk
Agendas, Reports and Minutes are available on: http://ashford.moderngov.co.uk

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Agenda Item 2

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/5962/2193362.pdf

(b) The Kent Code of Conduct was adopted by the Full Council on 19 July 2012, 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 Corporate Director (Law and Governance) and Monitoring Officer or from other Solicitors in Legal and Democratic Services as early as possible, and in advance of the Meeting.

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Ashford Health and Wellbeing Board

Minutes of a Meeting of the Ashford Health & Wellbeing Board held on the
17th January 2018

Present:

Councillor Brad Bradford - Portfolio Holder for Highways, Wellbeing and Safety, ABC (Chairman)

Dr Navin Kumta – Clinical Lead and Chair, Ashford CCG (Vice-Chairman)
Councillor Jenny Webb, Deputy Portfolio Holder for Highways, Wellbeing and Safety, ABC
Sheila Davison – Head of Health, Parking and Community Safety, ABC
Karen Cook – Policy Advisor, KCC
John Bridle – HealthWatch
Chris Morley – Patient and Public Engagement (PPE) (Ashford CCG)
Roy Isworth – KALC
Deborah Smith – Public Health, KCC,
Lorraine Goodsell – Local Care Director, NHS Canterbury and Coastal CCG
Victoria Tatton – Ashford Vineyard
Chris Kimmance – Ashford Vineyard
Mark Wiltshire – KCC Early Help
Hannah Patton – HeadStart Kent
Sharon Williams – Head of Housing, ABC
Christina Fuller – Head of Culture, ABC
Belinda King – Management Assistant, ABC
Will Train – Corporate Scrutiny and Overview Officer, ABC
Keith Fearon – Member Services Manager, ABC

Apologies:

Tracey Kerly, Chief Executive, ABC, Simon Perks, Accountable Officer, CCG, Helen Anderson, Ashford Local Children's Partnership Group

1 Notes of the Meeting of the Board held on 18 October 2017

The Chairman referred to Minute No. 4(a)(v) and advised that he had still to action the letter to secondary schools about smoking cessation. **NB – Post Meeting Note – an email had been sent to CSP Head Teachers representative Sara Williamson.**

The Board agreed that the notes were a correct record.

2 Update on the Kent Health and Wellbeing Board Meeting – 22 November 2017

2.1 The Minutes of the Kent Health and Wellbeing Board meeting held on 22nd November 2017 could be accessed using the link provided under item 4 on the agenda. Navin Kumta summarised the items discussed at the

meeting, it being noted that there were no specific actions to be addressed by the Ashford Health and Wellbeing Board.

3 Update on Ashford Health and Wellbeing Board Priorities

(a) Stop Smoking Action Plan report 2017-2018: Quarter 3: October to December 2017

3.1 Debbie Smith introduced this item. She advised that there were an estimated 16,000 smokers in Ashford which was the 5th highest smoking prevalence in Kent. The One You Shop was proving very popular and now offered a clinic for pregnant women who smoked.

Resolved:

That the Board agreed that the report be received and noted.

(b) Healthy Weight Action Plan report 2017-18 Quarter 3: October to December 2017.

3.2 Debbie Smith drew attention to the progress report. The report advised that excess weight amongst children aged 4-5 and 10-11 year olds and overweight and obesity rates amongst adults were higher in Ashford than the national average.

Resolved:

That the Board agreed that the report be received and noted.

(c) Housing & Health

3.3 Please see the discussion under the presentation under item 5 below.

(d) Diabetes Update

3.4 The report presented an update on the current status of: - the proposed CCG pathway changes for diabetic care, using Tiers of Care approach; Ashford's progress against the Kent & Medway Structured Education Transformation Programme; and Ashford's progress in line with National Diabetes Prevention Programme: Healthier You.

Resolved:

That (i) the report be received and noted

(ii) a progress update be submitted in 6 months.

4 Presentation: Focus on Housing and Health

4.1 The report provided an overview of the progress in taking forward the new priority of Housing and Health. Sharon Williams also gave a presentation which had been published on the Council's web site under: https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=3240

4.2 Sharon Williams drew particular attention to the slide regarding Farrow Court and said that health professionals would be invited to view the facility and consider ways in which other health services could be provided from that site.

4.3 In response to a comment about the need for formal multi task meetings to take forward joined up health service provision, the Chairman explained that this was one of the functions of the Ashford Health and Wellbeing Board.

4.4 Sharon Williams also said that her team would be happy to feed into the current Sheltered Housing Consultation being conducted by KCC.

Resolved:

That the report and presentation be received and noted.

5 Presentation: Ashford Vineyard Church: Bringing life to Ashford

5.1 The report provided background to a presentation by Ashford Vineyard Church. Victoria Tatton and Chris Kimmance of Ashford Vineyard gave a presentation on their wellbeing activities. The report and presentation had been published on the Council's web site under: https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=3240

5.2 Chris Kimmance explained that the Church had been established about 10 years ago under the strapline 'bring life to Ashford'. Their work was based around two main arms of 'Gathering' and 'Compassion'. During the presentation 2 videos were also played regarding Ashford Sings and an example of help offered under their 'Mummy's Meals' scheme. In response to a question, it was explained that they did not charge for the meals and that they were provided to people who were in a potential crisis situation on a short term basis. They did not have the resource base to commit to this indefinitely as their funding came solely from donations to the church.

5.3 Victoria Tatton also explained that as part of Churches Together In Ashford, they had provided 200 beds from their building as part of the winter shelter scheme. This also included shower facilities and food and health care. Chris Kimmance then showed a final video titled '1000 Hours – A Kindness revolution' which showed that volunteers had given 5997 hours in Ashford in 2017.

5.4 The Chairman thanked the presenters for attending the meeting and said that he considered that they undertook excellent work. He said that ABC Officers would be happy to assist the Church in terms of access to any grant or funding applications they wished to make. Chris Kimmance distributed information packs which contained further information about the work of the church and relevant contact details.

Resolved:

The Board agreed that the presentation be received and noted.

6 Presentation: Annual Update from Local Children's Partnership Group and HeadStart Kent Phase 3

6.1 The report gave an overview of Local Children Partnership Groups (LCPGs) and the Ashford LCPG and sought to encourage further partnership commitment to achieving outcomes against identified local priorities for children and young people.

6.2 Hannah Patton of HeadStart gave a presentation on the work undertaken by HeadStart which had been published on the Council's Web Site under: https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=3240

6.3 The Chairman thanked Hannah Patton for her presentation.

Resolved:

That: (i) the local priorities as voted for by young people and as identified through the LCPG be used to provide direction for the Ashford Health and Wellbeing Board to inform partnership working on local priorities.

(ii) the integration of service delivery to families from both adult and children's services to be developed in Ashford be supported through the sharing of expertise and promotion of opportunities.

7 Ashford Estates Technology Transformation Fund (ETTF)

7.1 The report gave an update on the Ashford Estates Technology Transformation Fund (ETTF) premises scheme which had been successful in getting through the initial NHS England funding gateway in 2016. Lorraine Goodsell explained following publication of the report there had been discussions about the facts reported in paragraphs 8-13 and therefore this information would be reviewed and a revised report issued in due course.

7.2 Lorraine Goodsell explained the progress to date on the ETTF and said that in January 2017 NHS England had advised that £25,000 had been allocated as

pre-project costs to enable the appointment of professional advisers to support the project.

7.3 Following discussions with NHS England it had become clear that they were looking to the CCG to develop proposals that addressed the needs across the CCG area. A Business Case was also needed to be developed and work needed to be undertaken on population growth areas including activity to ensure full utilization of Section 106 resources. The process would involve working with ABC and the recruitment of a permanent officer at the CCG to undertake this work, was being pursued. In response to a question, Lorraine Goodsell said that the timescale for the submission of options appraisals was 31 March 2018. Sheila Davison considered that it was important for a person with the right skills to be recruited and Lorraine Goodsell said that she was happy for ABC to be involved in the recruitment process.

7.4 The Chairman expressed concern that despite funding of £1m being approved in January 2017 for health infrastructure projects, nothing definite had been agreed and no projects had actually been started. He believed that there was a deadline of 31 March 2018 to spend this money and he was very concerned that the funding would be lost to the Borough. The Chairman also was concerned that there appeared to be a lack of engagement by the CCG with ABC Officers. Lorraine Goodsell said she believed that the CCG had not effectively engaged with the Council or others and there was a need to develop a much stronger partnership with the Council and make it an absolute priority. Lorraine Goodsell advised that a new Ashford Estate Group has been formed and that this would provide the necessary direction on this vital issue. The Chairman suggested that the issue of improved partnership working be explored outside of the meeting.

Resolved:

That (i) the report be received and noted.

(ii) an Officer be nominated to join the Ashford Premises Group.

(iii) the CCG establish the position regarding the £1m grant and update the Chairman as soon as possible.

8 Sustainability and Transformation Plan

(a) Transforming Health & Care in East Kent

8.1 Lorraine Goodsell advised that unfortunately it had not been possible for a representative from the William Harvey Hospital to attend this meeting. She further advised that the presentation had been produced for her by Louise Dineley, East Kent STP Programme Director - email: louise.dineley@nhs.net The presentation had been published on the Council's web site under: https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=3240

8.2 The presentation explained the two potential options for the future provision of hospital services in East Kent and the next steps which would be to evaluate the options and then to undertake a consultation exercise. The presentation provided clarity on the assessment criteria for the hospital options. Loraine Goodsell said that a representative of East Kent Hospitals would be happy to attend a future meeting of the Board.

8.3 In response to a comment about the retention and attraction of staff, in particular consultants, Navin Kumta, said that this issue was being considered but it did not just relate to consultants and affected all staff. The principal aim was to reduce the number of people who needed to be seen by consultants. Sheila Davison highlighted the need to see the wider developments within Ashford and the fact that it was such an attractive area to live in (affordable housing, access to London, good transport links) This bigger picture would help attract the health workforce to the area and hospital for employment. She also advised that the interim Chief Executive of the Hospital Trust would be attending the next meeting in April.

(b) Implementation of Local Care – Ashford CCG

8.4 Navin Kumta gave a presentation on the key areas of Local Care Implementation. The presentation had been published on the Council's web site under: https://secure.ashford.gov.uk/committeesystem/ViewAgenda.aspx?MeetingId=3240

8.5 In response to a question, Navin Kumta explained that paramedic staff at the present time could not access patient records via the Cloud but they did have dedicated telephone access to the GP surgery which would enable the GP to give advice as to whether the patient should be taken to A&E or whether it was a pre-condition which could be treated by the surgery itself.

8.6 Roy Isworth referred to the Tenterden Day Centre and said that he believed that it would be helpful if there was a formal liaison process with the Day Centre Service in terms of managing recovering patients at home. He also referred to vacant space at West View hospital. Navin Kumta said that under the proposed arrangements engagement would take place with day centres but it was intended that there would be a move away from current practice and be based on either GP or hospital based support. John Bridle said that it was important in cases of patients with long term conditions to have access to practitioners who knew them.

8.7 In response to a comment, Navin Kumta explained that the NHS did have a workforce strategy in place which was used to enable upskilling of existing staff. He also said that prevention sat at the heart of local care and that work was continuing with Public Health. Lorraine Goodsell also explained that local care schemes in Canterbury had a close working relationship with the fire service and police who were able to provide a broader knowledge base and thus contribute to the prevention agenda.

8.8 Lorraine Goodsell advised that Matthew Capper would be the future representative from the CCG on the Ashford Health and Wellbeing Board.

Resolved:

That: (i) the presentations be received and noted

(ii) an update report on the Implementation of the Local Care agenda be submitted to the next meeting.

9 Partner Updates

(a) Clinical Commissioning Group

9.1 Update noted.

(b) Kent County Council (Public Health)

9.2 Update noted.

(c) Ashford Borough Council

9.3 Update noted.

(d) Voluntary Sector

9.4 Not provided as position currently vacant.

(e) HealthWatch

9.5 John Bridle said that if any members of the Board had any issues of concern he would be happy for them to be taken up by HealthWatch.

(f) Ashford Local Children's Partnership Group

9.6 Update noted.

10 Forward Plan

10.1 It was agreed that an item on the Ashford Clinical Providers would be on the agenda for the Board meeting on 18th April 2018.

11 Dates of Future Meetings

11.1 The next meeting would be held on 18th April 2018.

11.2 Subsequent dates:

18th July 2018
17th October 2018

Agenda Item No: 5(a)

Report To: **Ashford Health & Wellbeing Board**

Date: 18th April 2018

Report Title: Stop Smoking Action Plan report 2017-18 Quarter 4: January to March 2018.

Report Author: Deborah Smith
Organisation: Kent County Council, Public Health

Summary:

Smoking Prevalence is declining nationally and locally with Ashford rates estimated at 17.4%. Smoking among Routine and Manual workers has also decreased, however, the government has set a challenging target of no disparity of prevalence between social groups by 2022. Smoking in Pregnancy rates in Ashford (12.3%) are also a challenge.

Smoking is still the most important cause of preventable ill health and premature mortality, contributing to lung cancer, COPD and heart disease. Smoking is a modifiable lifestyle risk factor and effective measures can reduce the prevalence of smoking in the community.

This report highlights a number of key successes, particularly in promoting smokefree spaces with the aim to denormalise smoking in the community. The report also includes recommendations on what more can be done to reduce the risks of harms caused by smoking. The Ashford One You shop is growing in popularity and now delivers weekly stop smoking clinics, drop in services and a specialist clinic for pregnant women who smoke.

The recent restructure of the Kent Public Health Department has resulted in a lack of resources to continue to lead the task and finish group work in Ashford, but support will still be available to provide information and guidance when required and support the development of this work in line with the East Kent Public Health work on smoking and on the delivery of the Kent and Medway Sustainability and Transformation Plan for prevention.

Recommendations: **The Board be asked to:-**

i) Note the contents of this report
ii) Comment on the report

Purpose of the report

1. This report provides the Ashford Health and Wellbeing Board with a quarterly update and overall outcomes for the year 2017/18 on the Ashford Stop Smoking Action Plan.

Background

2. Reducing the risks and harms caused by smoking is one of the main priorities of the Ashford Health and Wellbeing Board. The Action Plan that supports this aim is delivered by the multi-partner agency Task and Finish group and is a localised form of the Kent and Medway Sustainability and Transformation Plan for prevention.

3. Since the last update, the local district authorities in the East of Kent have collectively adopted Ashford's Stop Smoking Action Plan so that a regional approach to reducing smoking can be delivered effectively and by sharing resources where possible.

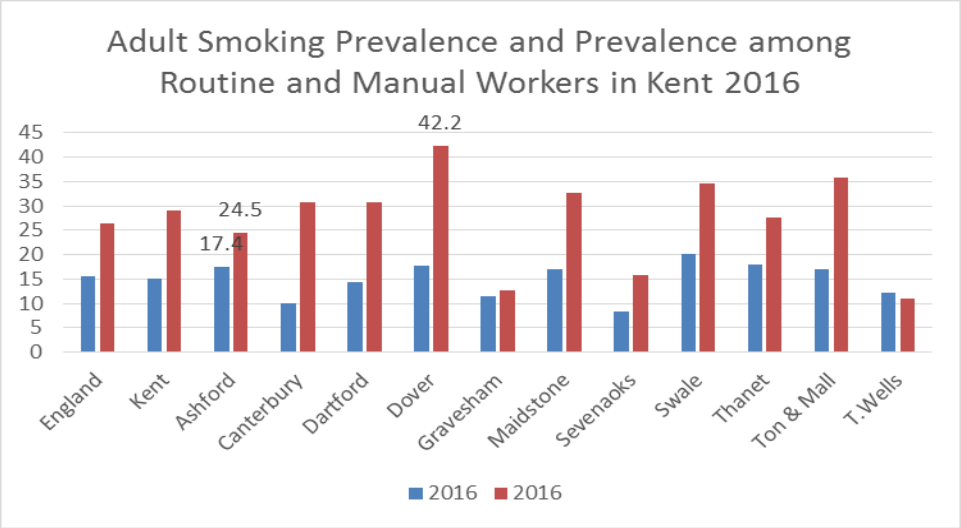
Smoking Prevalence in Ashford

4. Ashford smoking prevalence is estimated at 17.4% (1.9% above the national average). However, the percentage of smokers from Routine and Manual groups is 24.5%, 2% lower than the national average (26.5%) There are now more ex-smokers in Ashford than the national average (27.5% in Ashford and 26.2% nationally) and 31% of ex-smokers are from Routine and Manual groups in Ashford.

5. Smoking in pregnancy rates are measured as smoking status at time of delivery. Ashford rate is 12.3% slightly higher than the national average of 10.7%.

6. The following chart show that Ashford has the 5th highest smoking prevalence in Kent with an estimated 16,460 adult smokers.

Chart 1: Smoking Prevalence in Kent 2016



Source: Public Health England, Local Tobacco Control Profiles

Progress to Date:

7. An update on the Stop Smoking Action Plan activities are as follows:

Aim:	Progress to date:
1. William Harvey Hospital site to be fully smokefree in all areas of the hospital grounds (in compliance with NICE guidance PH48)	• Meetings with Senior Managers and Chief Executive Officer have identified agreed aim for the hospital to achieve smokefree status. Work to achieve this is ongoing. • Stop Smoking Quit service offered to staff and patients in the hospital. • Nicotine Replacement Therapy (NRT) available on wards. Staff training ongoing. • Stop smoking speaker system installed to alert smokers that the site is smokefree.

2. Smoking in Pregnancy Reduce smoking prevalence in pregnant women	• The two Ashford midwifery teams have one of the best babyclear compliance rates in Kent: achieving 85% and 96% CO monitoring and 89% and 100% referral rates, respectively. This helps ensure that smoking status of pregnant women is identified and appropriately referred to stop smoking services. • A dedicated stop smoking clinic for pregnant women and their partners who smoke is delivered by a Senior Midwife at the One You shop in Ashford. • Information and awareness on the harms of third hand smoke is available in the special care baby unit to reduce exposure of second and third hand smoke in babies.
3. Increase the number of Quitters in Ashford Ashford district currently has fewer smokers referred to and accessing stop smoking services.	• Posters and flyers promoting the stop smoking services have been distributed to GP surgeries, pharmacies, children's centres, vets, dentists, voluntary organisations and parish councils. Quit packs have also been offered to assist smokers to quit if they do not wish to access support services although interest in this has been low. • Stop smoking clinics are offered in the Ashford One You shop and are well received. To date 382 smokers have been encouraged to quit smoking in the One You shop. • Smoking +, an innovative evidence-based stop smoking model, working with GPs will be piloted in Ashford. Professor Robert West, who developed this model will be offering support to participating GP practices. Further updates available in due course. • Smokefree School Gates initiative has resulted in three primary schools to date operating a smokefree school gate policy. This will reduce the numbers of children exposed to second hand smoke in areas where children congregate. • There are 7 smokefree park areas in Ashford designed to request that adults do not smoke in areas where children play.
4. E-cigarettes Work with Vape retailers to support more people to quit smoking completely	Trading Standards are quality assuring e-cigarettes in line with new regulations. There is potential to work more closely with retailers to support quitters. This is being explored further.
5. Quit Coaches Reduce the number of young people who smoke	Insights work has revealed that the development of Quit Coaches to support young people to quit has been identified as best practice. Despite this, efforts to organize training within current resources has been difficult. The training programme scheduled for the 14th February had to be cancelled due to youth work staff availability. Further work at a strategic level is being undertaken to progress this further.
6. One You shop Increase number of people who quit smoking by accessing the Ashford One You shop.	To date, 382 people have received quit support in the One You shop. This is 19% of all services delivered there.
7. Campaigns Strategy Develop Multi-partnership to maximise potential to encourage people to stop smoking and live in a smokefree environment	• A dedicated campaign strategy led by Ashford Borough Council ensures that all Action Plan activity is communicated to the public and partners effectively to maximise opportunities to promote Smokefree lifestyles. This has covered the events at the One You shop, Smokefree Ashford Borough council and Smokefree parks and Smokefree School Gates. • Ashford Borough Council and Ashford Leisure Trust have

	embraced a Smokefree grounds policy that took effect from 1st January 2018.

Next Steps

8. The Public Health team has been restructured and reorganized within the County Council, with commissioning and project functions being aligned to a wider strategic department. Public Health will continue to provide strategic support across the Public Health portfolio for Kent but support at a local level will only be available as resources allow. The implication for the continued priority work for this board will mean that the task and finish groups will need to be led at a local level and public health will provide guidance and support when and where required. Opportunities for best responding to this are being pursued.

Conclusion

9. Ashford has seen a decrease in smoking prevalence, particularly among routine and manual groups, however, Ashford still has one of the lowest referral rates into stop smoking services, leaving opportunities to reduce smoking prevalence further. This is also vital among women who smoke in pregnancy, where smoking rates are still higher than the national average. Partners in Ashford should be proud of the achievements in promoting smokefree spaces, within council and leisure trust grounds, parks and at primary school gates; making a healthier and cleaner environment for its residents.

10. Further work to:
Ensure William Harvey Hospital grounds are smokefree
Smoking + model is adopted by Ashford GPs to increase the Quit rate
Young People who smoke be supported to quit by Quit Coaches
Reducing smoking in pregnancy

11. Should continue to be a priority. Public Health can continue to provide support with this work.

Contacts: Email: Deborah.Smith@kent.gov.uk
Tel: 03000 416696 (07850 210919)

Agenda Item No: 5(b)

Report To: **Ashford Health & Wellbeing Board**

Date: 18th April 2018

Report Title: Healthy Weight Action Plan report 2017-18 Quarter 4: January to March 2018

Report Author: Deborah Smith
Organisation: Kent County Council, Public Health

Summary: Adult excess weight and obesity rates in Ashford are higher than the national average (67.1% in Ashford compared to 61.3% nationally). The current action plan for Ashford based on the Kent Healthy Weight strategy identifies ways in which partners can contribute to improved obesity rates within current resources and the One You shop in Ashford has proven to be a prime resource to address healthy weight in the community. The end of year report on progress is currently being finalised with the recommendation that further actions be identified through the Kent and Medway Sustainability and Transformation Plan for prevention.
Excess weight among children aged 4-5 and 10-11 year olds are also higher in Ashford than the national average and are being addressed through multi-agency local and Kent-wide childrens groups.

Recommendations: **The Board be asked to:-**

i) Note the contents of this report
ii) Comment on the report
iii) Accept the recommendations in the conclusion of this report.

Purpose of the report

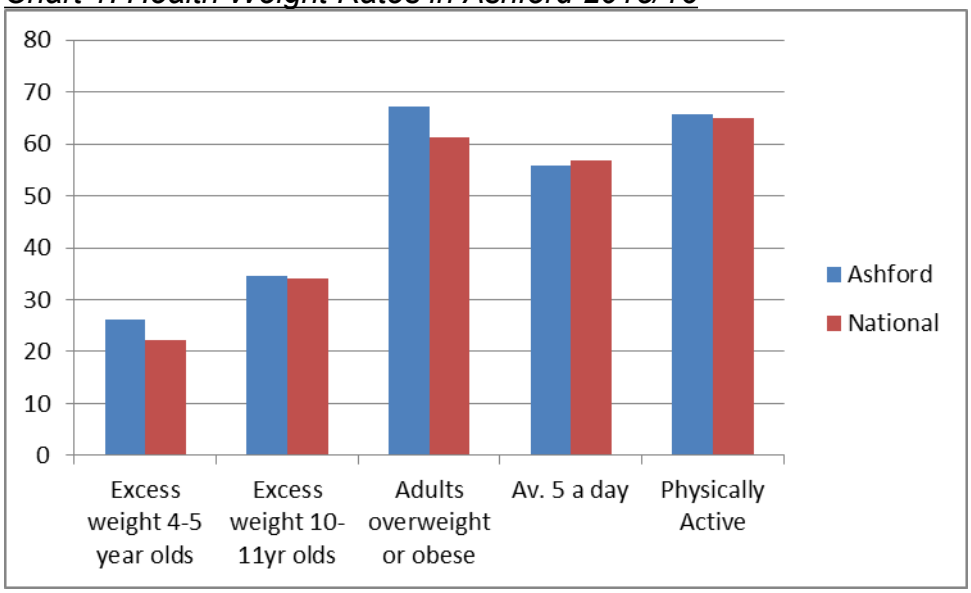
1. This report provides the Ashford Health and Wellbeing Board with a quarterly update and overall outcomes for the year 2017/18 on the Ashford Healthy Weight Action Plan.

Background

2. The Ashford HWB Task and Finish group aims to deliver the two priorities of the Health and Wellbeing Board, namely: to improve healthy weight rates and to reduce smoking prevalence in the Ashford area. This report provides an update on the progress on the healthy weight agenda to date.

3. Excess weight among adults in Ashford is higher than the national average (67.1% against 61.3% nationally). This is also higher than the regional average of 59.7%. The latest data used by Public Health England is based on 2015/16 estimates.

Chart 1: Health Weight Rates in Ashford 2015/16



Source: Public Health England, Local Tobacco Control Profiles

Progress to Date:

4. Key progresses on Ashford specific activities undertaken in the last quarter:

Aim:	Progress to date:
1. Healthy Weight insight work.	Local interviews conducted in the Victoria ward revealed insights into the attitudes and behaviours of local people in respect of their weight and obesity. The information on perceived weight and clothe sizing, attitudes to weight and motivators to take action are valuable for understanding how best to focus resources in the most effective way to obtain positive outcomes. These insights are being used along with other behaviour change techniques to increase access to weight management services delivered at the Ashford One You shop.
2. One You shop Update on healthy weight activities in the One You shop	The One You shop in Ashford offers Healthy Weight advice and drop-in 'weigh ins' are the most popular service in the One You shop. Nearly 1,000 of the 2,029 interventions have been regarding healthy weight or physical activity. The wards with the most people accessing healthy weight interventions are North Willesborough, Beaver Green, Stour and Victoria. A further 250 Health Check and Health MOTs have taken place and blood pressure checks account for 13% of all interventions. .

5. Further Activities in Progress/ recommended actions

The following are priorities identified in the Kent Healthy Weight strategy which the task and finish group have agreed should be completed to demonstrate Ashford's local contribution.

Strategy Recommendation	**Progress:**
1. Improve Food Standards	- The national audit of fast food outlets shows that Ashford performs well compared to the national average of density of fast food outlets per 100,000 population (rate: 61.6 in Ashford compared to 88.2). - Healthy Eating promotion delivered in childrens centres - Sugar Free campaign being promoted in appropriate settings, including the One You shop
2. Increase levels of Physical Activity in all settings	- 10% of all interventions in the One You shop have offered advice or referral to physical activity support. Referrals to the Ashford Leisure Trust are made from the One You shop and Health Walks commencing at the One You shop on a regular basis are being explored. - Awaiting report on how the Active Ashford Plan and the local Kent Active Travel Strategy will contribute to increased physical activity levels in Ashford.

Conclusion

4 Based on the Kent strategy, the current Ashford Healthy Weight Action Plan identifies a range of key activities already in place that can illustrate the contribution to Healthy Weight and physical activity in Ashford. Further healthy weight measures designed to reduce obesity rates at a Kent and Medway level are incorporated in the Sustainability and Transformation Plan (STP) for prevention. It is recommended that Ashford partners explore the STP further to consider which activities could be localised in Ashford to improve healthy weight and obesity rates at a local level.

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Agenda Item No: 5 (c)

Report To: **Ashford Health & Wellbeing Board**

Date: 18th April 2018

Report Title: Housing and Health

Report Author: Sharon Williams
Organisation: Ashford Borough Council, Housing

Summary: This report provides an overview of the progress in relation to the Housing and Health priority.

Recommendations: **The Board is requested to note the contents of the report.**

Purpose of the report

1. The Ashford Health and Wellbeing Board identified housing as a priority area in July 2017. This report provides an overview of progress made since that meeting in developing this priority area.

Background

2. During previous meetings, the Board has been advised of the council's aspiration to develop a Health and Housing Strategy to sit under its wider Housing Framework. This aspiration acknowledges the huge potential that housing has to play, not only in supporting the provision of safe and healthy homes, but also as a setting for the delivery of the preventative health agenda. Central to the strategy will be the aspiration to support local care as developing through the health transformation agenda.

3. For this piece of work to be meaningful, and to develop some realistic and achievable actions, it was agreed that input and active participation would be required from colleagues in both health and social care.

4. It was suggested that a workshop would be a useful starting point to discuss what the main issues are and where housing, health and social care can come together for the benefit of the resident(s).

Progress to date

5. Sadly, it proved difficult to arrange a meaningful workshop at this stage therefore this action has slipped. Since the last Board meeting a useful meeting has taken place between housing and health colleagues and a plan is being formulated to take forward various strands of work identifying where

housing has a significant part to play in progressing health priorities and vice versa.

6. Housing have a view that they can help deliver the Kent and Medway Sustainability and Transformation plan in a number of key areas. Particularly around the local care model (delivering care in or closer to home) and advoiding admissions and reducing length of stay in hospital.

7. The diagram at Appendix 1 identifies some key areas to develop further in the joint Housing and Health strategy. This is very much just a starting point and we will need to continue to develop this work with our health colleagues to prioritise and refine our action plan.

Conclusion

8. It is proposed that we develop joint actions and arrangements around the key strands identified at Appendix 1. At this stage it is recommended that we focus attention on developing these work strands and that we further postpone the idea of a health and housing workshop until such times as we have developed this work further with our health colleagues.

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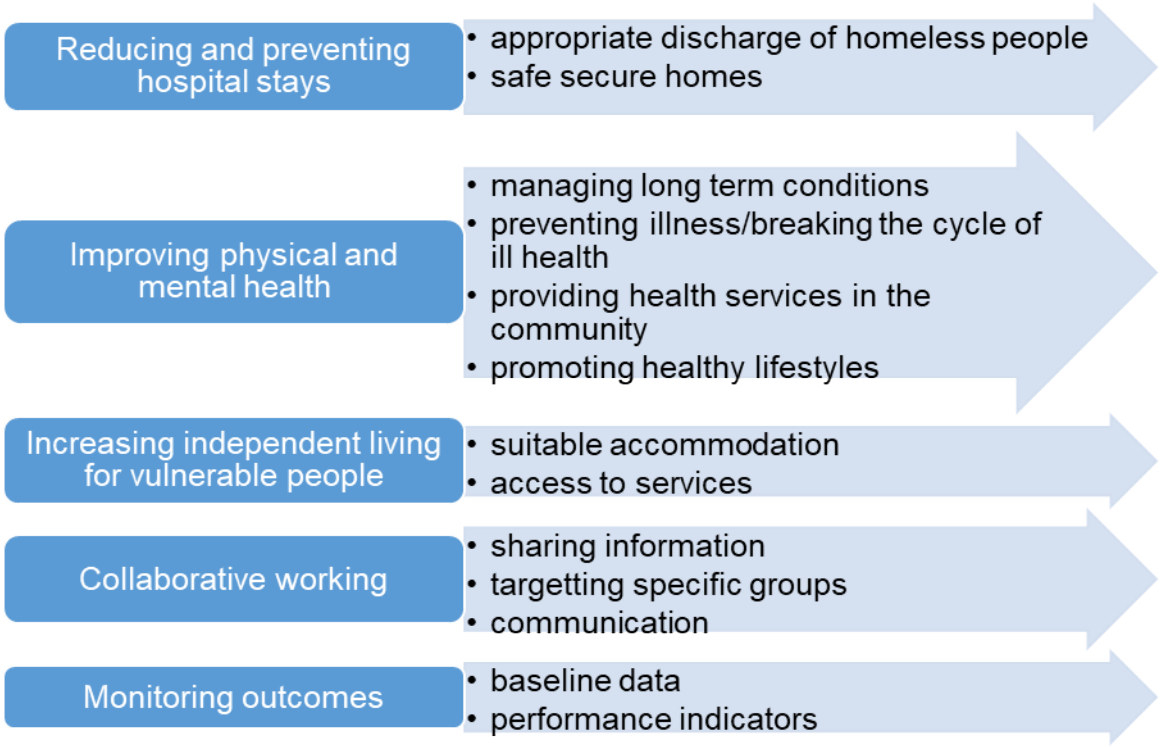
APPENDIX 1



- Early co-operation to ensure home is suitable for timely discharge
- Suitable accommodation available for homeless people
- Homes fit for purpose to avoid accidents and injury
- Homes warm and free from damp and mould and hazards
- Prevention of homelessness
- Promoting health promotion activities and signposting to services
- Sufficient affordable housing of the right size
- Developing new and refurbishing existing accommodation to meet the needs of vulnerable people to live independent lives
- Sharing of existing facilities (such as sheltered schemes) to deliver health and wellbeing services and tackle social isolation
- Link to other services and voluntary sector to maximise opportunities to reach disadvantaged groups

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East Kent Hospitals University NHS Foundation Trust

Kent and Medway Sustainability and Transformation Partnership and East Kent Acute Transformation

Ashford Health and Wellbeing Update

Introduction and Background

The Kent and Medway Sustainability and Transformation Plan was published in November 2016 and is one of forty-four STPs across England which are responding to the fundamental challenge of delivering a financially sustainable health and social care system as required in the NHS England Five Year Forward View. Following publication of the "*Five Year Forward View: The Next Steps"* in late March 2017, Sustainability and Transformation Plans became Sustainability and Transformation Partnerships (STP), as focus shifts from plan development to design of future service and commissioning arrangements

The work of Kent and Medway STP involves transforming acute care services across Kent and Medway develop a sustainable care model with the ability to manage demand. The aim is to ensure the provision of high-quality specialist services across Kent and Medway and also consider opportunities to optimise services and the estate footprint as the landscape of care provision becomes more local. The vision in East Kent is to create centres of excellence where specialist teams have the equipment and expert staff they need to give patients the best chance of survival and quality of life, helping patients to stay well and independent in their homes, communities and only come to the hospital when required.

Over the past months, the Trust has worked with other Trusts across Kent and Medway regarding the four priority areas for the Kent and Medway STP (prevention, local care, hospital care and mental health), to develop the East Kent acute care transformation programme. As part of the hospital care workstream, several services have been agreed as priority for public consultation.

This report summarise the progress made to date and the identified key next steps.

Progress to date and key next steps

The Kent and Medway STP has agreed a set of wave one consultations. These comprise of:

- vascular services across Kent and Medway (consultation may not be required);
- urgent and emergency care, including acute medicine, in east Kent;
- elective orthopaedics in east Kent; and
- stroke services across Kent and Medway

The clinical models for the above services have been shared with the South East Coast Clinical Senate and all relevant Clinical Commissioning Groups (CCGs). Feedback has been received and the work updated where possible. Clinical groups have been established to look at the areas requiring more clinical detail.

Kent and Medway Stroke Services:

Stroke is a serious life-threatening condition caused by a blood clot or bleed in a blood vessel in the brain. Around 3,000 people living near a Kent and Medway hospital have a stroke every year and over 800 people in Kent and Medway die from stroke each year and many more suffer on-going disability. Six of the seven hospitals in Kent and Medway currently provide some urgent stroke care services. National quality standards and best practice is not being consistently delivered and there is need for a transformational change across Kent and Medway.

As part of the Kent and Medway STP work, a stroke service review across Kent and Medway was completed and all future reconfiguration potential options identified, evaluated and analysed.

After careful and detailed consideration of a wide range of evidences, information and views, five options have been proposed for the location of three Hyper Acute Stroke Unit (HASU) to provide 24/7 stroke services across Kent and Medway.

Option	Hospitals		
A	Darent Valley	Medway Maritime	William Harvey
B	Darent Valley	Maidstone	William Harvey
C	Maidstone	Medway Maritime	William Harvey
D	Tunbridge Wells	Medway Maritime	William Harvey
E	Darent Valley	Tunbridge Wells	William Harvey

**Options are not ranked in order of preference and a preferred option will be agreed after consultation*

The five shortlisted options above were presented to the Joint CCG committee, Joint HOSC and NHSE with positive outcomes and the public consultation about the proposal was launched on Friday 2nd February 2018 for 10 weeks originally but extended by 1 week making 11 weeks due to patient and public feedback that more listening engagement was required. The public consultation has been widely promoted across individual NHS health and social care partners, including the third sector organisations, through their websites and other relevant communication channels. As at late-March, over 1300 consultation questionnaire responses had been received and over 6500 new visitors to the Kent and Medway STP website have been recorded. Various listening events have been held across Kent and Medway between March and April 2018. Thirteen of these events are in EK with hundreds of people in attendance.

The Trust is continuing to ensure staff engagement particularly with the stroke ward's staff across all sites to explain the process and implications of the upcoming transformational changes. Kent Healthwatch has been commissioned to facilitate staff forum events to further engage with the staff.

The public consultation is scheduled to close at midnight on 20 April. The analysis of the consultation feedback to identify the option for implementation and the development of the decision making business case for the Joint CCGs Committee consideration are the next steps are scheduled to happen between April and September 2018.

Kent and Medway Vascular Services:
Vascular Surgical services in Kent and Medway are currently provided by two NHS Trusts: Medway Foundation Trust and East Kent Hospitals University Foundation Trust.

In December 2014, NHS England Specialist Commissioning initiated a review of the vascular service provided by the current providers in Kent and Medway. This was followed by the publication of a detailed Case for Change (reviewed by the SE Clinical senate) for Vascular Surgery in Kent and Medway which articulated the need to reconfigure the local Vascular services across Kent and Medway in order to meet the National Service Specification (NSS) and Vascular Society's Provision Of Vascular Surgery standards (VS POVs).

In the past months, with agreement by the Vascular Review Programme Board, clinical reference group and feedback from the various engagement events with patients and public both Trust have worked to develop a network service based on a single arterial vascular centre supported by an enhanced non-arterial vascular site. This has been identified as a sustainable, efficient and effective longer-term solution for vascular surgical services provision across Kent and Medway. The network for vascular surgery across Kent and Medway has made positive operational progress.

The review process has also worked with the two Local Health Overview and Scrutiny Committees (HOSC) throughout the process. Regular presentations and discussions have been undertaken with the Joint Health Overview and Scrutiny Committees (JHOSC) and members have been invited to the engagement events.

Both Trust are now working together with NHS E on the development of the Outlined Business Case for Kent and Medway vascular service which will later be developed into a full business case to go through all the necessary approval process both internally and externally. It is expected that the agreed business case would be included in the wider Kent and Medway STP work.

EK Urgent & Emergency Care (including Acute Medicine Care) and Elective Orthopaedics (Major Joint Surgery):

There are a number of key drivers and challenges that the Trust faces which underpin a compelling case for change and includes both national and local factors including local population and demographics, increasing demand, workforce issues and Trust's current performance.

Workforce constraints prevent the delivery of 7 day services and 24/7 consultant cover across the main acute hospitals in east Kent. Sometimes, senior doctors are not present at the weekend or are trying to cover more than one clinical area at a time. Support services for discharge are also not available at the weekend.

Across Kent and Medway, attendances to major ED departments have risen by 2.2% per year over the last 3 years (twice the national average). East Kent Hospitals have some of the worst patient satisfaction scores in the country for ED. Performance on the 4 hour waiting target has deteriorated over the last few years.

In addition, the Trust is facing key challenges around the provision of inpatient elective orthopaedics (major joint surgery). There is an increasing long waiting lists for planned care (75% increase in the last 4 years) with an increasing number of on-day cancellations (31 in Jan 2017) due to increasing pressures from emergency admissions -"crowding out" planned care. Trust beds on orthopaedic wards are not "ring fenced" which is impacting on bed availability.

The demographics of the population is driving demand with an increasing number of the over 60's population and increasing numbers of the population suffering from being overweight or obese. There is an increasing demand for trauma services which frequently disrupt elective theatre schedules. Substantial evidence show that surgeons need to operate on a minimum number of patients per year to improve quality and patient outcomes

The vision in east Kent is to create centres of excellence where specialist teams have the expert staff and equipment they need to give patients the best chance of survival and quality of life. This will help patients to stay well and independent in their homes and communities and only come to the hospital when required.

In order to achieve this vision, over the past months East Kent Hospitals University NHS Foundation Trust (EKHUFT) has been working with other partners to progress the clinical strategy for EKHUFT.

The application of the hurdle criteria to the long list of options resulted in a medium list of two options for urgent and emergency care and six medium list options for elective orthopaedics. All medium list options will undergo detailed evaluation and analysis against quality, access, workforce, ability to deliver and finance to identify short list of options for public consultation.

EK joint CCGs committee met on November 30, 2017 to agree and approve the long-list of possible options, the outcome of the application of the hurdle criteria, the evaluation criteria and its application resulting in the medium list options.

Also, the output of the hurdle criteria has received formal sign off at the STP Hospital Care Workstream, the Clinical Board, the Finance Group and Programme Board. The development and progress of the design phase has regularly been reported at key stakeholder group meeting such as Patient and Public Advisory Group (or its predecessor arrangement the Patient and Public Engagement Group), Kent and Medway STP Programme Board, East Kent acute Transformation Group, East Kent Delivery Board and Kent County Council's Health Overview and Scrutiny Committee (HOSC).

The Trust and its partners have held a series of public listening events across east Kent, gathering feedback on the vision for future services, the evaluation criteria to assess the possible options, and the proposed model of care. These attracted around 750 attendees raising important questions and sharing valuable feedback on the model of care and feedback that has helped to refine the evaluation criteria.

Recently, an EKHUFT internal strategy event was held to further engage with Trust clinicians and operational staff on the impact of the two options on their service model as well as ensuring their involvement in the options evaluation process. In addition over 600 members of the public have responded to an online questionnaire to inform the possible weighting of the agreed evaluation criteria which will be used to evaluate the medium list of options. 'Engage Kent' was commissioned to run 15 face – face outreach groups and digital engage with seldom heard and protected characteristic populations between August and September 2017 to ensure their contributions into the option development process. This report is available at www.kentandmedway.nhs.uk/latest-news/new-reports-published-listening-engagement-events/

A patients and public listening event (Design by Dialogue) organised by the commissioners was held on 22 March 2018 to engage with public on existing local services and gain feedback to positively shape the future service provision across EK. Hundreds of people were in attendance at this event. The commissioners are looking to plan and organise more listening events across each locality in EK to further engage with patients and public.

We are now in discussion with the commissioners to agree the evaluation process of the medium list options and to therefore complete the options evaluation appraisal in order to identify the short list of option(s) for public consultation which will form part of the Pre-Consultation Business Case (PCBC) that is being developed.

Engagement with patients, public and Trust staff continues through various Trust and CCG communications channels.

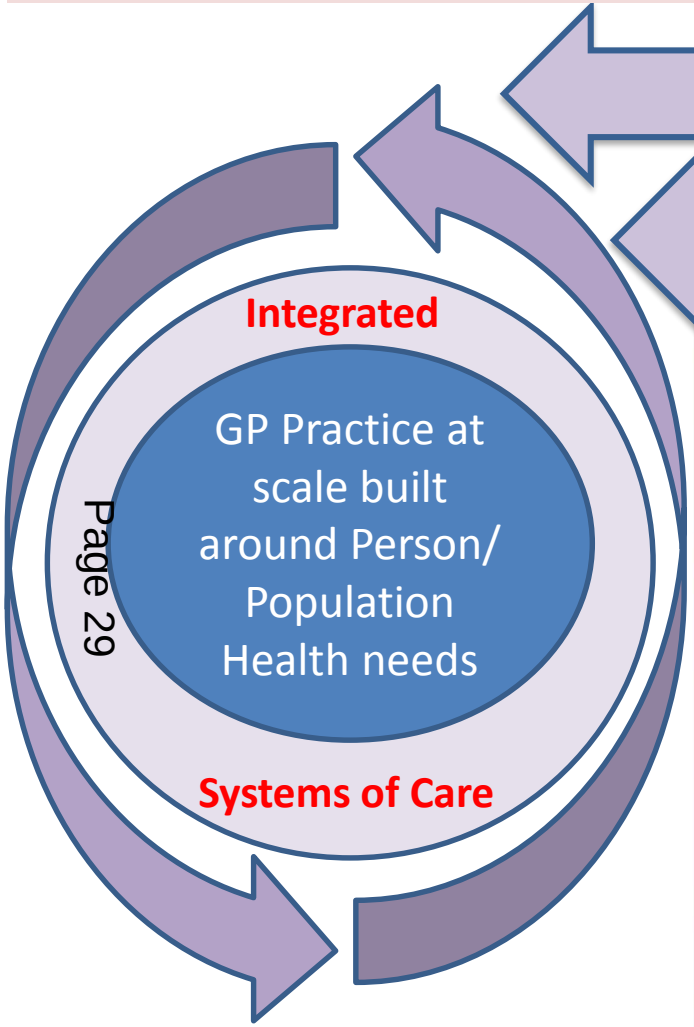
Implementation of Local Care

Ashford CCG

Key areas of Local Care Implementation

- The Local Care Model
- Implementation to date
- Plan for roll out across Ashford footprint
  - Detailed timelines
  - Anticipated impact
- Extended Access
- Frailty and other Tiers of Care Priorities

Local Care Model – Health, Social Care, Voluntary and Community involvement working together at scale – The Community Hub Operating Centre (CHOC) model



Number of People

Admission Avoidance

Routine, Prevention and Proactive Care –Integrated Case Management (ICM patient centred approach for admission avoidance, anticipatory care planning.

Emergency and Reactive Care – ICM approach for admission avoidance, rapid/ emergency response to avoid hospital admission to keep people well at home.

Acute Care - When intervention is essential. Working with IDT for repatriation at the earliest opportunity.

Tertiary Care - For highly specialist intervention. Repatriation at the earliest opportunity.

Level of Acuity

GP/MDT Clusters
Total Population 132,419
Each Cluster – 35-60,000

Ashford Rural Model and Impact

- Cluster level MDT working in place since late 2016
- Shared principles with Vanguard area of
  - regular multidisciplinary/ multi agency meetings
  - Identification of complex and vulnerable patients
  - Responsive care planning to maintain community care where appropriate
- Weekend urgent care response to avoid attendances at A&E
- Activity at month 6 shows reduction of 12.8% against contract baseline for the 5 frailty specialities combined.

Planned implementation of Local Care Integrated Case Management model to all localities

- Ashford CCG:
  - Ashford Rural Cluster ***In Place***
  - Ashford North Cluster ***December 2017***
  - Ashford Urban Cluster ***December 2017***

Implementation Progress

- Principles of Encompass Vanguard model agreed across Ashford CCG area and reflected in Kent and Medway Local Care model
- Detailed summary of maturity of each locality undertaken
- Detailed road map of roll out of full model undertaken per locality (ongoing)
- Detailed activity impact modelled per locality based on planned timelines

Implementation key milestones

- Ashford Rural/ Encompass MDT model to roll out to Ashford Urban and North Clusters with initial mobilisation in November 2017 and full implementation from January 2018.

- Ashford Clusters to mobilise integrated pathways in Catheter Care, Wounds Care and Aural Care in a cluster phased approach from January 2018.

Extended Access- Ashford

- Ashford CCG on track to deliver GPFV extended access across CCG in a phased approach by end 2018/19:
  - Development scheme in place to support practices
  - Enables Ashford practices to mobilise early with a phased approach, plan to achieve 25% of GPFV seven day access by March 2018.
  - Initial mobilisation across all three clusters planned for quarter 4 – go live achieved in December 17
  - Scaling up of provision planned to full delivery during 2018/19.

Frailty Implementation

- Rolling out integrated case management forms the core of the local delivery of frailty intervention across Ashford
  - Identification of patient with moderate and severe frailty
  - Planned care approach to anticipatory care planning and community MDT support
  - Reactive element to initiate rapid response and facilitate discharge from hospital
- East Kent wide frailty pathway implementation linked to locality deliver via a single strategic/ clinical steering group for key elements of pathway:
  - Clinical Support to Care Homes
  - Enhanced senior clinical workforce
  - Review of falls pathway
  - Planning digital solutions/ supports to pathway (use of PTL and telemedicine).

Tiers of Care Implementation

Planned local delivery (via Clusters) of Tier 1 and 2 elements of the East Kent Clinical Transformation Plans:

- Cardiology – Plan to implement T2 across Ashford & Canterbury areas from April 2018
- Rheumatology – decision re: EK procurement
- Dermatology - Triage process in place in Ashford, implementation.
- Respiratory

How is the integrated case management model is supporting the Frailty Pathway:

In the following ways;

- Been part of the **pneumonia pathway** work across east Kent, which went live on the 2/10/17 (attached). This has been extensively socialised with each GP, clinical leads and practice managers

- From Decemer 2017, **increasing numbers going through MDTs** – risk stratified per practice using programme to identify vulnerable and at risk patients,

- Working with all partners to have a **coordinated approach** with SECAmb, to avoid hospital admissions

- From Dec 2017 have implemented **extended hours** (as per our GPFV) creating capacity for extra consultations

- Part of the **urgent care pathway work** across east Kent, supporting GP pathway/access within Acute setting (to alleviate pressure on the Acute)

- Linking in with the **care home strategy**- supporting care planning, early identification of the deteriorating patient and training for staff

- Linking in **with New provider for OOHs/111**, as of Dec 2017 (existing provision has not met expected requirements).

Enablers

- Digital solutions: Common digital systems and solutions being used to support consistent working at scale and integration between organisations (EMIS clinical services, Local Care PTL development)
- Alignment of CCG resources to Local Care implementation to enable rapid roll out of successful models
- Development of Alliance working with Kent Community Trust to align all partner organisations and workforce to the model of care

Risks

- Enhanced Frailty Workforce Recruitment to deliver frailty implementation plan
- Primary Care workforce demands to deliver in hours, extended access, out of hours and support to emergency system
- Fragility of immature alliance partnerships
- Delay in NHS Digital procurement - support implementation of key milestones

Winter Preparedness Proposals– East Kent Initiatives

- Recommission 80 health & social care beds Dec-March
- Spot purchase 10 additional packages of care for dementia/challenging behaviour patients
- Extend length of rapid response package to 5 days
- Dedicated fast track hospice beds
- Dedicated nurse practitioner for care homes
- Expansion of Care Navigator service to community hospitals
- Health Navigators in secondary care to support self management
- Additional support for non weight bearing packages

ESTATES STRATEGY AND IMPLEMENTATION PLAN

Prepared By Neil McElduff
NHS Ashford CCG

DOCUMENT CONTROL SHEET

DOCUMENT TITLE	Strategic Estates Strategy and Implementation Plan
REPORT TITLE	Estates Strategy and Implementation Plan
ISSUE	V10.0
STATUS	Draft
CONTROL DATE	15 Feb 2018

Record of Issue

Issue	Status	Author	Date	Check	Date	Authorised	Date
1.0	Draft	NM	12/2017				
1.1	Draft	NM	12/2017	Amended after review with Wendy Malkinson			
1.2	Draft	NM	01/2018	Amended with comments from Louise Matthews			
2.0	Draft	NM	01/2018	Added population by practice details.			
3.0	Draft	NM	02/2018	Amended from consultation with GP Federation			
4.0	Final Draft	NM	02/2018	Submitted to estates group for approval			
5.0	Final draft amended	NM	02/2018	Amended from feedback from Philip Blake			
6.0	Final draft amended 2	NM	02/2018	Amended following consultation with NHSE			
7.0 8.0 9.0	Final draft amended 3	NM	02/2018	January list sizes input and other changes from practices			
10.0	Rewrite	NM	02/2018	Rewrite following review at estates strategies meeting to include focus on local care shift.			

Approved for Issue Name	Signature	Date

Important Notes

1. **With regard to any need to undertake service change and comply with various statutory duties: -**

   The options set out in this document are for discussion purposes. The involved NHS bodies understand and will comply with their statutory obligations when seeking to make decisions over estate strategies which impact on the provision of care to patients and the public. The options set out do not represent a commitment to any particular course of action on the part of the organisations involved.

2. **In respect of any request for disclosure under the FoIA: -**

   This is a confidential document for discussion purposes and any application for disclosure under the Freedom of Information Act 2000 should be considered against the potential exemptions contained in s.22 (Information intended for future publication), s.36 (Prejudice to effective conduct of public affairs) and s.43 (Commercial Interests). Prior to any disclosure under the FoIA the parties should discuss the potential impact of releasing such information as is requested.

EXECUTIVE SUMMARY

This strategy addresses the question: has the CCG got access to sufficient infrastructure to allow its future commissioning plans to be delivered. As such it is an enabling strategy of the overall CCG commissioning intentions.

In making this assessment we have considered the CCG vision and strategic goals, the population, health need and regeneration drivers for change. Service drivers such as the five year forward view, the GP forward view, vision for local care and local primary care ambitions have been studied, along with technological drivers and estate drivers, such as condition, compliance with minimum standards and current use patterns. The population growth has been aligned with individual GP practices. This has allowed an assessment of sufficient capacity for primary and other services in out of hospital settings, whilst looking to improve access to effective care.

We found:

- **Two buildings that did not meet minimum standards**
- **Four buildings that were at capacity**
- **Six buildings that were close to capacity**

There is very limited capacity to allow for future primary care provision and local care shift to be delivered. Investment is required, primarily in the Urban cluster practices which need extensions and in one instance reallocation of space. Two practices in North Cluster need extension and two rural practices. The estimated capital costs of these projects are circa £6 million.

There is no capacity in the primary care estate to deliver hubs to allow service transformation. The rural cluster could use East Cross clinic for this purpose and the North cluster should explore using the William Harvey Hospital site to provide the required estate. However, the Urban cluster, which is where the majority of the population growth is, has a preferred option of a new build to allow service transformation. This paper outlines options and suggests a multi stakeholder option appraisal is conducted. There will be a significant cost (both revenue and capital) to deliver these projects and the funds must follow the service.

There are various sources of funds to explore. NHS England Estates and Technology Transformation fund will fund the Ivy Court development. Section 106 contributions will help with other extensions. NHS England capital can be bid for subject to PID and business case processes. Private Finance can be accessed to design, build and finance new schemes. Local authority funding could be explored, and Landlords would be approached to extend their buildings in return for rent.

The key challenges for the CCG are: the changing growth scenario,; stakeholder management; Improving access to services; pressures on primary care and delivery of out of hospital / local care strategy.

Key risks are the capacity to manage the agenda, national economy which may affect development plans, section 106 funds, failure to get engagement with stakeholders and managing expectations – the premises cost directions limit what funds can be given to General Practices for premises developments.

Other key enabling risks are GP providers closing lists, GP aspiring to take on local care but not open to increasing primary care provision and workforce strategy.

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1. INTRODUCTION AND LOCAL OVERVIEW

1.1. Purpose

The *Estates Strategy and Implementation Plan* (SIP) presents the Ashford strategy for the provision of its future healthcare estate in support of national and regional policies and an increasing demand and evolving requirement for healthcare services in the borough.

The SIP is a live document, which will be reviewed in light of potential changes to the service provision or population figures. This document, therefore, points out the direction of travel concerning estates and will be the foundation for any responses to new models of care.

The SIP is also supportive to the wider 'Sustainable Transformation programme within which *estates* is one of the enabler work streams.

The purpose of the Estates Strategy and Implementation Plan is to ensure there is the required community based healthcare infrastructure in place to meet the needs of the Ashford population over the next decade. It will need to be reviewed and refreshed annually to ensure that it is still relevant and reflects the current and future infrastructure needs of the borough.

1.2. Ashford Clinical Commissioning Group

NHS Ashford Clinical Commissioning Group (CCG) is a clinically-led organisation that was established in April 2013. Made up of all 13 general practices in Ashford, it is committed to bringing about better health for the local population, constantly improving services and ensuring that best use is made of the NHS resources allocated to the CCG.

1.3. Vision and Strategic Goals

Ashford CCGs prospectus outlines the CCG's approach to delivering transformational change in health and social care, to improve health and social outcomes over the course of the next five years. The strategic goals are:

- **Priority 1:** Maintain Health Status - Promote health and wellbeing, enabling Ashford's population to be as healthy as they can be and make informed choices about their health and lifestyle;
- **Priority 2:** Reduce Health Inequalities - Utilise the knowledge and skills of our GP membership, ensuring patient centred, consistent primary care for the people of Ashford;
- **Priority 3:** Maintain clinical effectiveness - Ensure Right Care First Time. Working with patients, the public, GPs, the Local Authority, service providers and other stakeholders, and develop local and joined up care- we will work with primary care, the Council and other health and social care partners, to streamline and join up complex care and support for the frail and elderly and those with complex long term conditions, with care provided at home or as close to home as possible.

Ashford CCG has the following vision for its healthcare estate:

> *To create an efficient and sustainable estate which is fit for purpose and flexibly, effectively and efficiently supports new and emerging models of care and positive patient experiences. Investment in the estate will ensure services keep up with population growth whilst adjusting to the changes introduced by new, integrated, care models to improving health and well-being in Ashford.*

A high quality Estates Strategy and Implementation Plan is vital to the delivery of this vision and the following allied estates strategic aims; regarding the future management and development of the Ashford healthcare estate, underpin this SIP document:

- Estates development will have a recognised role in supporting the improvement of patient experiences and positive patient outcomes
- The estate will be of high quality – achieving performance targets asset assessment methodology, benchmarking favourably against equivalent facilities elsewhere and progressively delivering improved value for money

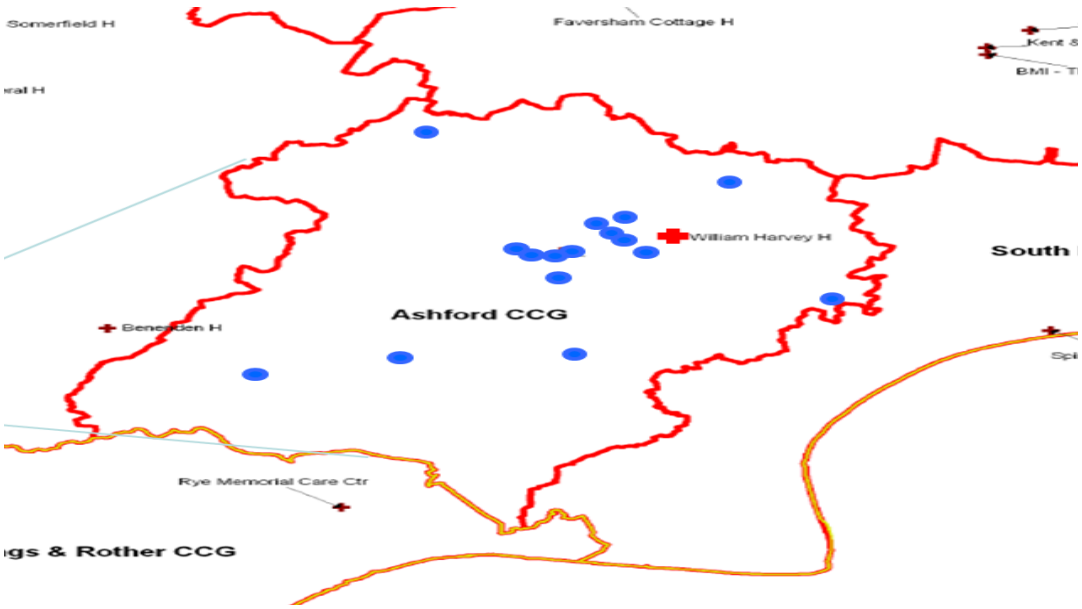
1.4. Scope

The scope of this estates strategy includes:

- All 13 GP practices currently operating out of 15 sites
- All community sites where healthcare services are provided
- Non-clinical NHS estate, such as office/administrative bases.
- Pharmacies, Dentists, Ophthalmology premises will be considered where relevant to this strategy.
- Whilst this estates strategy does not seek to address every organisation's estates plans, the aim of the engagement process has sought to identify where there are clear synergies, opportunities and needs that partners can help each other to address in an efficient and cost-effective way.

As more defined plans are formed around occupation of specific sites, engagement with secondary care, community and third sector organisations will be undertaken where necessary.

1.5. Ashford CCG Area



A series of buildings and land make up Ashford health estate. Whilst the CCG does not directly own any land or buildings, it funds them all via rent payments, contractual payments or void payment and is thus the defacto head tenant. It is thus essential that the CCG ensures the assets are used optimally and deliver its service and commissioning strategy. The CCG is responsible for strategic estate planning to ensure the buildings are fit for purpose, compliant, well maintained and well utilised. The over-riding

purpose of the estate is to provide sustainable, cost effective, flexible and adaptable facilities to deliver health services and achieve positive health impacts.

1.6. Programme Oversight Group

The SIP will be managed through a Local Estates Group. The forum is to be chaired by Ashford CCG. Participants in the forum will include NHS England, Ashford CCG, GP Federation, East Kent Hospitals NHS Trust, Kent Community Health NHS Trust, Kent County Council (social care, public health) and Ashford Borough Council (planning).

1.7. Stakeholder Engagement

A wide group of relevant stakeholders have been positively and constructively engaged in development of the Estates Strategy and Implementation Plan - through team workshops and individual meetings.

Providers

General Practice (GPs) – General Practitioners look after the health of people in their local community and deal with a range of health problems. A Kent Local Medical Committee representative and Practice representatives sit on the Estates Working Group.

Kent Community Health Services NHS Foundation Trust (KCHFT) – provide wide-ranging NHS care for people in the community, in a range of settings including people's own homes; nursing homes; health clinics; community hospitals; minor injury units and in mobile units.

They are one of the largest NHS community health providers in England, serving a population of about 1.4 million across Kent and 600,000 in East Sussex and London and employ more than 5,000 staff, including doctors, community nurses, physiotherapists, dietitians and many other healthcare professionals.

Ashford Clinical Providers (ACP) – There is a single GP federation operating in Ashford, known as Ashford Clinical Providers. This consists of all member practices and provides the entity for practices to work together at scale. This is both a strategic response to the commissioning framework for primary care but is also necessary to mitigate the workload and financial pressures which practices report that they are experiencing.

East Kent Hospitals University foundation Trust (EKHUFT) – East Kent Hospitals is one of the largest Acute Trusts in the country, serving a population of around 720,500. It has three major hospital sites in Ashford (William Harvey Hospital), Canterbury (Kent and Canterbury) and Margate (Queen Elizabeth the Queen Mother).

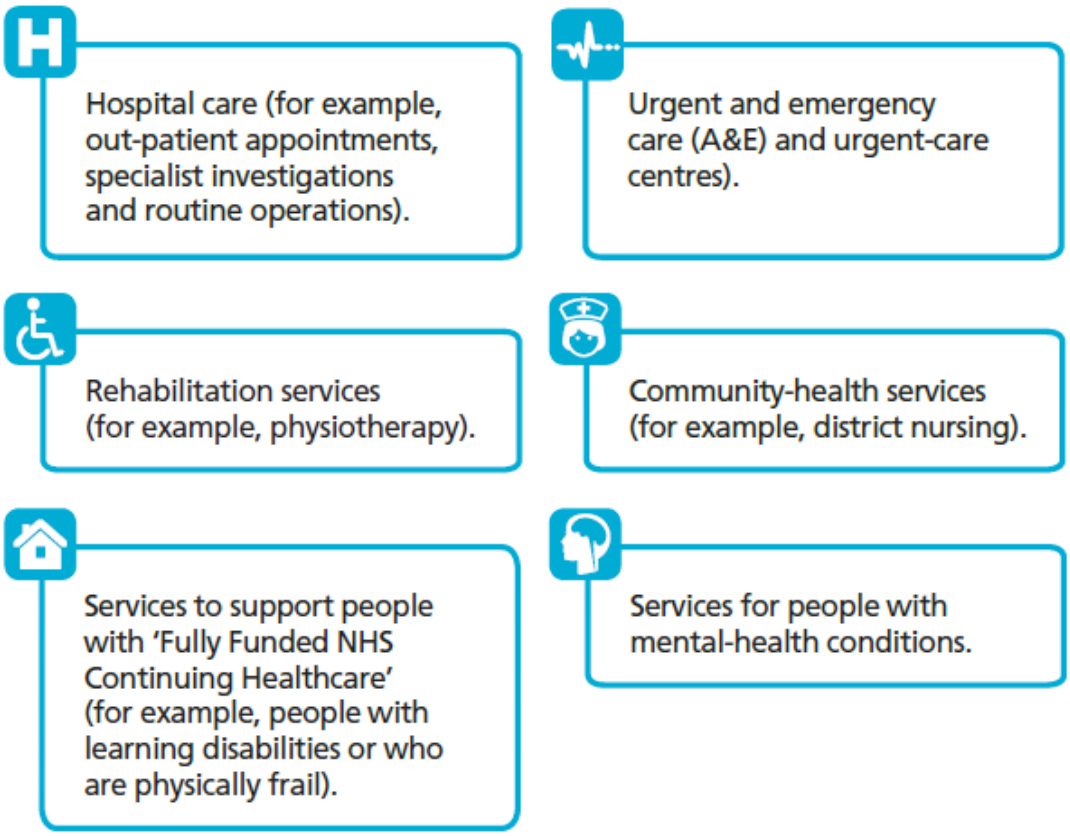
Mental Health - Kent and Medway NHS and Social Care Partnership Trust provides mental health and social care services for Kent in partnership with Kent County Council

Other primary care providers – include pharmacies, opticians, dentists.

Following the introduction of the Health and Social Care Act in 2012, CCGs are now responsible for commissioning most hospital, community-based and mental health services, and as from 2015 primary care services.

2. DRIVERS FOR CHANGE

NHS Ashford CCG is responsible for planning, monitoring and commissioning the majority of health services used by Ashford residents. This includes



Kent County Council is responsible for commissioning social care and local public health services including:

- Social care services
- The Healthy Child programme for school age children, including school nursing
- Sexual health services
- Mental health promotion, mental illness prevention and suicide prevention
- Local programmes around nutrition, physical inactivity and obesity
- Substance misuse services
- Early diagnosis of dementia and delivery of dementia services

Ashford Borough Council formulates the wider regeneration and development plans for the borough enabling infrastructure and population growth to be adequately taken into account in planning for future population pressures, service impacts and hence estate needs.

There are a number of factors leading to the need for a clear strategy for changing the way that services are delivered in Ashford and hence the estate infrastructure. These drivers for change are described in this section under the following themes:

- Population, health need and regeneration drivers
- Service drivers
- Technological drivers
- Estates drivers

2.1 Population, Health Need and Regeneration Drivers

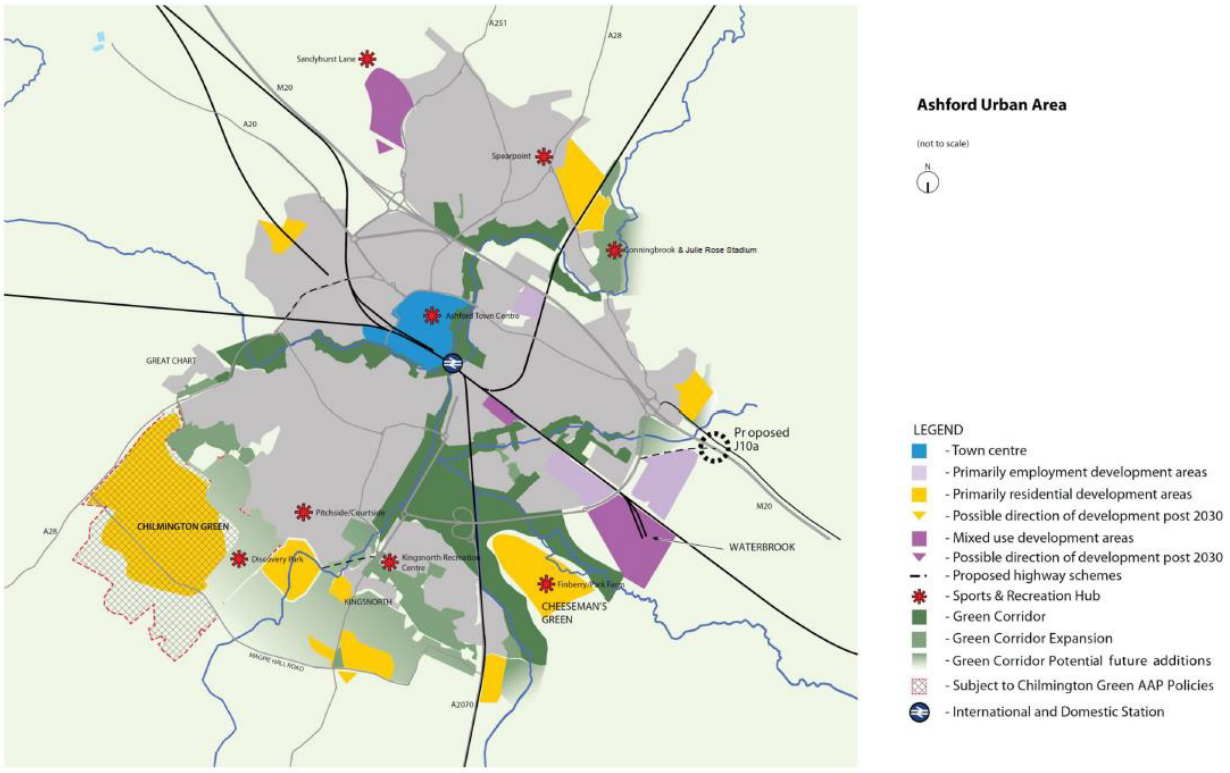
2.1.1 Demand Modelling

The Office for National Statistice (ONC) data shows that the population of Ashford is projected to grow by around 28,100 people. This is a 23.7% increase, which is notably above the projected increases in Kent, the South East, and across England (which range from 14.6% to 19.2% growth). This is likely in part to reflect the town's historic Growth Area status.

By 2030, depending on the scenario, the population could reach 158,800, a 38% increase. The projected growth is thus very significant. ONS estimates show there will be an increase in population across all age groups.

Population density is sparse across Ashford CCG, only those wards near to the town centre have a higher population density, with the highest being in Stanhope (71-120 people per hectare).

The wards in Ashford that show the highest population change are Tenterden South, Weald East, Godington, North Willesborough, Aylesford Green and Victoria with an increase of 10%. Apart from the Tenterden South ward, all other wards are situated near the town of Ashford. More rural areas show a decline in population change.



2.1.2 HOUSING GROWTH

There is expected to be an increase of 17294 houses by 2030.

- 5750 will be at Chilmington .
- 2082 units are in the Rural cluster, the greater proportion of which is Ivy Court
- 2067 are in North cluster, mainly at New Hayesbank which has already been extended
- 6616 is Urban impacting on Sydenham, Willesborough, Kingsnorth and South Ashford Medics. For the latter a review of room usage is required to create more primary care rooms.

2.1.3 DEMOGRAPHIC GROWTH IN ASHFORD

The Premises Assessment shows that there are currently 7133 metres square of net internal space available across Ashford CCG area to provide primary medical services to 132,812 patients. This equates to a CCG average of 18.61 patients per square metre. This is a high level benchmark and does not differentiate clinical and admin space. It also does not look at how well the space is utilised, hence productivity of the estate is a key issue.

When considered at a cluster level, the Ashford Urban cluster as a whole exceeds the CCG average of net internal area patients per sq metre by 1.78 metres square, whilst Ashford North and Ashford Rural are below the CCG average patient per sq m.

The Ashford Urban cluster is approximately twice the size of the other clusters and consideration could be given to splitting the cluster into two grouping to fit with local care model of around 30,000 patients

Ashford Cluster	Net Internal Area m^2 (current)	Patients (01/07/17)	Patient per metre sq (current)
Ashford Urban	2994	63230	21.11
Ashford Rural	2072	35065	16.92
Ashford North	2067	34517	16.70

CCG	7133	132812	19.61

As a result of planned residential development of key strategic sites across Ashford, this growth will not be distributed equally but focused mainly in a small number of areas; the data only includes projected increase in patient list sizes for primary care and not the impact estimated from the shift in local care.

When considered at a practice level Musgrove and Ivy Court Surgery are showing as the practice with the greatest space pressure at 39.41 and 32.32 patients per metres square respectively, followed by Willesborough Health Centre (27.34), Sydenham House Medical Practice (21.70) and Hollington Surgery (20.80). All other practices are showing as around or below the CCG average metres square per patient.

Otterpool Park

Otterpool Park is a proposed new garden town near Folkestone. It will be 12000 homes and a potential population of 29,000. Whilst not in Ashford, the nearest GP practices are in the Ashford border. The population increase would require a new building and the impact on local Ashford practices would need to be considered. The development has not yet received Government approval but the development needs to be monitored.

2.1.4 HEALTH CONSIDERATIONS

Key statistics from the Joint Strategic Needs Assessment (JSNA) as outlined in the Ashford CCG Group Prospectus:

- Life expectancy is years lower for men and 5 years lower in the most deprived areas of Ashford. Ashford has the highest life expectancy in Kent at 82.5 years, however inequalities exist between affluent and deprived wards. In the most deprived wards people die 9 years earlier then people living in the affluent wards. There appears to be a link between deprivation and health outcomes. Adult obesity and smoking prevalence is higher (30% and 20%) in the wards south of Ashford town (Beaver, Stanhope, Norman and Aylesford Green).
- The elderly population is projected to increase by 21% over the next 15 years.

'Healthy life expectancy' is the number of years from birth that a person can expect to remain in 'good' or 'very good' health. The services have to be designed around these particular needs of some of the population if inequalities are to be reduced.

2.1.5 ASHFORD HEALTH & WELLBEING STRATEGY PRIORITIES

All local authorities and linked CCGs are responsible for developing a joint Health and Wellbeing Strategy that sets out the local priorities on which commissioning plans will be based. Ashford has such a strategy which sets the following four priorities:

- Preparation for a healthy life: Improving outcomes for babies, young children and their families by focusing on early years settings and supporting parents' especially older and first time mothers.
- Wellbeing in the Community: Creating circumstances that enable people to have greater life opportunities. We will focus on improving mental health and wellbeing for all and supporting people to gain and retain employment and promote healthy workplaces.
- How we live: Encouraging healthier lifestyles with a key focusing on reducing obesity and preventing ill health through promotion of physical activity..

- Integrated Care: Providing care and support to facilitate good outcomes and improve user experience. We will focus on continuing to work to integrate health and social care services.

2.2 Service Drivers

The NHS is facing challenging times, with a growing demand due to population growth, people living longer and an increase in people with long term illnesses. STP groups are looking at system wide changes to the provision of health and social care.

To address these underlying issues, the way services are delivered, and where, is changing. This strategy sets out how the NHS estate in Ashford will adapt to the changing circumstances and support the delivery of a changing health economy that is promoting collaborations across a wide partnership of organisations and that requires access to services closer to patient's homes.

2.2.1 Service Transformation

The 'Five Year Forward View' sets out the future vision for NHS, the challenges it is facing together with what the future may look like.

In line with the Department of Health strategic directions, set out in "Five Year Forward View, ACCG has been contributing to the Kent and Medway Sustainability and Transformation Plan (STP) which describes how health services will need to be transformed to meet future needs of our growing and ageing population. The STP model for Kent and Medway is working towards delivering local care models scaling up primary care into clusters and hub based multi community specialty providers

The STP describes practices working closer together in alliances along with social care, community NHS and acute NHS clinical staff and services. To this end, Ashford CCG practices have grouped themselves into three connected hubs for shared working arrangements – North Ashford, Urban Ashford and Rural Ashford.

The STP system planning includes more development of new care models , care for people closer to home, delivered by local teams of health and social care professionals, working in GP surgeries, health centres and local communities so for day to day care and treatment, some people won't have to go to hospital as they currently do. The local care shift is an important factor in estate planning.

2.2.2 Vision for Local Care

Our aim is to develop healthy communities across Kent and Medway, where local people are informed and involved regarding their own health. Care provided to local communities will ensure that people are supported to be well and healthy in their own homes and communities. This will be delivered through new models of care that facilitate a connected system, where local people are at the centre of its design and delivery.

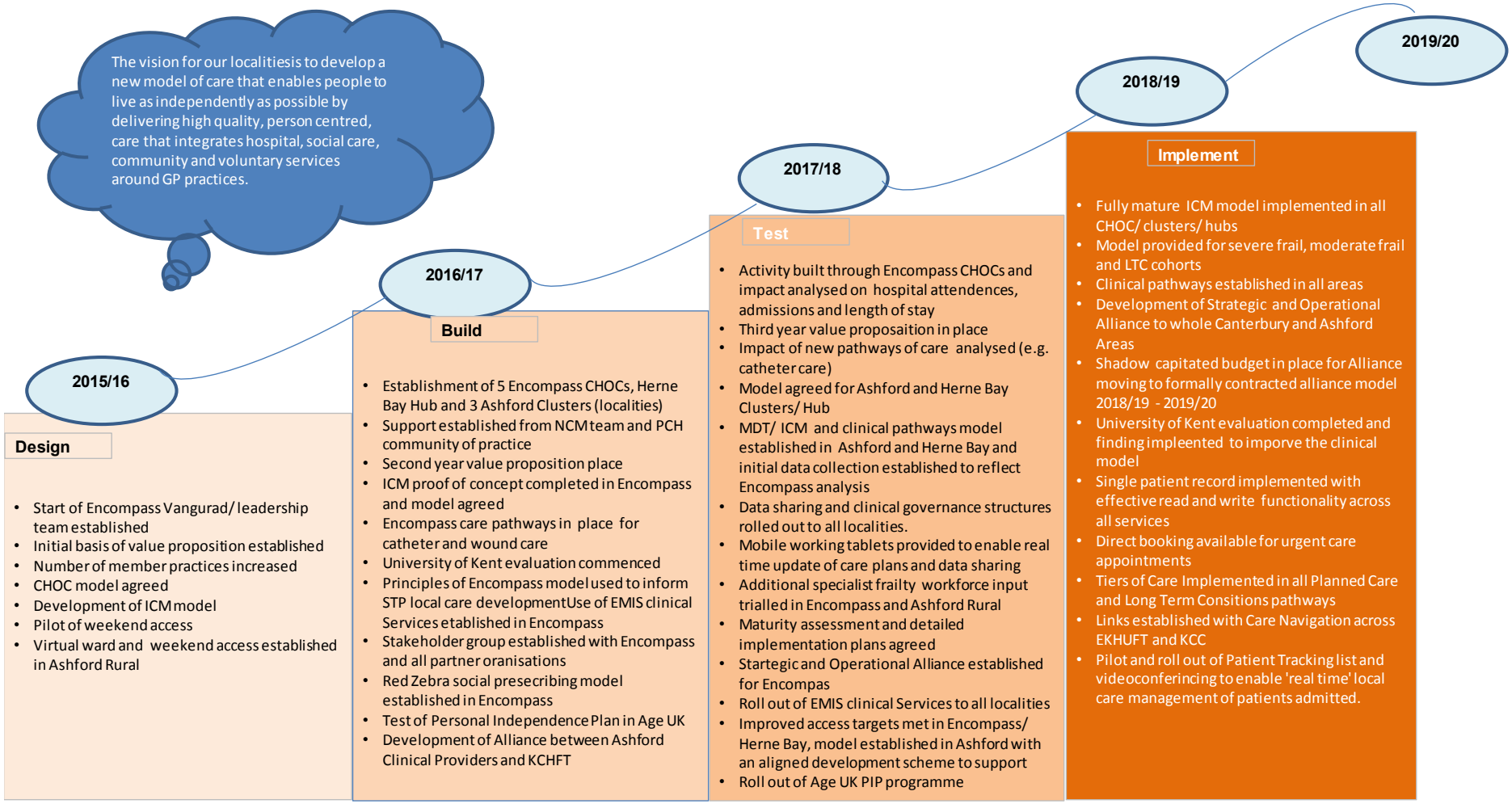
People will make fewer trips to hospital, instead accessing services at specialist clinics provided in local GP surgeries, hubs or making different use of the William Harvey Hospital estate. Furthermore integrated health and social services will ensure holistic, patient centred community and home based care.

Implementation of new local care models will be via delivery of integrated health and social care teams planned and delivered primarily to clusters of surgeries totalling a 30-60,000 list size. 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.

A possible example of future GP practices (note not applicable to every practice and models will need to be adapted)

Within each practice	Aligned to each practice but working across a wider geography / at-scale primary care organisations
GPs, practice nurses, GP nurse practitioners / nurse prescribers, volunteers, receptionists, managers, health care assistants and may also include physician associates.	Prescribing advisors, GPs with a special interest (GPWSIs), care coordinators, wellbeing teams, and 'super practice managers/directors' with sufficient skills to lead the development and operational management of at-scale primary care organisations As part of, for example, a wider Multi-speciality Community Provider (MCP): secondary care specialists, social care, mental health and community services teams, and community pharmacy.

For this type of GP practices to work, the Ashford expectation is for the list sizes to be a minimum of 8,000 patients. This may not be practical in some locations. However, where Hubs are operational they should support 30,000 – 60,000 patients. For the purpose of this document, a hub can be a building or a series of buildings working together.


The vision for our localitiesis to develop a new model of care that enables people to live as independently as possible by delivering high quality, person centred, care that integrates hospital, social care, community and voluntary services around GP practices.
2015/16
Design
Start of Encompass Vangurad/ leadership team established
Initial basis of value proposition established
Number of member practices increased
CHOC model agreed
Development of ICM model
Pilot of weekend access
Virtual ward and weekend access established in Ashford Rural
2016/17
Build
Establishment of 5 Encompass CHOCs, Herne Bay Hub and 3 Ashford Clusters (localities)
Support established from NCM team and PCH community of practice
Second year value proposition place
ICM proof of concept completed in Encompass and model agreed
Encompass care pathways in place for catheter and wound care
University of Kent evaluation commenced
Principles of Encompass model used to inform STP local care developmentUse of EMIS clinical Services established in Encompass
Stakeholder group established with Encompass and all partner oranisations
Red Zebra social presecribing model established in Encompass
Test of Personal Independence Plan in Age UK
Development of Alliance between Ashford Clinical Providers and KCHFT
2017/18
Test
Activity built through Encompass CHOCs and impact analysed on hospital attendences, admissions and length of stay
Third year value proposaition in place
Impact of new pathways of care analysed (e.g. catheter care)
Model agreed for Ashford and Herne Bay Clusters/ Hub
MDT/ ICM and clinical pathways model established in Ashford and Herne Bay and initial data collection established to reflect Encompass analysis
Data sharing and clinical governance structures rolled out to all localities.
Mobile working tablets provided to enable real time update of care plans and data sharing
Additional specialist frailty workforce input trialled in Encompass and Ashford Rural
Maturity assessment and detailed implementation plans agreed
Startegic and Operational Alliance established for Encompas
Roll out of EMIS clinical Services to all localities
Improved access targets met in Encompass/ Herne Bay, model established in Ashford with an aligned development scheme to support
Roll out of Age UK PIP programme
2018/19
Implement
Fully mature ICM model implemented in all CHOC/ clusters/ hubs
Model provided for severe frail, moderate frail and LTC cohorts
Clinical pathways established in all areas
Development of Strategic and Operational Alliance to whole Canterbury and Ashford Areas
Shadow capitated budget in place for Alliance moving to formally contracted alliance model 2018/19 - 2019/20
University of Kent evaluation completed and finding impleented to imporve the clinical model
Single patient record implemented with effective read and write functionality across all services
Direct booking available for urgent care appointments
Tiers of Care Implemented in all Planned Care and Long Term Consitions pathways
Links established with Care Navigation across EKHUFT and KCC
Pilot and roll out of Patient Tracking list and videoconferincing to enable 'real time' local care management of patients admitted.
2019/20

2.2.3 General Practice

The General Practice Forward View gives a clear steer to how services should be delivered in the future and has a commitment to continue to provide a list based GP system. It states that primary care estate will be developed and there will be investment in better technology.

- Investment in general practice estates and infrastructure, supported by continued public sector capital investment, estimated to reach over £900 million in the next 5 years.

- A greater use of technologies to enhance patient care, drive productivity of assets and positively affect on footfall at practice premises. The impact of record sharing, health apps, self-care management / reporting etc. must be considered against estates investment and the impact of technological advancement in health on patient demand / access must be recognised.

To be able to cope with the increase in demand, the patient offer may look different depending on what type of service user it is. An emphasis will be on preventative and self-care, to avoid drainage on the health system.

Who is providing the service will also change depending on the need. There will be a mix of care and support available from different professionals. This will require a mix of professionals and services available closer to patients' homes (diagnostics, pharmacy, social workers, community charities, advice services, support groups).

The majority of GP practices will not be able to offer all services directly from their practice as there is no scope or capacity within the infrastructure to do so. However, the estate structure across the area will require hubs to be created in NHS owned / leased assets so that all patients will be able to access services, albeit some may be at an alternative site to their GP/Core services. There is no capacity in the current estate to achieve this.

Partnerships with all health providers will be essential for success, but also closer working with the Council and their services through links with community centres and children centres.

In 2016/17 the CCG has signalled a clear commitment to explore new models to help it meet the challenges it faces in Ashford. In summary it agreed it needed sustainable system(s) of health and social care which deliver the best outcomes for our respective residents and is affordable. There are many new models of care being discussed nationally and internationally including multispecialty community providers (MCPs), primary and acute systems (PACs) and Accountable Care Organisations (ACO) (or variants of these).

2.2.4 Local Primary Care Ambitions

Ashford CCG has full delegation for the commissioning and performance management of primary care. Following discussion with the GP membership of the CCG seven primary care ambitions have been identified which will improve local services for our patients:

- **Ambition 1 – Patient Access, Quality and Outcomes:** Every patient will have access to a core offer of high quality primary care which is continuously improving and delivering excellent health outcomes
- **Ambition 2 – Patient Participation:** We will have effective engagement with our patients, and their carers, to ensure that our services and information meet their needs and lifestyles
- **Ambition 3 – Workforce:** We will have an attractive training environment which develops our doctors, nurses and allied staff to be the best healthcare workforce

- **Ambition 4 – Premises:** The premises used to deliver services will be fit for purpose meeting the current, and future, needs of our growing population
- **Ambition 5 – Integration:** Improved patient care will be delivered by removing boundaries between primary, community, hospital and social care
- **Ambition 6 – Technology:** We will use technology to deliver the highest quality care in the most appropriate manner
- **Ambition 7 – Payment and Investment:** We will ensure that there is a payment and incentive system to support improved outcomes, ensure value for money and reflect the workload.

2.3 Technological Drivers

- Primary and community care services are already making considerable advances in the use of information technology and this will continue to grow over the years benefiting patients, providers and practices whilst facilitating more cost effective services. The emphasis will continue to be on reducing paper processes and putting in place systems and procedures that will speed up services whilst at the same time improving data quality and data capture. The aim is also to enable more holistic patient care through the sharing of patient data with local Ashford providers for the purposes of direct patient care.
- Information and IT is a key enabler for service transformation locally and can support staff in new ways of working and empower patients to be active participants in their care.
- Each CCG has its own IM&T strategy and implementation plans. In Ashford, technological investment priorities will focus on a number of key programmes as follow 9will need investment before being progressed):
- Digitalisation of patient records – exploring whether hard copies of the GP patient record (Lloyd George notes) can either be stored off site or scanned and destroyed. This will help free up capacity within practices allowing space to be used for clinical purposes.
- Electronic Discharge Notifications (EDN) – aimed to eliminate the need for sending discharge summaries by post and include automated capture into GP system work flows.
- Electronic Prescription Service Release (EPSR2)
- Business grade secure WIFI devices for all practice sites
- Web conferencing; the aim being to reduce time spent travelling and to maximise effective use of time and resource.
- Providing GP patient data access to the local providers in the acute and community setting
- Mobile devices such as iPads and laptops are increasingly being used by practices and providers.
- Patients Online Services is supporting GP practices to offer and promote online services to patients, including access to records, online appointment booking and online repeat prescriptions. The CCG is exploring alternative methods and opportunities to enhance the utilisation and uptake of patient online services through the wider health and care network.
- iPlato is a SMS replacement service for NHS Mail SMS which allows practices to send appointment reminders to patients and enables patients to respond to the text alert to confirm or cancel the appointment. It also allows health promotion messaging to be sent to patients.
- Electronic Referrals (eReferrals) integrated into the GP IT system with longer term development including the ability for GPs and patients to track where the patient is in the system following the initial referral.
- Use of health Apps need to be explored and scoped to identify which might be of benefit to our population.

- Ensuring that GP systems of choice are fit for purpose and the future and capable of delivering the technological change agenda.
- The CCG would want to explore out of hospital care and the continuity of care provision using tele-healthcare service developments.
- To facilitate improved access, the CCG will need to initiate a central bookings facility in order to manage this enhanced service, ensuring fair access to appointments and ease for patients.
- The provision of extended hours (8-8) in new hubs or existing GP practice sites. This may include a Federated level central telephone hub or central telephone hubs per LCN. This will improve patient experience and facilitate both working at scale and extended opening hours. It is the most cost effective way of providing more clinical space.
- As the CCG becomes aware of practice mergers and / or practice developments, or practice system migrations take place, the CCG would need to support this and funding would be required. Core GP IT infrastructure & software investment will need to be available to meet the needs of practice organic/incremental growth, practice developments e.g. mergers and possibly significant primary care developments such as new builds or the development of a local care network.

2.4 Estates Drivers

There are a number of estates issues that are driving the need for the public sector to review its estates strategy. These are summarised below

- As a mixed rural and urban borough, Ashford has more space relative to the more densely populated boroughs. Ashford is already able to respond to the pressing need for more housing. The regeneration plans shows how the Urban part of the borough will be regenerated to develop
- The quality and efficiency of usage of the national NHS estate is highly variable and much does not meet evolving needs. There is significant scope to transform the way that estate is used across. In Ashford there is small variability in the quality of the primary care estate. There are a number of practices that operate out of converted residential premises that do not necessarily provide the functional and flexible space required. Opportunities for site reconfiguration, practice mergers and branch rationalisation will be considered to improve the efficiency of practices' operations and services to their patients
- Poor utilisation and unsuitable types of estate has been a result of:- perverse incentives, insufficient investment and fragmented decision-making on primary and out-of-hospital estate,; A lack of incentives for GPs to rationalise the use of estate, and Inflexibility of lease arrangements. Productivity reviews of key sites will be required to support business cases for investment.
- There is a need to unlock value: The NHS does not have any new money and therefore must look at how to unlock value from the current estate and capital regime to address the issues within the system. Partnership working one a One Public Estate principle is essential as almost all oractices are at full capacity.
- There are opportunities across the public sector for organisations to co-locate and share sites to meet the growing pressures of more housing and school places.
- Ensuring that all GP practices are fit for purpose in line with Care Quality Commission requirements and are Disability Discrimination Act 1995 compliant, energy efficient and comply with infection control standards.

3. FUTURE ESTATES INFRASTRUCTURE

3.1 Future Model of Care and Service Priorities

As part of the CCG's aim of bringing care closer to home primary, community and social care services need to be more accessible and better integrated, supporting a preventative and holistic approach to patient care over time.

Primary care plays an integral role in delivering our strategic priorities, whether as a provider within the care pathway, or by ensuring that there are good processes in place for referral and management of patients following their interaction with more specialist acute or community services.

The services available will be proactive, accessible, coordinated and provide continuity; with a flexible, holistic approach to ensure every contact counts. This will be primary care delivered to geographically coherent populations, at scale, whilst still encouraging self-reliance. This will be a universal service covering the whole population 'cradle to grave'.

This care network approach will involve primary, community and social care colleagues working together and drawing on others from across the health, social care and voluntary sector to provide proactive patient centred care. Services within will be delivered in ways that respond to the varied needs and characteristics of the community it serves.

In Ashford there are three clusters that align with the proposed model:

Ashford Cluster	Net Internal Area m^2 (current)	Patients (01/07/17)	Patients per metre square (current)
Ashford Urban	3241.92	62666	19.33
Ashford Rural	2071.81	34807	16.80
Ashford North	2202.80	34428	15.63
CCG	7516.53	131,901	17.55

3.2 Our vision

It is critical that public sector organisations locally make the most efficient and effective use of their estate so that over the long-term, there is the required infrastructure in place to support the delivery of services in the locations that best respond to the need. In terms of primary care, it is vital that the technological and estate infrastructure reflects new models of service delivery which form part of the primary care transformation agenda and the development of care networks. In order to do this, there needs to be fit-for-purpose, well utilised, sustainable, affordable estate located to best meet the health needs of the population.

The development of primary and community care infrastructure in Ashford needs to help facilitate delivery of the following priorities:

- Aligns with the Ashford Growth Strategy and addresses any service and infrastructure needs that result, including ensuring sufficient GP provision across Ashford
- Ensures there is sufficient capacity for primary and community care services to be provided in out of hospital settings.
- Advance technological solutions that reduce the need for face-to-face consultations, better equip patients to self-manage, enable more preventative care and strengthen communication and

collaboration between organisations. This will include utilising web conferencing facilities, and other web based solutions, between practices, practices / branches and practices / patients. This will enable practice education to be undertaken virtually to reduce staff travel time, increasing time available for patients and reduce patient travel time as patients can be seen remotely. In addition, the GP systems of choice need to be fit for purpose both now and in the future.

- Reduces reliance on clinical and office space through use of remote and mobile working.
- Improve access to effective care.
- Seeks to rationalise branch sites where this enables more efficient ways of working, without hindering patient access, ensuring remaining practices, across the borough, are fit for purpose and have the required capacity to meet the needs of Ashford's population.
- Ensures that all practices in the borough are CQC compliant, meet minimum standards, DDA regulations and that premises are fit for purpose and meet the CQC requirements.
- Ensures that there is sufficient training and workforce development capacity and improved accessibility across practices,; improving the learning culture across Ashford. This will also facilitate an increase in the number of practices able to offer placements for all student healthcare professionals.
- Greater partnership working across providers through co-location of services.
- Delivers the emerging strategy including the consideration of hub sites.
- Maximises the use of purpose built, high quality estate for clinical purposes through exploring the potential for the relocation of administrative and storage functions off site at a lower cost, or through digitalisation.
- Identifies where buildings are surplus to requirement for all partners and investigating there potential for use across the borough before disposing of assets.
- Ensure any changes are beneficial to patient access and do not exacerbate health inequalities. This will include reviewing recommendations within CQC reports and instigating improvements to ensure that premises are fit for purpose.
- Maximise the use of space through exploring with partner organisations how space can be reconfigured to deliver maximum value to the public sector and improved facilities for patients.
- Ensures the maximisation of digital technology to facilitate patient care.

4.4 GP list sizes

Ashford current spread of list sizes by building (not practice) ranges from 1,000 for the smallest to 21,000 for the largest. The CCG ambition is to move to list sizes of 8,000 plus per practice. 7 GPs currently have a list size smaller than 8,000. It is noted that it is part of the primary care strategy to determine the optimal list size range and the primary care patient offer. When this has been decided an estate assessment may be needed if the plan is to follow the ambition, as current GP estate will not be able to accommodate such list sizes. Rural practices might not be sustainable at the targeted level so the CCG need to consider how the policy is applied in rural areas.

Current GP building list size	No.
GPs > 5,000	3
GPs - 5,001 - 8,000	4

GPs - 8,001 - 15,000	6
GPs - 15,001 <	2

3.4 The Current Estate

The current estate within Ashford CCG area comprises the following;

Ashford Borough Asset Overview	
1	Acute Hospital
0	Community Hospitals
3	Health Centres
14	GP Practices

Borough of Ashford Asset Overview

The configuration of estate will form a significant part in understanding where we are now and where we want to be in the future, and this section provides a more substantial breakdown in understanding the location, quantity of estate and its dispersion throughout Ashford. This will help inform decisions about key estate, which will be addressed later on in the document. Note, NHS services are also provided from pharmacies, dentists and opticians but the are not considered in this document.

The GP estate in Ashford is privately owned, leased or leased from NHSPS. Building surveys were carried out by an independent surveyor and the results of these surveys identifies that in the main the primary care estate is in a good condition but the age profile suggests an investment programme be developed to address issues driven by age.

The surveys which have been rated on a High, Significant and Low risk rating have been translated into a Red, Amber and Green scale respectively. Figure 4 identifies Red and Amber sites i.e. properties which should be regarded as High or Significant risks which fail to meet statutory compliance.

The GP, under their contract, is required to provide suitable and compliant premises from which to deliver services. Where they fail to do so the properties fall into disrepair and are no longer fit for purpose. The CCG needs to ensure it does not take on additional liability than it needs to and must drive best value out of investment being, made through rental payments and improvement grants. The CCG must drive this by ensuring its contractors are doing what they have committed under their contract. Breach notices can and should be issued where the facilities are poor and sub-standard. It is also important that the leases are managed effectively.

All premises investments must be subject to the achievement and maintenance of minimum premises standards in line with Premises Cost Directions.

Cluster	Address	Tenure	Age Profile	RAG Rating	NIA m2	List size 01/07/17	GP Estate
Urban	Sydenham House Medical Practice	Leased			614	13324	Post 1998 purpose built new generation primary healthcare premises. Clinical rooms on the ground floor; administration on the first floor. The building is DDA compliant. The surgery specification is 20 years old and some fixtures and fittings no longer meet the more demanding current infection control standards. On-site parking for staff, visitors and patients.
Urban	Musgrove Park (Branch of Sydenham)	Leased			186	7322	Pre 1998 purpose built surgery premises. Principally single storey accommodation with loft storage area. Well maintained and improved premises but further planned upgrading of the clinical rooms and reception is required. DDA compliant except in respect of a disabled car parking space in the surgery car park. Local amenities are a short distance from the surgery including additional car parking adjacent to commercial premises.
Urban	Kingsnorth Medical Practice	Leased			751	11797	Post 1998 purpose built surgery premises. New generation primary healthcare centre. Generally DDA compliant. Barn style one and one half storey accommodation. Continuous planned programme of improvements have kept the premises and facilities up to date. Close to public transport links. Developed by G.P Premises Ltd. Premises are in flood plain which may limit expansion potential.
Urban	Singleton Health Centre	Leased			174	7838	Pre 1998 purpose built surgery premises. Single storey accommodation which is intensively used. Some clinical rooms have been partly refurbished but the remainder of the surgery is in need of a general upgrade and improvements. Adjacent to the local centre car park which is available for users of the medical centre. The surgery received an increase in the patient list following the closure of Singleton Surgery opposite.
Urban	Stanhope Surgery (Branch of Singleton Surgery)	Owned			102		Non purpose built converted and extended (1990) small surgery premises. Clinical accommodation on ground floor; administration or vacant rooms on first floor. Limited improvements have been undertaken over a prolonged period and the accommodation is poor and now requires upgrading or disposal. Low list size. Limited on-street parking only. Garage excluded. Public transport links are close by.
Urban	South Ashford Medics	Leased			653	8842	Post 1998 purpose built new generation primary healthcare centre. Full range of primary care, community and dental services. Fully DDA compliant. Local transport links to Ashford town centre are close-by. On-site car parking for staff, visitors and patients. Development by Assura PLC, leased and managed by NHSPS
Urban	Willesborough Health Centre	Owned			514	14107	Pre 1998 purpose built surgery premises (1993). Clinical accommodation on ground floor; administration on first floor. No lift. Older style surgery premises with some recent upgrading to nurses clinical rooms. Further upgrading to floor coverings are proposed. More significant plans to extend the first floor accommodation and reconfigure the ground floor area. Limited on-site car parking with additional car parking on an adjacent site. Local transport links are close by.
North	Hollington Surgery	Leased			166	3503	Non purpose built converted surgery premises. Two storey building not fully DDA compliant. Twenty year old conversion with only minor improvements undertaken in the intervening period. Now in need of a major upgrade to the facilities and the fixtures and fittings. No Lift. Transport links are within short walking distance from the surgery. Town centre is approximately 200 metres. Limited on-site car parking.

Cluster	Address	Tenure	Age Profile	RAG Rating	NIA m2	List size 01/07/17	GP Estate
North	New Hayesbank Surgery	Owned			912	17439	Pre 1998 purpose built surgery premises (1988). Multiple extensions have been undertaken including a recently completed two storey extension part funded with a MIG. The building is DDA compliant and generally modernised and maintained to a good standard. Some older clinical rooms remain to be upgraded. Ample car parking available.
North	Sellindge Surgery	Leased			413	4883	Post 1998 purpose built surgery premises. New generation primary healthcare centre. Modern facilities throughout. DDA compliant. Public transport links are a short walk.
North	Wye Surgery	Owned			576	8692	Pre 1998 purpose built surgery premises. Two storey building not fully DDA compliant. Well maintained surgery with evidence of a planned maintenance programme. However, the older design and specification is of its time and some areas of the surgery require an upgrade to the layout, fixtures and fittings to meet current standards. No lift. Car parking for staff visitors and patients.
Rural	Charing Surgery	Owned			613	9812	Pre 1998 purpose built surgery premises.Clinical rooms on ground floor; administration first floor. One and one half storey accommodation. Largely DDA compliant. Modern surgery premises with integral pharmacy. Busy practice with growing list. Large car park.
Rural	Hamstreet Surgery	Owned			491	7186	Pre 1998 purpose built surgery premises. Extended 1994 and 2011. Modern two storey extension with clinical rooms and meeting room. Older part is principally used for administration, dispensary and staff facilities. Further proposals to extend and alter the accommodation to facilitate training places. The surgery car park is shared with the village hall. Additional staff car park located close by.
Rural	Ivy Court Surgery	Owned			439	14194	Pre 1998 purpose built and extended surgery premises. One and one half storey accommodation. Some limited upgrading of the accommodation. Various extension have resulted in a difficult layout with four stairs to first floor but no lift. Substantial proposals to extend the accommodation at first and second floor together with additional upgrading to clinical rooms and DDA compliance. Transport links, shops and services are a short walk.
Rural	Woodchurch Surgery	Owned			317	3950	Pre 1998 purpose built surgery premises. Single storey accommodation extended from the original. Older style layout and fixtures in the reception, waiting area and common parts. More modern extension with clinical rooms to the side. Well maintained throughout. OFCH. Large car park is full at busy periods as public transport services are limited. Serves large rural area.
					7133	132812	

Group 1	Non purpose built converted surgery premises
Group 2	Pre 1998 purpose built surgery premises
Group 3	Post 1998 purpose built surgery premises

3.5 Individual GP premises assessment

In consultation with the GP federation, the impact of population growth on individual practices has been considered and its impact on space and cost of new space assessed. No assessment of asset productivity has been included or other suggested methods of increasing clinical space such as by moving out administration functions and ensuring optimum opening hours. As such the comments below are observation: they may require agreement from third parties and will need to develop a feasible and financially affordable / viable project for the CCG to support. By their inclusion in this paper, no suggestion as to the underwriting of rent by the CCG is intended without a full review of the project and its finances in line with CCG governance processes.

Premises assessment

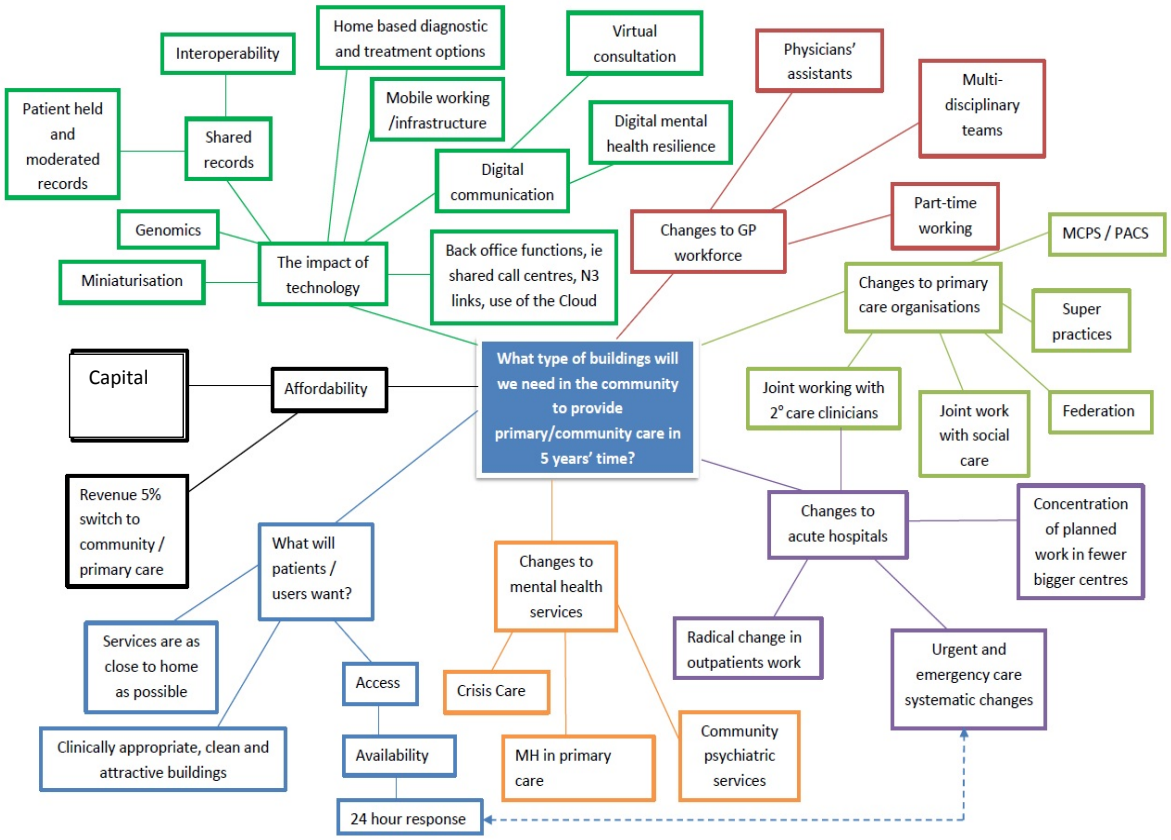
Sydenham House Medical Practice. The population growth between the two practices is estimated at 3489. This equates to 291m2 and an estimated cost of £640,200 plus project costs. The premises have development potential. The current ration of patients to space is high so additional space is necessary.
Musgrove Park (Branch of Sydenham). Heavy current space pressure suggests extension be scoped and implemented.. Need to determine how much extension can be built.
Stanhope Surgery (Branch of Singleton Surgery) No changes required but the list size is small and premises poor so closure should be considered.
Kingsnorth Medical Practice This practice expects a population growth of 3323.). Potentially, and without other productivity assessments this could generate a space need of 277 m2 (estimated cost £609,000 plus project fees). Any extension would necessitate addressing the current flood plain issues, the current ownership arrangements and extending the current lease.
Singleton Health Centre The population increase assigned to this practice is 213 which would require 1 additional clinical room, although it may well be able to be absorbed as is.productivity study to assess.
South Ashford Medics A significant population growth of 4327 equates to 361m2. The building has limited expansion potential but is a large building and rooms could be converted to primary care. A productivity review of the centre is urgently required.
Willesborough Health Centre The population growth impact is significant (4528). Potentially, and without other productivity assessments, a space increase of 377m2 may be required, estimates cost £830,000 plus project costs. However, there is only limited scope for extension so a review of existing space use is essential. Patient per sq m ratio is high.
Hollington Surgery The allocation of growth suggests that an additional1968patients could register at this practice, 164m2 additional space. However the premises are RED rated and not capable of extension. The population growth will have to be absorbed by other practices in the boundary area. .
New Hayesbank Surgery The population impact is expected to be 4062 people. The site has recently been estended and so should be able to address this growth.
Sellindge Surgery The population increase assigned to this practice is 204 which would require 1 additional clinical room, although it should be able to be absorbed as is. However the Otterpool park development may require a different solution.
Wye Surgery A small extension (37m2) would allow the increased population forecast of 449 to be treated, estimated cost £81,400 plus project costs.
Charing Surgery The population impact on Charing Surgery is expected to be 2232 people. The premises have been extended to cater for 10,000 patients and current list size is 9812, The site has the potential for extension and growth and to deliver r other services. An extension of circa 200m (est cost £410,000 plus fees) is needed just for primary care growth.
Hamstreet Surgery Although there are no firm plans at the moment, do have the potential to expand above on part of the premises. There has been a recent expansion and the population increase for the practice is assessed as 732 which should be absorbed in the existing footprint..
Ivy Court Surgery This surgery has a very high patient to area ratio and needs expansion to cope now but with the population growth (2422 people) and additional 202m2 is needed. A project to extend above the existing surgery will add approximately 600m2 to the building and is being funded though NHS England capital funds. The scheme will take the existing occupants of East Cross Clinic leaving that building vacant. This could be used as a Hub for the Rural cluster (subject to refurbishment and internal redesign) or if not needed, sold. This is the priority scheme for the CCG
Woodchurch Surgery The premises are pretty much at capacity now, so with the historical patient growth pattern of the past ten years and projected growth they will be needing support to extend the premises to meet the anticipated future demand of current service provision and the additional demands of services being passed down from secondary care and the district nursing service. However the forecast population growth is only 59 people so no action is recommended.
New development at Chilmington This will be built under s106 funding and is 1000m2 in size, serving 5750 patients. The CCG must consider how it manages the patients prior to development being ready.

There will be additional rental implications for the suggested extensions which will affect CCG revenue. Increases in rateable values are also likely and potentially clinical waste costs.

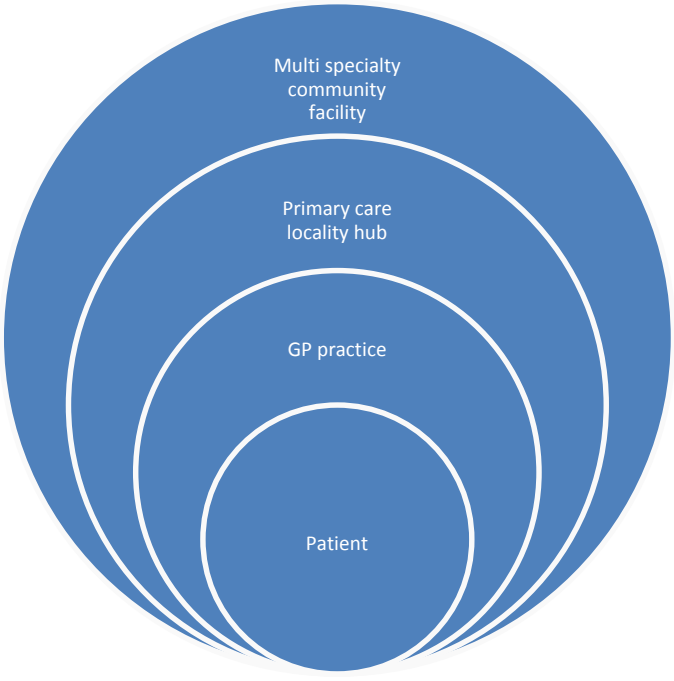
Double running costs whilst projects are being developed are likely.

3.6 Local Care Shift estate strategy: transforming service change

Hubs are a stated priority and this paper estimates at least three hubs will be required to serve populations of circa 30,000 - 50,000. There is no capacity in the local primary care estate.



Hubs will be either multi-speciality community facilities or primary care locality hubs. This section addresses the MSC issue. GPs are already working as care locality hubs in several cases.



Potential ways to achieve the MSC hub development are:

Rural Cluster

- Use of East Cross Clinic for rural cluster, redesign and possible extension funded by S106 contributions. This removes void liability.

North Cluster

- Enter discussions with East Kent Hospitals NHS Trust to look at utilisation of estate on William Harvey Hospital site that can be converted for local care use. Target S106 funds to achieve conversion.

Urban Cluster

This is the priority area with the highest population and no suitable estate.

- Preferred option: That the Court Lodge development is used as an enabler to allow space for a 2000m2 standalone MCP hub with expansion potential and s106 monies from Chilmington to be diverted so this Hub would service the Primary and local care needs of both Court Lodge and Chilmington populations. This would require identification of around 3 acres of spare land
- Option 1: extend the agreed development at Chilmington Green by circa 1000 sq metres to facilitate integrated care solution whilst delivering local primary care needs. Potential additional funding from Court Lodge development (as yet not negotiated) section 106 agreement.
- Option 2: negotiate S106 for Court Lodge on same basis as Chilmington and move S106 funds from Chilmington to help fund development of circa 2000 sq m.
- Option 3: work with local authority to secure land and move S106 from both developments to fund new centre
- Option 4: dependant on environmental survey utilise Court Lodge funding and other S106 contributions and redevelop Kingsnorth practice
- Option 5: explore opportunities to co-locate healthcare services with other public sector bodies and services, such as the LA, as per One Public Estate principles
- Option 6: explore opportunities to convert existing public assets to hubs
- Option 7: Explore with local authority potential for funds to build centres and lease back

To develop these options, an option appraisal process with key stakeholders is necessary

It must be noted that this will have significant capital, revenue and project management implications for the CCG, which has not undertaken a project of this size previously. Revenue from services currently provided in a hospital setting will need to be freed to help fund the premises. A new hub build would be around 2500 m2 and cost £3,500 per m2 to construct. Running costs are around £700 m2.

This is a key work stream that must be managed as strategies firm up. Decisions on locations, service make up, number are crucial to facilitating service change. The projects are multiyear and need to start imminently.

3.7 Clusters

The Kent & Medway Sustainability Transformation Plan describes practices working closer together in alliances along with social care, community NHS and acute NHS clinical staff and services. To this end practices have grouped themselves into three connected hubs for shared working arrangements – Ashford North, Ashford Urban and Ashford Rural.

- Ashford North includes: Hollington Surgery, New Hayesbank Surgery, Sellindge Surgery and Wye Surgery.
- Ashford Rural includes: Woodchurch Surgery, Ivy Court Surgery, Charing Surgery and Hamstreet Surgery.
- Ashford Urban includes: Sydenham House Surgery, Willesborough Health Centre, Singleton Health Centre, Kingsnorth Medical Centre and South Ashford Medics.

The following premises have development potential in terms of land available for development:

3.7.1 URBAN CLUSTER

- Sydenham House Surgery
- Musgrove Park (Branch of Sydenham House)
- Kingsnorth Medical Practice (subject to environmental advice)
- Willesborough Health Centre
- St Stephens Health Centre (South Ashford Medics)

3.7.2 RURAL CLUSTER

- Charing Surgery
- Ivy Court Surgery
- Woodchurch Surgery

3.7.3 NORTH CLUSTER

- Wye Surgery
- Sellindge Surgery

Further potential for increased clinical activity include:

- Ensuring extended opening hours
- Productivity review of rooms and how they are used
- Movement of admin staff to leased office space and conversion of freed to clinical space

3.8 Community Premises

East Cross Clinic, Tenterden	Health Centre	Purpose built health centre; occupies site adjacent to Ivy Court GP surgery. Long term hold. Very underused and void costs apply. Potential hub
Vicarage Lane Clinic, Ashford	Health Centre	1980s purpose-built health centre. Long term hold. Review of use and potential use as hub.
St Stephens	Health Centre	Purpose built health centre. Primary Care and other services. Review of use and internal service plan to generate more clinical activity.

3.9 CCG Headquarters

The CCG HQ building is located at Inca House. The building is leased by NHS PS, The CCG has undertaken an options appraisal to review its HQ base and the most cost effective solution. As a result notice has been given to vacate the premise in September 2018 and relocate to Canterbury and Ashford Council premises.

4. Challenges and Opportunities

The NHS and in turn the CCGs are under financial pressure to ensure that the health estate is rationalised and that assets are maximised to their full potential. This will present a number of challenges as well as opportunities to improve the functionality of the estate in line with the service strategy.

Engagement with the key stakeholders in the borough has led to identification of the challenges and opportunities that Ashford faces. Identification of these will enable the chance to address these issues and act on the opportunities that arise.

Challenges	Mitigation
Growth scenarios still being developed for the Ashford growth strategy but will cover the next 30 years	Maintaining a constant dialogue about long term housing development and population growth through the Local Estates Forum with relevant stakeholders
Monitoring the proposed housing developments over the next 30 years and ensuring S106 and CIL opportunities are captured	Maintaining dialogue with Ashford Council's planning and development department.
Not knowing what accommodation (particularly clinical) is available.	Development of shared estates database that can be accessed by all stakeholders.
How to create an effective system that allows different organisations to share flexible space and facilities effectively.	Develop / invest inroom booking system, which potentially can be rolled out across Ashford.
Lack of capital investment for development/reconfiguration	Local Estate Strategy will set out improvement that can be applied for though NHS England capital funding or private finance
Large number of stakeholders	Maintain the Local Estates Forum and ensure all stakeholders, remain fully engaged.
Constraints of leases and budgets	Working with the NHSE, creating a flexible lease framework for service providers.
Population distribution and health inequalities	Ensuring Health hubs are accessible for all
Lack of transparency within each agency	Creating local estates meeting with key stakeholders on a regular basis to encourage engagement.
No facilities capable of housing out of hospital services	Option appraisal and working with LA
Under investment in core primary care could act as disincentive to grow list sizes	Revise investment strategy for primary care
National NHS workforce crisis removes ability to staff services	Work with NHSE on recruitment initiatives

4.1 Estates and technology opportunities

- Maximising the use, and realising the benefits, of digital technology which will include data sharing across and within the health economy, digitalising records and enabling practices to work in different ways to maximise the available estate, allowing absorption of growth, and improving

patients' experience and outcomes. The Local estate strategy will set out to create meaningful forums to discuss needs and match with capacity.
- Improve the use of clinical rooms in all key estate.
- Engage in cross boundary discussions to ensure that the need for health services is met in the borough.
- Create a hierarchy of services – decide what we want, how we provide it and where.
- Creating one voice for the estate.
- Look at other boroughs where success is evident, in terms of technology, estate strategy and patient care.
- Co-locate services where possible and sensible.
- Create a system for all health estate and wider public estate so that organisations have the opportunities to share, swap and borrow buildings
- Dispose of single service sites over time and where sensible.
- Identify any existing leases where there is poor value for money.
- Rationalise branch sites where possible and it is in the best interests of the population and value for money.
- Maximise the use of Ashford's health facilities and ensuring all sites are fit for purpose, DDA and CQC compliant.
- Map, collect and maintain real estate information across the estate.

4.2 The Estate Challenges

This section focuses on regeneration and population growth and change. The future estate will need to accommodate an increasing demand for services resulting from population growth and demographic change. The development and regeneration of areas provides site opportunities to modernise and rationalise the estate. The planning system can help identify future health infrastructure requirements and secure financial contributions from developers in the form of section 106 and Community Infrastructure Levy (CIL) to mitigate the impact of development.

The STP estates group have stated that the role of estates is to identify way of achieving best value and to consider the accommodation required to support new ways of working in health and social care. In Ashford this is driven by two factors: increased capacity in primary care due to population growth and capacity for shift of services from acute to community.

The initial assessment confirms that the current GP estate is in relatively good condition. What is also clear is that Ashford will be part of a major population growth over the next 10 years at the same time as the way health is provided will change to cope with increased financial pressures and patient needs. Ashford is a mix of town and rural locations and this will affect the estate solutions proposed.

The care models are becoming more integrated across health and social care with the GP still in the centre providing access to care for their patients. With the evolving health landscape the estate has to be flexible to be able to adapt to changing needs and future partnerships. How the estates supports new service models will therefore be reviewed on an on-going basis.

The primary care estate is a vital part of the health estate infrastructure in the area and the CCG is committed to ensuring that, under the GP contract, contractors deliver premises which are fit for purpose, compliant, provide sufficient capacity to respond to population growth and align with national and local commissioning priorities.

This will identify where investment in the primary care estate infrastructure is needed in the future. This assessment will take into account planned investment via the creation of Out of Hospital Hubs, the NHS England capital and Section 106/Community Infrastructure Levy opportunities.

The key criteria identified nationally, and supported locally, for investment in primary care premises are:

- Improved access to effective care
- increase capacity of Primary Care
- enable access to wider range of services to reduce unplanned admissions to hospital
- increase training capacity in general practice
- support the delivery of the Out of Hospital Strategy and delivery of community based services as part of the CCG commissioning intentions

In addition to increasing demand and changes to service models, the estate also has to meet quality requirements and be viable over the medium to long term for care delivery.

The aim is to have a fit-for-purpose and efficient estate, which provides value for money with increased sustainability and facilitates flexible working. A dual approach to maximising the estate is needed, simultaneously improving the quality of current estate where needed and taking forward a capital programme to future proof the estate.

The required estate is thus defined by the implications of service moves to community, the population growth over the next decade and the significant increase in elderly population.

The population growth is primarily in the Ashford Urban cluster and it is this area that requires the significant increase in estate.

A rolling capital programme for upgrade should be considered to support GPs in their contractual liabilities.

Work has gone into understanding the future demand over the coming 15 years. This identifies areas of focus that need to be assessed further as a priority.

Decisions about new models of care or the introduction of new technologies will impact on the estate needed, and the Estates Strategy and Implementation Plan will have to be revised and go through a re-iterative process to establish the final programme of interventions.

Options for hub development to facilitate shift of local care are urgently required. This is of fundamental importance if service delivery is going to be transformed.

4.3 Future footprint needed vs void

The additional footprint needed based on the projected figures has here been mapped to known void space.

5. SOURCES OF INVESTMENT

The Local Estates Strategy seeks to coordinate and make best use of all available funding for premises development. This includes the Estates and Technology Transformation Fund (ETTF) (previously Primary Care Infrastructure Fund (PCIF) and Primary Care Transformation Fund (PCTF)), NHSPS customer and landlord capital, NHS Trust capital investment, and developer contributions in the form of Section 106 contributions or CIL and private finance.

To some extent additional demand can be accommodated within the existing estate by using the estate more effectively, but are demand hotspots where new investment is needed, particularly in the Opportunity Areas.

5.1 Section 106 contributions / Community Infrastructure Levy (CIL)

Prior to the introduction of the borough Community Infrastructure Levy (CIL), s106 health contributions were routinely secured from planning applications.. Future contributions may be received as developments commence and are completed. The process for securing funds has changed and investment proposals are now required. NHS England receive the funds and then the case for draw down has to be made. It is important to demonstrate that the proposed project can be fully funded.

To facilitate developments management of section 106 and CIL funding is essential.

S106 is agreed for the Chilmington development.

Note: a temporary solution is required at Chilmington as the project is not triggered until 1800 homes is reached.

5.2 The Estates and Technology Transformation Fund

The Estates and Technology Fund (ETTF) is a multi-year £1billion investment programme to help general practice make improvements, including in premises and technology. It is part of the additional NHS funding, announced by the Government in December 2014, to enable the direction of travel set out in the NHS Five Year Forward View.

Stronger GP services are the cornerstone of delivering a new deal for primary care and this fund is designed to accelerate investment in infrastructure to enable the improvement and expansion of joined-up out of hospital care for patients. Alongside programmes like the GP access Fund, it will support new ways of working that are needed to deliver a wider range of services and a new deal for primary care.

Ashford has one scheme funded, Ivy Court Practice.

5.3 NHS England Capital

This can be bid for and is subject to business case review and approval.

5.4 Private Finance

Third party developers are available to design, build, finance and in some cases operate new premises subject to agreement on rental payments.

Where investment is going to be required, feasibility studies need to be commissioned and subsequently project teams need to be formed. Project Initiation Documents (PIDs) need to be approved and the

business case process should be commenced with a view to providing facilities on time to meet the increased population's needs..

The business case process is set out in the NHS England, Business Case Approval Process – capital, investment, property & ICT guidance. It will require early engagement with NHSE, Projects Appraisal Unit PAU), who assure property and ICT investment business cases for the NHS England Board, prior to approval.

All cases at each key stage (e.g. strategic outline case (SOC), outline business case (OBC), full business case (FBC), as appropriate are required to adhere to the principles of best practice set out in the HM Treasury Green Book, the Capital Investment Manual and the (DH 1994) and NHS Estates Code (DH 2007).

As this process can be lengthy, the CCG and its partners need to plan ahead and engage with key stakeholders. Essential to this process is early knowledge of development proposals and an assessment of their likely impact on health services in that ward. Horizon scanning and placing of markers with the Local Authority that additional facilities may need to be provided is essential. Also, markers should be placed in estates strategies and with NHSE PAU to highlight future funding requirements.

The financial resources currently known to be available to the CCG will include:

- S106/CIL monies: The CCG is able to apply for health contributions for all new housing developments through a section 106 agreement by way of an application to the local planning authority in order to meet the primary medical services needs arising from new populations. This is done by evidencing the impact arising from the development on primary care provision. This requires consistent engagement with the Local Authority.
- For Chilmington Green (5750 homes), a section 106 agreement is close to being finalised with a value of approximately £4.8 million that will provide 1000 metres square of space to provide 6 GP consulting rooms.
- For Finberry (1100 – 4300 homes) the section 106 agreement was approved back in 2002 with an approximate value of £3.6 million that will provide land of 600 m2 and building for the provision of primary health care.
- For Court Lodge Farm (950 homes) no formal discussion on health contributions have taken place and will commence as planning applications start to come forward. Similarly land North of Steeds Lane and Magpie Hall Road at 400, which will probably progress at different rates and other sites e.g. Land North-East of Willesborough Road, Kennington with 750 homes Conningbrook, Kennington 600 homes. The CCG needs to manage engagement on all major sites.
- Where a section 106 investment has been secured to provide a healthcare facility for new populations, alternative sources of NHS funding will not be released to meet the same population need.
- For new populations such as those highlighted, the CCG will need to engage local practices whose boundaries cover these locations to commission primary medical services for these new communities
- NHS England capital funds subject to viable and affordable scheme development
- Redistribution of current rent and rates payments from premises relocating/closing
- Ensure tariff funding shifts with services and monies secured from the commissioning of out of hospital services i.e. moving PBR funds from acute to community. This is essential to fund estate required by local care shifts
- Increase capitation payments following increased population must happen but the time lag needs urgent discussion as up front funding is needed
- The work in this document is theoretical unless agreement is reached with practices to actually increase list sizes.

6 ESTATE DEVELOPMENT

The realisation of the full vision (and specifically a high quality estate) is a continuing process, requiring on-going and progressive estates improvements over a number of years and benefitting from some or all of the following principles:

- Opportunities to maximise use of current estate in the networks and/or localities.
- Opportunities to co-locate healthcare services with other public sector bodies and services; notably Local Authorities, to achieve more efficient use of the public sector estate as per the One Public Estate Programme
- Opportunities to rationalise the healthcare estate through co-location and/or consolidation of healthcare services.
- Out of hospital estate is funded by the in hospital tariff.
- Disposal of inefficient or functionally unsuitable buildings in conjunction with estates rationalisation. Capital is likely to be taken nationally but revenue savings will stay locally
- More efficient use of buildings through improved space utilisation.
- Innovative approaches to the delivery of healthcare services reducing demands on the healthcare estate, e.g. use of technology.
- Only invest in substantial capital development works where these are supportive of strategy delivery.
- Only undertaking new build where opportunities to rationalise and/or maximise use and efficiency of the existing estate have been realised or where such developments deliver a whole life cost saving versus continuing use of the current estate.

All sites should be initially assessed for investment on the basis of the emerging NHS England criteria as follows:

- Increased capacity for primary care services out of hospital,
- Commitment to a wider range of services as set out in commissioning intentions to reduce unplanned admissions to hospital,
- Improving access to effective care,
- Increased training capacity.

Other investment criteria to include are:

- Evidence of patient involvement,
- Consistency with the local estates strategy,
- Clear identified need,
- Sustainable in the long term,
- Flexible design.

Additionally consideration could be given to the following complementary criteria for analysing premises for investment.

- Good geographic location to support growth areas,
- Good public transport accessibility,
- Statutory compliance – including access to and around buildings,
- Fit for purpose and capable of being ICT enabled,
- Capacity to co-locate integrated services into multi-use accommodation,
- Functionally suitable, good quality, flexible accommodation,
- Sustainable premises capable of working at scale,

- A minimum patient list size.

Consideration could then be given to exit those sites that do not meet the above criteria if and when alternative facilities are available. However, Hospitals are considered fixed points and must be secured for the population. Therefore, if any review shows under-utilisation, on these sites, the services will be expanded to maximise use.

6.1 Outline Estates Strategy – what we will do

Model	Secondary	Local care shift	Primary	Admin
ESTATE TO REDUCE/ EXIT				Inca House to be vacated mid 2018
ESTATE TO INCREASE		Provision of new hub(s) to provide out of hospital services Fill existing voids	New primary care provision; possible extension to existing practices Chilmington Green development Potential Tenderden reconfiguration/extension Subject to viable scheme being achieved in timeframe	CCG to explore options to relocate HQ
ESTATE TO OPTIMISE			Utilisation reviews of GP practices to explore potential underused capacity Use of void space by local care shift	

6.1 IMPLEMENTATION PLANNING

Delivering the strategy will require ACCG to share its vision and undertake further work practices and other stakeholders to secure change, ensuring full patient and public engagement at the same time.

The strategy assures alignment to the geographical and demographic need of the population. The improved facilities will enable services out of hospital to be commissioned, increasing the range of diagnostic and community services to be available more locally.

ACCG will need to identify resources to take forward the change agenda and secure the estate that will enable delivery of care well into the 2020's

The implementation plan has been developed to ensure the health economy in Ashford is supported by a fit for purpose estate over the next 10 years. The Estates Strategy and Implementation Plan is a constant work in progress and will need to be considered when major changes happen to care models and introductions of new technologies take place.

• 2017/18	• 2018/19	• 2020+
• Revised estate strategy Mar 2018 with primary care additions	•	•
• Notice given on Inca House •	• CCG HQ relocation •	• •
• PID and business case development •	• Development of projects •	• Construction / occupation •
• Understand impact of local care shift	• Hub development potential	•

6.2 Short Term Work Plan

1. Development and implementation of primary care estates strategy; identify all future hubs and service reconfiguration required to enable new models of care.
2. Support for all other new models of care planned for the system using infrastructure as an enabler.
3. Ensure all fixed points in the system are fully occupied and utilised
4. Productivity and utilisation assessments of key sites
5. Every NHS PS building to be statutory compliant with agreed programme of landlord works if needed; Vicarage Lane, East Cross, St Stephens
6. Buildings identified for disposal or lease surrender to be disposed of in a timely manner and void charges to cease such as Inca House
7. Liaise with the council to overlay health and other public sector estate to identify further opportunities for integrated care and estates optimisation.
8. Feasibility study across Ashford to firm up accommodation projections made in this paper for GMS
9. Demonstrated that the scheme meets the strategic plans of the local commissioners, in particular , addressing the provision for new and extended growth plans for the area
10. The availability of section 106 contributions need to be explored and the use of any available funding verified and built into the plan, identifying how each investment pot will be used to the benefit of primary care across Ashford
11. Undertake a detailed piece of work to ascertain the S106/community infrastructure levy health contributions that have been secured, are still being negotiated and where discussions are yet to commence.
12. Confirm the section 106/community infrastructure resources available,
13. Identify development areas within local plan where s106/CIL resources still need to be negotiated (such as Court Lodge Farm).
14. Review the terms of each section 106/CIL Agreements their attached conditions and ascertain commercial flexibility to reconcile with options
15. Proposals then need to come forward as to where the S106 investment should be directed across Ashford CCG area to mitigate planned growth and the impact on primary medical services.
16. Engage with the developers and Ashford Borough Council to propose alternative development options, timing and preferred procurement route to enable best value recurring revenue costs.
17. It is also anticipated that there will be a clear link with the STP estates stream, a link with NHS Property Services estate and an indicative premises disposals list.
18. Identify where further feasibility work is needed on key growth areas if not covered by section 106/CIL agreements.
19. Assist Ivy Court practice in development of scheme for NHS England capital funds by end March
20. Individual practices/groups of practices will then make proposals on contracting routes that will be explored and provide proposals for testing and confirming the right solution. This will include occupancy arrangements, tenures/lease length and management, break clauses, NHS design and specification
21. Need to secure new HQ, negotiate lease and manage move from Inca House.

6.3 Ongoing medium and long term work plan

Ongoing medium and long term priorities:

1. Impact of acute reconfiguration on local care shift and community estate
2. Regeneration/housing growth
3. Use of technology and agile working to further optimise estate
4. Work with the local councils to reduce public sector estate across each borough and identify any potential for co-location which may lead to rationalisation

6.4 Workforce

- Similar to the finance point made above, a workforce strategy is required to ensure sufficient staffing resources as available to manage the additional care required. This will need close liaison by CCG and GP Federation.

  ACCG will need to consider resourcing an estates lead who will:

- Lead the implementation of the strategy with stakeholders, support PID and business case development and the procurement of schemes – possible access to finance. PIDS and business cases will be to implement CCG strategy
- Manage STP estate engagement and ensure Ashford strategy is reflected in this work
- Receive and review applications for estate and technology transition funding against the strategic direction set out in this strategy
- engage with stakeholders
- engage with residents and practices' communities,
- review practice delivery against the quality framework to ensure practices are meeting their contractual targets
- offer guidance to practices for developing PIDs and business cases for schemes with ACCG agreement

6.5 Enablers of change and managing constraints

- Analysis of data from the 6-facet and utilization surveys
- Undertaking the surveys of the condition of GP premises, whether there is underutilised accommodation and whether there is a potential to extend/develop will provide clarity for investment priorities. It will also provide information on where additional out of hospital services may be offered.
- NHS Ashford Clinical Commissioning Group must remain responsive to evolving Government policy and initiatives and to patient need when commissioning future health services. It would be the intention of the NHS to secure development monies via Section 106 agreements where provision relates to a localised need or as identified through the site allocations in the Local Plan. Alternatively the NHS would seek to secure Community Infrastructure Levy receipts to deliver strategic health provision across the borough..
- NHS Ashford CCG would like to enable planning permission and s106 investment (or CIL where appropriate) to be granted for
- The provision of new purpose built primary health care facilities (hubs) on suitable sites where this would not conflict with other policies in this Plan. This may also include the provision of back office functions that support the provision of primary medical services at scale.
- The refurbishment, extension or mergers of general practice.
- NHS England capital funding (subject to viable scheme submission)
- Development of GP locality hubs

- Fundamental to the strategy is the development of larger premises that can support the delivery of a wider range of services to a population.. The CCG will need to work through the constraints and concerns of smaller practices not wishing to connect or relocate to larger locations, through available commissioning routes and funding opportunities. This may be using:
- Identifying levers to 'encourage' relocation
- Encouraging occupiers of one premises share limited resources across a wider patient base
- Providing the patients with information on how and where to access services, which may encourage change
- Workforce development and enlargement in context of National workforce situtaion
- Management of disincentives to grow list sizes

6.6 Risks and Mitigations

Risk	Mitigation
Lack of capacity and estates expertise to further the agenda	Procurement of estates and project management expertise
National economy and housing market	No mitigation identified
NHS funding – changes in priorities	No mitigation identified
Inadequate and poor data	Work with partners to make data as up to date and reliable as possible
S106/CIL contributions	Ensure good, consistent engagement with Ashford LA to ensure health requirements are fed into local development plan. Map existing contributions status, develop process maps for management of same.
Failure to obtain engagement for the long term CCG ambition for the borough with GPs	Stakeholder management, financial strategy, workforce strategy
Failure to obtain engagement for the long term CCG ambition for the borough with local authority	Ensuring effective shared vision and building on the work of the Health and Wellbeing Board/ public health links
Failure to obtain engagement for the long term CCG ambition for the borough with acute Trust	Need to link with acute Estates strategy Agreement through commissioning on the timescale of relocation and recommissioning of hospital services that will impact on estates requirements
Predicted population growth does not materialise	Ensure that plans include a timeframe that is realistically ahead of the population growth curve and includes options for alternative temporary use of facilities by other stakeholders
Poor engagement from providers	Ensure strong leadership and buy in from all parties to the value of working together
Lack of capital funding	Explore all routes, support GPs in business case development
Lack of project development funds	Seek project support from NHSE
Unable to attract a sufficient and effective primary care workforce as nationally there are predicted shortages of GPs and practice nurses	Ensure training opportunities within practices are maximised, recognising GPs often practice from where they have trained

	Work with universities to encourage nurses to undertake APN roles and support the backfill Subsidise training programmes
Building not operated to maximum effect and no incentives to drive utilisation though building management	Implement processes so that estate is managed and maintained through a shared overarching asset management system using an agreed programme methodology; created in collaboration with healthcare service providers and estate asset owners and operators; governed by the Ashford CCG.

7 GOVERNANCE

An Estates Strategy and Implementation Plan is always a work in progress and will have to be considered as and when new service models are introduced or delivery improvements such as technology introductions are made. It is the role of the governance framework to oversee and manage delivery effectively; as well as on-going strategic asset management.

A strong governance structure will ensure all estate needs are assessed holistically and prioritisations are made with the system as a whole taken into account. It is envisaged that all new estate needs are presented to the Local Estate Group in accordance with the Treasury five case model and prioritised in line with the development approaches outlined in section 4.2 of this strategy.

Strong links to be developed to the council's Infrastructure Development Forum to ensure health needs are part of the future Community Infrastructure Levy (CIL) plan.

Figure 7.1 – Outlined Governance

Master Assumptions List

A number of assumptions have been made to draft this SIP. The main assumptions have been listed below:

- Population growth data from LA
- The estates baseline is based on the NHSPS data

8 Glossary

ACCG	Ashford Clinical Commissioning Group
ACO	Accountable Care Organisation
CCG	Clinical Commissioning Group
CIL	Community Infrastructure Levy
ETTF	Estates Technology Transformation Fund
FM	Facilities Management
GP	General Practitioner
GPWSIs	GPs With Special Interest
HQ	Headquarters

JSNA	Joint Strategic Needs Assessment
LA	Local Authority
MCP	Multi-speciality Community Provider
NHS	National Health Service
ONS	Office for National Statistics
PACS	Primary and Acute Systems
S106	Section 106 of the Town and County Planning Act 1990
SIP	Estates Strategy and Implementation Plan
STP	Sustainability Transformation Plan

Agenda Item No: 8

Report To: **Ashford Health & Wellbeing Board**

Date: 18th April 2018

Report Title: Sustainability of Primary Care in Ashford (impact of Growth and Local care shift).

Report Author: Dr Jim Kelly
Organisation: Ashford Clinical Providers Ltd (ACP Ltd)

Summary: Report highlighting the risks to stability and sustainability of Primary Care in Ashford if growth (in population and out of hospital "Local" care) is inadequately resourced and managed.

Recommendations: **The Board be asked to:-**

Note the impending premises, resource, workforce and workload crisis in Primary care which threatens to derail the plans for population and Local Care growth in Ashford.

Support the necessary partnership work with the local GP Federation (ACP Ltd) and the CCG to ensure Primary Care is enabled to meet the additional challenges of population and local care growth and avoid destabilisation of existing services.

Purpose of the report

1. To highlight the risks to primary care stability without extra resource to cope with population growth;

2. The risk to local care capacity without assistance in securing fit for future land/buildings to accommodate the shift of care from hospital into the community.

Background

3. General Practice has long been regarded as the Jewel in the Crown of the NHS and has been the envy of the world in terms of its cost effectiveness.

4. Public confidence in Doctors (and GP's in particular) are consistently highest among all professions and has not waivered to the extent it has it has in other sectors of health and social care.

5. However, nationally, Primary Care (and General Practice in particular) is under immense pressure, like never before. Satisfaction with GP services has in the last year started to fall as a testimony to the fact Primary care is

"creaking at the seams". 90% of all patient contacts take place in Primary care but resources have fallen from 10% of the total NHS budget in 2006 to just 7% last year. GP consultation rates have increased by 40% but (perversely) NHS spend in **secondary** care has increased by the same proportion over this period.

6. The Government have attempted to bolster funding with the GP forward view published in 2016, but the strings attached to this inadequate funding including politically driven aspirations for longer opening hours for routine care have only added to the burden on practices. An additional 5000 new GPs were promised but last year the number of WTE GPs fell again.

7. The "sticking plaster" of GPFV is inadequate to stop the haemorrhage of staff who feel they can no longer work safely with the current unsustainable inadequate core funding and local practices are struggling to recruit and retain staff may carrying unfilled vacancies. The GP Core contract (GMS) is funded at £88 per "weighted" patient per year from this April.

Local Perspective

8. On 20th July 2016 I was invited to speak on how KCCs Public Health department proved that one of our practices managed to save £250 per patient per year in other health and social care sectors by the additional investment of an extra £30 into core GP services through PMS flexibilities. The GMS "global sum" of £88 fails to compensate GPs for providing an unlimited number of consultations with ever increasing levels of demand and complexity.

9. The situation is further compounded for populations with a relatively youthful demographic like tour own Urban Hub (population 63,000) as this "weighting" means only a proportion of the urban practices lists (55,000) will be funded. This (8000 patient) funding "gap" was brought into sharp focus by the plight of one Folkestone practice with a low "weighting" who was recently forced to close its branch surgery.

10. The CCG attempted to disperse its list of only 5000 patients onto the books of neighbouring practices all of whom were already struggling to cope. Even this relatively small increase in list size would have destabilised the surrounding practices and they (en-masse) decided to close their lists to protect patient safety.

11. The CCG was publicly forced to recognise that the current level of core funding (which is paid to GPs quarterly in arrears) was inadequate to incentivise/allow rapid increases in list sizes.

12. All Ashford GP's but particularly those practices in the Urban hub are struggling to cope with current demand and some recent CQC reports bear testimony to this fact. None-the-less the quality of Primary Care provision and recruitment in Ashford practices has been largely maintained by closer inter-practice support though our Federation.

13. The NHS landscape is changing at pace and the current local CCG commissioning functions will soon be subsumed by the GP Federation working in partnership with other NHS providers as part of an Integrated Care

System which can hold local capitated budgets and be accountable for both local commissioning and provision.

14. Our GP Federation is and will continue to be an integral part of the fabric of Local health and Public services. Our Shareholders and Directors are drawn from all 12 practices in Ashford and we offer **only** NHS services to the entire local population.

Further opportunities

15. Ashford Borough Council and CCG have an opportunity to learn lessons from the recent Folkestone crisis and pre-empt this by partnering with our GP federation to find innovative premises and resourcing solutions to ensure Primary Care is equipped to meet both the immediate challenges of population and local care growth.

16. The Federation has been vocal in expressing our vision for the Premises needed to accommodate growth in population and Local care and we have contributed to the CCGs recently developed Strategic Estates and Local Care Plans.

17. We have, however, had little opportunity to engage directly with the borough council and would welcome the Health and Wellbeing board supporting their council colleagues to engage with us now so as not to lose the invaluable "provider perspective" at this critical stage of planning for the future health needs of Ashford residents.

18. We ask the board to encourage and assist the CCG in taking immediate steps to maintain and enhance the current Local Primary care service which is the bedrock of the local NHS but which is rapidly becoming unsustainable.

19. An example of where we feel the borough council need to urgently involve our federation is in addressing the immediate threat to current services arising from the large housing developments on the southern fringe of our Urban Hub, namely Chilmington, Finberry and Court lodge.

20. The council's current local plans for this population growth does not accommodate the necessary shift to Local Care as described in the National NHS Five year forward view.

21. It is the Federation view that using the Court Lodge project as an enabling development, resources from the neighbouring developments could be redirected to provide a standalone parcel of land on which to build bespoke healthcare premises to allow the necessary expansion of Primary and Local Care provision for these new (and some existing) Ashford residents.

22. In fact NHS England recently awarded the Kingsnorth Medical Practice the promise of £3 million of central funding to facilitate such a plan (which unfortunately fell foul of the overly stringent National funding drawdown schedules).

Conclusion

23. It is recognised that over the next 10 years there will be significant growth in Ashford and the pressures on healthcare will continue to grow with increasing risk to the stability Primary Care GMS/PMS provision. We would ask the committee to note that although ACP Ltd in partnership with Ashford CCG have an Estates Strategy, our Federation should be invited to play an integral role in discussions and decisions regarding new housing developments to ensure current and future health premises provision is fit for purpose.

Contacts: Email: Jkelly5@nhs.net
Tel: 01233 658806

Councillor Brad Bradshaw
Chair of Ashford Health & Well-Being Board
C/O Ashford Borough Council
Civic Centre,
Tannery Lane,
Ashford,
Kent, TN23 1PL

Dr Jonathan Sexton
Chair of Primary Care Co-commissioning Committee in Common,
Canterbury & Coastal Clinical Commissioning Group,
Canterbury Council Offices,
Military Road,
Canterbury, CT1 1YW

5 March 2018

Dear Councillor Bradshaw,

Ashford Health and Well-Being Board Representation

The Primary Care Co-commissioning Committee (PCCC) in Common for Ashford and Canterbury & Coastal Clinical Commissioning Groups meets bi monthly to make collective decisions on the review, planning and procurement of primary care services within the Ashford and Canterbury & Coastal areas, under delegated authority from NHS England.

Although we have some members of the Committee who also attend the Ashford Health and Well-Being Board, we do not currently have a nominated Health and Well-Being representative. Under the terms of reference of the Committee, I would like to invite you to nominate a representative of the local Health and Well-Being to attend these meetings.

For your information I attach a copy of the terms of reference and details of the 2018/19 meeting dates. Please forward details of your nominated representative to louise.matthews5@nhs.net or 03000 424107 who will also be able to answer any queries you may have in relation to the PCCC.

Yours sincerely,

Jonathan Sexton

Chair of the Primary Care Commissioning Committee in Common for Ashford and Canterbury & Coastal Clinical Commissioning Groups

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Annex A – Appendix C – Primary Care Commissioning Committee

Ashford and Canterbury CCG Primary Care Commissioning Committee-in-common terms of reference

Introduction

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Canterbury & Coastal CCG. The delegation is set out in Schedule 1.

The CCG has established the NHS Ashford CCG Primary Care Commissioning Committee ("the Committee"). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

These terms of reference provide specific guidance on how to ensure potential conflicts arising from GP participation in strategic discussions on primary care issues can be managed. These are in addition to the clauses within the CCG constitution and Standards of Business Conduct and Conflicts of Interest Policy.

NHS Ashford CCG and NHS Canterbury & Coastal CCG have agreed to establish a committee ("committee-in-common") with the same membership and the same terms of reference as the committee established by the CCG. The two committees shall be known together as the Ashford and Canterbury Primary Care Commissioning Committee-in-Common.

Notwithstanding that the Committee shall also operate as a committee–in-common, where it does so, it shall always do so in recognition of the CCG's own duties to the patients and population of the Ashford CCG area.

Statutory Framework

5. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board and the CCG.

7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);

b) Duty to promote the NHS Constitution (section 14P);

c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);

d) Duty as to improvement in quality of services (section 14R);

e) Duty in relation to quality of primary medical services (section 14S);

f) Duties as to reducing inequalities (section 14T);

g) Duty to promote the involvement of each patient (section 14U);

h) Duty as to patient choice (section 14V);

i) Duty as to promoting integration (section 14Z1);

j) Public involvement and consultation (section 14Z2).

8. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

- Duty to have regard to impact on services in certain areas (section 13O);
- Duty as respects variation in provision of health services (section 13P).

9. The Committee is established as a committee of the CCG in accordance with Schedule 1A of the "NHS Act".

10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions in common with NHS Ashford CCG on the review, planning and procurement of primary care services within the Ashford and Canterbury & Coastal areas, under delegated authority from NHS England.

12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and Canterbury & Coastal CCG, which will sit alongside the delegation and terms of reference.

13. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

15. This includes the following:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);

- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);

- Decision making on whether to establish new GP practices in an area;

- Approving practice mergers; and

- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

16. The CCG will also carry out the following activities:

a. To plan, including needs assessment, primary medical care services in the Canterbury & Coastal area;

b. To undertake reviews of primary medical care services in the Canterbury & Coastal area;

c. To co-ordinate a common approach to the commissioning of primary care services generally;

d. To manage the budget for commissioning of primary medical care services in the Canterbury & Coastal area.

Membership

The voting membership of the committee shall consist of:

- Three (3) Lay Members from the NHS Ashford CCG Governing Body, one of whom will be Chair'
- The Secondary Care Doctor (independent member) from the NHS Ashford CCG
- One (1) General Practitioner members from the NHS Ashford Governing Body
- The Managing Director (East Kent CCGs)
- The Chief Financial Officer (Ashford and Canterbury & Coastal CCGs)
- The Chief Nurse (Ashford and Canterbury & Coastal CCGs)
- The Interim Local Care Director for Ashford (Ashford and Canterbury & Coastal CCGs)
- The Interim Local Care Director for Canterbury (Ashford and Canterbury & Coastal CCGs)
- The Interim Director of Urgent Care (Ashford and Canterbury & Coastal CCGs)

In addition, the following non-voting members of the Committee-in-Common shall be in attendance:

- Clinical Chair, Ashford CCG
- Clinical Chair, Canterbury & Coastal CCG

The following shall be in attendance as members of the Committee-in-Common, but shall be non-voting with regards to matters that affect Ashford CCG only:

- Secondary Care Doctor (independent member) from Canterbury and Coastal CCG
- Two (2) Lay Members from Canterbury and Coastal CCG
- One (1) General Practitioner members from Canterbury and Coastal CCG

The Committee Chair and Vice Chair shall be selected from amongst the lay membership of the Committee-in-Common (across Ashford and Canterbury & Coastal), but shall not be the lay member for Audit.

If a member is not able to attend, then they must nominate an appropriate deputy, who may attend on their behalf, subject to the agreement of the Committee Chair.

The following will be invited to all meetings of the Committee-in-Common, but shall not be members and shall not be entitled to vote:

- A representative from the local Health and Wellbeing Board
- A representative from Healthwatch
- A representative from the Kent Local Medical Committee
- The Head of Primary Care Commissioning/Contracting
- A representative from NHS England

Meetings and Voting

22. The Committee will operate in accordance with the CCG's Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than seven days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

23. Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

Quorum

A quorum shall be five voting members which must include at least two lay members, one executive member and one clinical member of the CCG who is not a GP.

To ensure effective management of potential conflicts of interest, the membership of the committee shall be constituted so as to ensure that the majority is held by lay and executive members at all times. If these members themselves have a conflict of interest, then the committee may call on expertise from neighbouring CCGs to act as deputies, therefore allowing decisions to be made and avoid conflict.

For the avoidance of doubt, in order for the meeting to be quorate, the non GP membership must always be in the majority.

If the committee cannot be quorate for the purposes of any business, the committee shall have the power to co-opt one or more lay members or secondary care clinicians from another CCG's Governing Body onto the committee

Frequency of meetings

24. The Committee will meet at least monthly and more frequently if required. The frequency of meetings shall be reviewed on a quarterly basis.

25. Meetings of the Committee shall:

a) be held in public, subject to the application of 25(b);

b) the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

26. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

27. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

28. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

29. Members of the Committee shall respect confidentiality requirements as set out in the CCG's Constitution.

30. The Committee will present its minutes to **NHS England South (South East) area team** of NHS England and the governing body of **Ashford** CCG quarterly for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph 27 above.

31. The CCG will also comply with any reporting requirements set out in its constitution.

32. It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions.

Accountability of the Committee

The CCG has Prime Financial Policies, and this Committee shall act in accordance with these.

For the avoidance of doubt, in the event of any conflict between the terms of this Scheme of Delegation and Terms of Reference and the Standing Orders of Standing Financial Instructions of any of the members, the latter will prevail.

The Committee will have regard to the CCG's duties to make arrangements to secure that individuals to whom the services are being or may be provided are involved in the planning of the commissioning arrangements by the group, and in the development and consideration of proposals by the CCG for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and in decisions of the CCG affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Procurement of Agreed Services

The detailed arrangements regarding procurement will be set out in the delegation agreement, but for the avoidance of doubt, the Committee will consider the CCG's procurement law duties as set out in the following:

- The Public Contracts Regulations 2006 (as amended from time to time);
- Overarching principles enshrined in the treaty on the Functioning of the European Union; and
- The National Health Service (Procurement, patient Choice and Competition) No.2 Regulations 1023 ("the S75 Regulations") and Monitor's substantive and enforcement guidance on the S75 Regulations or any such additional/replacement guidance and/or regulations from time to time in force.

Decisions

The Committee will make decisions within the bounds of its remit.

The Committee will ensure that any conflicts of interest are dealt with in accordance with the CCG's constitution and Standards of Business Conduct and Conflicts of Interest Policy

The decisions of the Committee shall be binding on NHS England and **NHS Ashford** CCG.

The Committee will produce an executive summary report which will be presented to **NHS England South (South East) area team** of NHS England and the governing body of **NHS Ashford** CCG on at least a quarterly basis.

Ashford Health & Wellbeing Board (AHWB) - Item 10 (b)

Partner Quarterly Update for Public Health – Quarter 4: January to March 2018

What's going on in our world	• The Sustainability and Transformation Plan: Prevention work stream has been finalised and approved. Funding is still being sought for Kent and Medway to deliver this work. • East Kent Officers Group have agreed the Stop Smoking Action Plan based on the actions identified in the Ashford Plan. This will enable resources and knowledge to be shared across local authority areas. • Kent Public Health department is currently being restructured as part of Kent County Council Transformation and final arrangements will be shared within the next few weeks.
Success stories since last AHWB	• GPS in Ashford are being invited to take part in a Smoking + pilot which is based on an evidence based model of GP led Quit Smoking support. Professor Robert West from University College London will be meeting with local GPs to agree developing this further.
What we are focusing on for the next quarter <u>specific to the key projects</u>	• We will be working with William Harvey Hospital for the grounds to be truly Smokefree. • Smoking in Pregnancy and Adult Smoking Prevalence rates will be addressed further as part of the Sustainability and Transformation Plan delivery on prevention.
Anything else relevant to AHWB priorities NOT mentioned above	• The Kent Sensory Impairment Strategy has been updated and is now publicly available. • **End of Life Care (EoLC)** The EoLC Needs Assessment for East Kent was updated at the end of 2017. It contains relevant data relating to Ashford CCG area including 1075 deaths in 2015 which is 0.87% of the registered population. This is the lowest rate in the East Kent area. Health and social care services should expect circa 1% of the local population to die in any year. The majority of deaths during 2015 were caused by chronic conditions including cancer (28%), respiratory disease (15%), coronary heart disease (27%), stroke (7%) and other circulatory disease (9%). The proportion of deaths occurring in hospital has decreased by nearly 22% between 2006-08 and 2013-15, from 51.1% in 2006-08 to 40.0% in 2013-15. These deaths have moved to care homes, the patient's own home and in hospices. Ashford has the lowest proportion in East Kent, of its deaths occurring in both care homes and hospices and the

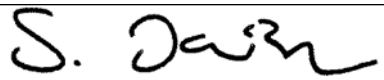
	percentage in hospices did not change appreciably over the decade. More detail can be provided if required. • The School Public Health Service has a new contract for school aged children (not necessarily in school) and will take referrals from all professionals https://www.kentcht.nhs.uk/service/school-health/
Strategic challenges & risks including horizon scanning?	Possible reduced public health resources as a result of departmental restructuring.
Anything else the Board needs to know	N/A
Signed & dated	Deborah A- Smith 4th April 2018

Ashford Health & Wellbeing Board (AHWB) – Item 10 (c)

Partner Quarterly Update for the Ashford Borough Council – Quarter 4: January to March 2018

What's going on in our world	• **Leisure Provision** – The Council & Ashford Leisure Trust are working together to transform the way leisure is provided by procuring a new leisure operation. Operator from May 2020 who will work with the partners to enhance provision. • **Create Festival** – The 23rd Create Festival on Saturday 21st July in Victoria Park will be headlined by DJ Jazzy Jeff. The event will be complimented by a weeklong arts programme in the town, called "Create Platform". • **Ashford Community Safety Partnership Priorities** – Now set for 2018/19 as follows: Antisocial Behaviour; Domestic Abuse; Serious & Organised Crime; Safeguarding Adults; Safeguarding Children. All to have a crosscutting theme of mental health. • **Domestic Abuse Services**– Ashford Domestic Abuse Forum introducing a new scheme in Ashford aimed at helping perpetrators understand the impact they are having. This will be in conjunction with the Kent, Surrey & Sussex Community Rehabilitation Company. Additional funding secured to provide a support network for adolescent boys & girls and a specialist one-to-one service for children affected by domestic abuse. The One-Stop-Shop continues to be one of the busiest in the county and this could be attributed to the leadership, delivery and awareness of the facility. • **Refurbishment of Ashford Police Station** – The Police & Crime Commissioner, Matthew Scott, has agreed to release funds from his investment reserves to make significant improvements to the police station, which includes the replacement of the external concrete cladding. This follows on from a recommendation by the Kent Chief Constable, Alan Pughsley, to retain and develop the Tufton Street premises. Works are estimated to take around 18 months to complete. • **Community Councils** – Residents of Kennington and South Willesborough & Newton have been asked for volunteers to assist in the setting up of the two community councils. A shadow council for each area is being established. • **Junction 10a** – Works started in February on setting up a site compound ahead of the main construction that is due to commence in spring. • **A28 Widening** – This project has been delayed. • **Ashford International Station** - Work has begun to prepare Ashford's International high-speed platforms for new international trains. This will safeguard direct high-speed international services from Ashford. The work is part of a £10m project being backed by KCC and ABC with funding coming from the South East Local Enterprise Partnership thorough the Local Growth Fund. • **WYE3 Masterplan** – The consultation for this has commenced. This follows on from a year of collaboration between the Council, Parish Council and landowner & the involvement of residents, businesses and local organisations. It has been supported by a number of technical studies on issues such as transport, landscape & drainage and community consultation**.** The plan is looking towards the provision of 60 new homes, a 50 bedroom residential care home or extra care home, public open space and business space. The closing date for the consultation is 01.15.18 (www.ashford.gov.uk/consult). • **Conningbrook Lakes (New development)** – Construction of the 300 high-quality new private homes has commenced. First occupations are expected in autumn 2018. The masterplan for the park is emerging. • **Elwick Place Development –** Works continue on the construction of this mixed-use leisure development incorporating cinema, hotel, restaurants and car park. Due for completion November 2018.

	• **Repton Connect (the new Community Centre)** – The new building will offer an activity/meeting space, large field, a multi-use games and a car park which will be open mid-2018. • **Bespoke Wheelchair-User Friendly Bungalow** – This has been a joint construction between Ashford Council and a contractor (DCB). The property, located in Noakes Meadow, occupational therapists have commented that it should be the blueprint for bespoke wheelchair-friendly accommodation across the county. • **Local Plan** – The Local Plan examination hearings will open on 11th April and are scheduled to finish on the 13th June. Details of the Inspectors' questions and parties' responses to them are available via the Council's website (https://www.ashford.gov.uk/planning-and-building-control/planning-policy/local-plan-to-2030/local-plan-2030-examination/). • **Commercial Quarter (CQ 38)** – Construction continues on the first phase of this development - a building that comprises of 80,500 sq. ft. of exceptional and adaptable office space with retail and restaurants on the ground floor, along with public realm improvements and additional car parking – with completion planned for spring 2018. First occupations will be in Spring 2018. For more information about Ashford's priority regeneration projects and many success stories visit www.ashfordfor.com. • **Victoria Park Redevelopment** –Submission to the Heritage Lottery Fund. Decision on the £3.2m investment will be known in June 2019. • **Ashford Voice** – See latest edition of the council's newsletter via http://ashfordvoice.ashford.gov.uk/february-2018/welcome/welcome-to-februarys-issue-of-ashford-voice. Next edition out soon. • **Active Everyday (activities for the over 60's)** – The calendar can be downloaded via the following link: http://www.ashford.gov.uk/active-everyday.
Success stories since last AHWB	• **The Wellbeing Symposium 2018 -** This national conference took place at the Ashford International Hotel on 21 February 2018, with Ashford Borough Council as headline sponsor. The event, which also included a workshop on One You and the Chair of the Ashford Health & Wellbeing Board as one of the speakers, was well attended and has received lots of positive feedback. • **Recent awards** Engagement Excellence Awards 2015, 2016 & 2017 WINNER; LGC Awards 2018 FINALIST; UKHA INSIDE HOUSING 201 Finalist
What we are focusing on for the next quarter specific to the key projects	• **Dementia: Ask the Experts Day -** The Ashford & Canterbury Dementia Action Alliance is holding a Dementia 'Ask the Experts' Day at St Marys Church on Friday 28th September between 10am – 1pm (details are attached). • **Chilmington** – The first reserved matters application for Hodson was considered by the Planning Committee on 14 February and it was resolved to grant RM approval subject to the receipt of amended plans. These amendments are being worked on by the applicants. Construction is expected to start this summer with occupations early 2019. Proving layouts for the community hub as well as the health provision are agreed. Currently includes provision for GP's as per the S106. Discussions have begun with East Kent CCG (Neil McElduff) over degree of fit with NHS long-term plans. An Estates Strategy for Primary Care has been drafted and agreed by the PCC but is likely to evolve and change as discussions evolve and the hospital agenda is clearer. ABC is working closely with the CCG to shape plans and assist where possible. A location for temporary health provision for Chilmington is provisionally agreed, subject to further capacity testing. The Community Development Strategy was adopted by Ashford Borough Council in December 2017 with an action plan drafted and to be agreed by partners early in 2018. A

	community facilities and activities audit will be started in April 2018 to inform community development action later in 2018.
Anything else relevant to AHWB priorities NOT mentioned above	• The Homelessness Reduction Act 2017 came into force on 3rd April 2018. This Act provides a greater emphasis on the prevention of homelessness and places a duty on the local housing authority to work with clients under threat of homelessness within 56 days in order to attempt to prevent or relieve homelessness. There will be a requirement placed on the client to cooperate in taking steps to prevent their own homelessness. A new duty on statutory agencies to refer clients under threat of homelessness will come into force in October 2018. • Civic Awards 2018 – Nominations open for our community 'heroes and heroines' to recognise and honour those people who have contributed substantially to their community and who enrich the lives of others within the borough. Further information at https://www.ashford.gov.uk/your-community/civic-awards-2018/
Strategic challenges & risks including horizon scanning?	
Anything else the Board needs to know	• **Development Update** – The October 2017 newsletter highlights the major projects that now being delivered across the borough. This will be available at http://www.ashford.gov.uk/development-update. Next edition out soon. • **Ashford Tourism & Leisure Website** – Website redesigned – see www.visitashfordandtenterden.co.uk.
Signed & dated	 Sheila Davison – 9 April 2018

Dementia: Ask the Experts Day

Alzheimer's Research UK

Find out more about latest research, tools, techniques and specialist services

FREE EVENT – ALL WELCOME

Friday 28th September 2018 (10am – 1pm)
St Mary's Church, Ashford TN23 1QG

Market Place:
Local dementia services drop-in exhibition
(10am - 1pm)

Specialist Speakers:
Cutting-edge research and care know-how
(11-12.30pm)

For more information, contact
alisoncarter@noplacelikehome.eu or 01795 597983

Keynote speeches from:

Reinhard Guss
Clinical Psychologist and Co-Chair of Dementia Action Alliance England

Dr Jamie Bilsland
Head of Neurodegeneration Alzheimer's Research UK, Drug Discovery Institute, UCL

Your Checklist...

- ✓ **What should I do if I'm worried about my memory?**
- ✓ **Am I fully prepared for the future both legally and financially?**
- ✓ **What can I do to support my loved one to live a good life with dementia?**
- ✓ **What is the difference between Alzheimer's and dementia?**
- ✓ **Does dementia run in the family?**

Our event aims to answer these questions and much more...

DAA
Dementia Action Alliance
Canterbury & Ashford

Working to become Dementia Friendly

Ashford Health & Wellbeing Board (AHWB) – Item 10 (d)

Partner Quarterly Update for Healthwatch Kent– Quarter 4: January to March 2018

What's going on in our world	• We continue to work closely with EKUHFT to support them in their plans. We are an active member of their Patient Experience Committee. • We have been holding ongoing conversations with EKUHFT about how they support patients with accessibility or communication needs. This is following three Enter & View visits to East Kent hospitals to review their performance against the Accessible Information Standard in partnership with East Kent Mencap. The report detailing these visits will be published in March. • We continue to invest significant resource in gathering feedback from people who have been discharged from hospital in East Kent. We are currently visiting people at Broadmeadow, West View and West Brook. • We've recently spoken with 158 carers from across Kent to understand their experiences. The majority of them weren't receiving any support from health or social services
Success stories since last AHWB	• We are an active part of the Stroke Programme Board and have been promoting public involvement in the consultation. We have a statutory responsibility to scruitinise public consultations. You can read the positive findings from this scrutiny on our website • We have published a report detailing improvements to Outpatients in East Kent as a result of patient feedback. You can read it on our website • We have just finished a programme of Enter & View visits to 24 Care Homes across Kent looking at what makes a good care home. The report will be published after purdah •
What we are focusing on for the next quarter <u>specific to the key projects</u>	• Finishing our work around hospital discharge in East Kent • Agreeing a plan of action with EKUHFT to improve their accessibility • Our annual report will be published in June • We have agreed three new priorities for the financial year o Community mental health o Autism o Hospital •
Anything else relevant to AHWB priorities NOT mentioned above	•
Strategic challenges & risks including horizon scanning?	• Changes to strategic commissioning • KCC are developing a new specification for the Healthwatch contract

Any thing else the Board needs to know	•
Signed & dated	Healthwatch Kent March 2018

Ashford Health & Wellbeing Board (AHWB)

Partner Quarterly Update for LCPG – Quarter 4: January to March 2018

What's going on in our world	• HeadStart is in embedded in Ashford, there are 5 secondary schools involved and 10 primary schools, working within the HeadStart programme. • There is a comprehensive training programme available from HeadStart in the district and the tools/resources are available and can be accessed on the Resilience Hub (www.HeadStartKent,org.uk). • There are 3 key priorities in place for the grant-funded services to deliver against this financial year: Adolescent Aspirations, Family Well-being and Best start in Life. • The grant funded services have been selected via a "Dragon's Den" approach involving agencies represented on the LCPG sub-group to undertake this task.
Success stories since last AHWB	• There were 5 providers chosen to deliver services against the 3 priorities that the LCPG agreed for this financial year: Maidstone & Mid Kent Mind, Rising Sun, Home start Ashford, PSB Breastfeeding, Step Outdoors Learning, Training & Therapy CIC. • A variety of training opportunities from Headstart related to emotional health and well-being are already being accessed by schools and partner agencies. • The Early Years SEND Summit at the end of March was very successful in having parents and professionals at an event where they were able to explore the best ways of supporting children together. A range of speakers and workshops were very well received. • The Born to Move training and development opportunities have been refreshed and are building on the success to date so that all parents and agencies working with families have the information and resources available.
What we are focusing on for the next quarter specific to the key projects	• Ensuring all the grant funded services are up and running, access to them is understood and they are making a difference to children, young people and families in Ashford through the work that is being undertaken. • Reviewing the membership of the LCPG to ensure there is appropriate representation to achieve strategic linkage with other boards and meetings about the Ashford picture/provision for children, young people and families in Ashford. • Having themed meetings to pick up the key issues that are identified in Ashford and ensuring there is information sharing and connectivity with other meetings/events and opportunities so all partner agencies are well-informed.
Anything else relevant to AHWB priorities NOT mentioned above	• The funding for LCPG/Ashford Supporting Families has been brought together in the next financial year. • Ashford has an Adolescent Pilot in place which has developed a multi-agency approach to working with adolescents … looking at ways to work more creatively to manage risk but understanding the context that the young people are living in and what is most effective in terms of engaging them. • The Children's Centres ran some very well-attended sessions over the Easter holidays which promoted dental health. • Early Help and SCS are meeting with Ashford GPs to look at further opportunities to work together more closely.
Strategic challenges	• Sustainability of projects/programmes so that they can continue to provide what is required into the future needs co-ordinated, strategic approach.

& risks including horizon scanning?	• Adult services and Children's services need connectivity • Partners need to be keeping up-to-date with new developments in terms of benefits changes, service developments and other local intelligence so that best use of all funding can be achieved.
Anything else the Board needs to know	• For further information about HeadStart: www.HeadStartKent.org.uk Or contact the Ashford Project Manager (Victoria.Saward@kent.gov.uk) • For further information about the grant funded services, contact The District Partnership Manager, Mark Wiltshire (Mark.Wiltshire2@kent.gov.uk)
Signed & dated	Helen Anderson – April 2018