KENT COUNTY COUNCIL

SELECT COMMITTEE - CORPORATE PARENTING

MINUTES of a meeting of the Select Committee - Corporate Parenting held in the Wantsum Room, Sessions House, County Hall, Maidstone on Monday, 5 October 2015.

PRESENT: Mrs Z Wiltshire (Chairman), Mr R E Brookbank, Ms C J Cribbon, Mr S J G Koowaree, Mr B Neaves, Mr M J Northey, Mrs P A V Stockell and Mrs J Whittle

IN ATTENDANCE: Ms D Fitch (Democratic Services Manager (Council)), Dr J Maiden-Brooks, Mr A Saul (Democratic Services Officer) and Miss L Adam (Scrutiny Research Officer)

UNRESTRICTED ITEMS

4. Interview with Andrew Scott-Clark - Director of Public Health (KCC)
(Item 2)

(1) The Chairman welcomed the guests to the meeting and invited Andrew to introduce himself and outline his role. Andrew explained that the Director of Public Health role had transferred from Primary Care Trusts to local authorities two years ago. He stated that there were three key areas which the Director of Public Health was now responsible for. The first area was health protection; the Director of Public Health had to ensure that a system was in place to deal with public health emergencies such as communicable diseases and major incidents involving a public health threats. The Director of Public Health was part of the Scientific and Technical Advisory Cell which provided advice on health issues to Strategic Coordinating Groups during an emergency response or recovery. The second area was the provision of public health advice to Clinical Commissioning Groups (CCGs) to enable them to commission effective services based on the need and demand of their local population. Each CCG in Kent had a Public Health Consultant as part of their Governing Body. The third area was the commissioning of health improvement services which had a ring-fenced budget. These services ranged from mandatory sexual health services, Child Measurement Programme and NHS Health Checks, through to the provision of services to support smoking cessation, promoting physical exercise and addressing obesity which were based on local priorities. He noted that the Joint Strategic Needs Assessment (JSNA) was produced by local authorities' public health departments to identify health needs within its population; the JSNA was used to develop the Health & Wellbeing Strategy and inform commissioning of health services. He stated that each upper-tier and unitary authority, acting jointly with the Secretary of State for Health was required to appoint a Director of Public Health.

Q – Are you employed by Kent County Council?

(2) Andrew explained that he was a Kent County Council employee but the Director of Public Health role was a joint appointment between the Council and the Secretary of State for Health.

Q – How is Kent's Public Health department supporting Children in Care?

(3) Andrew stated that Public Health was involved in the commissioning of services for children in care and providing data about the health needs of children in care. He referenced the data provided in the Kent Children in Care JSNA Chapter Summary Update which was produced in 2014 and continued to be a live document. A copy of the chapter was circulated to Members at the conclusion of the interview.

Q – Are there any limitations with the data?

(4) Andrew reported that there were limitations with the data availability particularly with unaccompanied asylum-seeking children who were a subset of the children in care cohort. He referenced the statutory guidance from the Department of Education and the Department of Health 'Promoting the health and wellbeing of looked-after children' which set out the responsibilities for the planning, commissioning and delivery of health services for children in care. This guidance had led to fragmentation of data. He reported that whilst individual Health Assessments were completed for children in care, the information from the assessment was not collated to achieve a wider strategic overview of the overall health needs for children in care. Public Health did not have a detailed understanding of the health of children in care as the data was not available; it was reliant on national data which was related back to children in care in Kent. He highlighted that some GPs carried out health assessments but Public Health had no access to GPs' systems to extract the data. He noted that the data available included convictions, exclusions, education performance and health assessments.

Q – What are your key concerns about the health and wellbeing of children in care?

(5) Andrew noted that due to the information infrastructure, it was difficult to know. He reported that there was emerging evidence that the health and wellbeing of unaccompanied asylum seeking children was a cause for concern. He reported that immunisations and dental checks for children in care were good but stated that there was a underreporting of dental health amongst the general population. He explained that young females in care were more likely to become pregnant but he was unable to state the number of young women in care who were expecting or had delivered a baby because of data limitations.

Q – How could the data be improved?

(6) Andrew explained that a multiagency group including the Police and Social Care was pulling data together to produce a database to improve system knowledge and provide a whole picture of children in care. The system was due to go live shortly.

Q – What sexual health services are available to children in care?

(7) Andrew stated that Public Health commissioned standard genitourinary medicine **(**GUM**)** and outreach health promotion and sexual health services. He reported that they had developed a mobile phone app which helped young people to access emergency contraception and had improved access to chlamydia testing

through user friendly testing kits available from pharmacies. He noted that there had been a shift from family planning to a focus on the needs of young people. He reported that if a young female in care arrived in a sexual health clinic, she would be treated like anyone else.

Q – Does the chlamydia test enable self-assessment?

(8) Andrew explained that the test needed to be sent away for scientific analysis. He reported that improved access helped to reduce barriers to services. He noted that the Teenage Pregnancy Strategy published last week showed that teenage pregnancies continued to fall.

Q – What percentage of teenagers, who are pregnant, are children in care?

(9) Andrew reported that this figure was unknown. He explained that teenage pregnancies in Thanet had reduced except for Cliftonville due to the turnover of population and different cultures including Roma, Slovak and Eastern Europeans.

Q – Are the Police and Social Services gathering data for the new database?

(10) Andrew stated that with the new information system they would be able to gather data. Public Health had requested that the social care case management system, Liberi, include the NHS number of the client so that the data could flow into the data collected by GPs, Hospitals, Community Services and other providers. He stressed the importance of connecting the health service data with the social care Liberi data.

Q – Is the Teenage Pregnancy Strategy effective for children in care?

(11) Andrew explained that the strategy was reducing teenage pregnancy overall in Kent due to good PSHE and sex and relationship education. He noted that because the data was not connected, it was difficult to provide sub analysis on children in care. As the overall number of teenage pregnancies was reducing, it could be assumed that the rate of teenage pregnancies in children in care was also reducing. He highlighted the importance of connecting the Liberi and NHS data.

Q – Maidstone previously had the highest teenage pregnancy rate in the Country due to the availability of one and two bedroom flats which resulted in out of area placements, has the teenage pregnancy rate reduced?

(12) Andrew explained that the teenage pregnancy rate in Parkwood and Shepway had come down. He acknowledged that it was not just due to the health service and local authority, it was a societal response. He noted that the dataset did not include out-of-area children in care; CCGs should be notified when a child is placed within their area but this does not happen very often. He reported it was difficult to know the totality of children in care due to data limitations.

Q – If a 14 year old is diagnosed with a sexually transmitted infection, is there an obligation on the GP to notify the child's social worker?

(13) Karen reported that GP's have statutory safeguarding duties. There is also Department of Health best practice guidance for doctors on the provision of advice and treatment to YP on contraception, which outlines that Doctors and health

professionals have a duty of care and a duty of confidentiality to all patients, including under 16s. However where any health professional believes that there is a risk to the health, safety or welfare of a young person or others and it is so serious it outweighs the young person’s right to privacy, they should follow locally agreed child protection protocols In these circumstances, the over-riding objective must be to safeguard the young person.

(14) Karen reported that there was a statutory duty for a GP to use Gillick competence to decide whether a child (16 years or younger) was able to consent to his or her own medical treatment, without the need for parental permission or knowledge. She noted that if a child was closer to 16 years, they may be more competent in comparison to a 14 year old presenting without an adult. She explained that she would expect the GP to apply competency and report it to the social worker if they deemed the young person not to be competent. Andrew stated that the CCGs had undergone a lot of training to understand safeguarding responsibilities and recognise safeguarding issues.

Q – How can communication be streamlined?

(15) Andrew noted that there was a complex system in Kent due to the two tiers of local authorities. He stressed the importance of putting the child at the centre of the process. He highlighted the importance of integrating health records so the JSNA had the totality of the data to inform commissioning. He reported that Kent was one of the few systems which kept its health information service together. This meant it was able to hold multiple datasets and publish pseudo-anonymised data. He reported that Kent County Council’s Public Health team had been “highly commended” at the Health Service Journal Awards for its work in combining Adult Social Care and NHS datasets for the Kent Year of Care Commissioning Model.

(16) Karen reported that Health Visiting and the Family Nurse Partnership Programme for young mums had transferred to Public Health last week. This transfer had enabled Public Health to have much quicker access to the data as it was previously held by NHS England. She noted that under the new information system; it would not matter who held the data, it would be shared amongst the multiagency group. She advised that the CCGs commissioned and held data about health assessments. She also noted that a significant proportion of young mums involved in the Family Nurse Partnership could be children in care.

(17) Andrew explained noted the Corporate Parenting Panel and Social Care DMT had received the recommendations from the Kent Children in Care JSNA Chapter Summary Update which included addressing the data limitations. He explained that the Looked After Children Fostering Health Group, chaired by the CCGs, had drawn up an action plan to implement the recommendations. He acknowledged that there was pressure on the system due to unaccompanied asylum seeking children and health assessments was the current priority.

Q – What are the mental health needs of children in care?

(18) Andrew reported that children in care were more at risk of developing mental health issues. He stated that the statistics were held by the providers.

Q – Is the CAMHS contract fit for purpose?

(19) Andrew stated the current pathway does not function properly. CAMHS is a secondary tier of the pathway. He stressed the importance of preventative services for children and young people, if effective they would not require CAMHS. He acknowledged that there had been significant work to improve the pathway.

(20) He noted that unaccompanied asylum seeking children had profound mental health needs; they could have faced abuse in their home country or on their way to the UK. He reported that the Looked After Children Fostering Health Group was developing a health needs assessment for unaccompanied asylum seeking children.

Q – Who is responsible for the Looked After Children Fostering Health Group?

(21) Andrew explained that it was chaired by Hazel Carpenter as the lead CCG commissioner for children in care. The group reports to the CCG and provides updates to the Children's Health and Wellbeing Board.

Q – What can the Select Committee do?

(22) Andrew stressed the importance of the dataset and sharing clinical data between social care and health. He noted that it was key for Kent County Council as a commissioning authority, to have the whole picture.

(23) A Member of the Select Committee highlighted an article in The Observer about refugee children arriving in Kent, the funding implications, and what is being done for them. The article was circulated to the Committee at the conclusion of the interview.

(24) On behalf of the Committee, the Chairman thanked Andrew and Karen for attending the meeting and answering questions from Members.

5. Interview with Carol Infanti - Commissioning Officer - Social Care, Health and Wellbeing - KCC

(Item 3)

(1) Ms Infanti was welcomed to the meeting. She had been in her position in the team for the past 3 years. Her responsibility is around managing the emotional wellbeing contract and the children in care element of the child and young people mental health service provided by Sussex Partnership Foundation Trust. Ms Infanti works alongside West Kent CCG which is the lead commissioner

Q: Has there been an improvement on waiting times?

(2) The concern around waiting times had been brought to member's attention and was discussed at previous HOSC meetings. The waiting time has since come down to an acceptable level. Across Kent the average waiting time from referral through to assessment is now at 10 weeks. The average waiting time for treatment (from referral) is now at 16 weeks.

Q: Are you finding pressure from the number of referrals?

(3) The number of referrals has increased dramatically in recent years, particularly emergency and Out of Hours referrals. This is not a pattern unique to Kent and has been seen nationally. Since the start of the contract the number of out of hours referrals has been high, it was anticipated that there would be around 10 per month, it has been averaging around 100. The response to these is within the contract requirements. 90% of children in care had their assessment within 6 weeks, 70% within 4 weeks and 90% had their treatment within 10 weeks.

Q: What sort of problems do these children have? How can we help?

(4) The best way to describe this is to give examples. The first is a 14 year old boy who was in care as he had been experiencing neglect and exposure to substance misuse and domestic abuse. He was referred to the child and young people's mental health service because of his disruptive behaviour with his foster carers and he would soil himself often. The foster carers also wanted guidance to support him while changing schools. To accommodate for his needs they worked with the network (foster carer, school, social worker, Virtual School Kent) to advise and assist how to respond to his behavioural problems. The children in care CAMHS team also did some direct with the young person. This gave very positive results, his behaviour improved and he successfully moved school and, his attachment to the foster carer improved.

(5) The other example was that of an 8 year old child living with a foster carer, he was expressing distress with disruptive behaviour, being verbally aggressive and trying to run away. This child was supported by the children in care CAMHS working with the network, helping the foster carer change how she responded to the child's behaviour and by the school providing play therapy.

Q: In this first example, did the boy in question move schools to go to his new placement?

Yes, he did move schools for the new placement.

Q: Are you seeing an increase of issues that come about due to cyberbullying?

(6) An increase in cyberbullying has been recognised. Providers are aware that is the case and are prepared to deal with it. Young Healthy Minds have had a number of cases involving the use of social media. Their staff are fully aware of safeguarding issues and have/will be attending KSCB e-safety training.

Q: What ability does KCC have to provide Therapy to help children in care with mental health conditions?

(7) I would like to briefly outline the new emotional wellbeing and mental health services that KCC and the CCGs are planning to jointly commission next year. There are three elements within the new service. Firstly, a Mental Health Service provided by mental health practitioners, this is at the highest level of our new model. It does not include the inpatient beds. This will be a specialist mental health service. Secondly there will be staff with mental health expertise who will work in the community and based in early help units. There will also be more skilled support for children and young people with emotional wellbeing needs provided in universal settings. KCC will commission this service. Currently the Young Healthy Minds Service that KCC commissions, provides a time limited intervention, this is accessed

via the early help process. At the lowest/universal level there are school counselling services. In the new model children in care would be able to access therapy at the level that was most appropriate to their needs.

Q: How effective is the children in care mental health contract?

(8) It's a good service. There is a very fast response time to service users. Surveys to ascertain from service users whether they are satisfied have been used, such as the NHS friends and family test, there have been 6 responses for the children in care service - all were positive. The provider also uses the Commission for Health Improvement Satisfaction Survey. Responses have been positive.

Q: How many children have used this service over the past year?

(9) Around 400 to 450 Children in Care are using the service at any one time

Q: What has been built into rewriting the bid for CAMHS to ensure a better service?

(10) The current contract ends next year. Rewriting this will be a whole system approach including the Emotional Wellbeing and Mental Health Contract as I outline earlier. This is a joint commissioning initiative with Public Health and Education and Young Peoples Services, Specialist Children's Services and the CCGs. There will be an additional £1.2m available to help ensure a better service. These additional funds are intended for further resources giving more support before escalation into specialist mental health services. These resources will be used to up-skill workers and provide more drop in services. They will work with children and young people in complex family situations where this is impacting on the child's mental health.

(11) There has been a great deal of consultation around this to inform the new whole system model. Two summits were held last year, young people were involved in making a video, there was a good response to the online consultation and more recently the Kent Youth Parliament has also been given the chance to discuss the model and share their ideas to give young people input into this service.

Q: How involved will schools be?

(12) There will be strong involvement of schools. Early Help workers will build links to particular schools so this service is easily accessible.

Q: Will this incorporate children seeking asylum who need support with mental health?

(13) Yes. They have been included in this.

Q: Which of the commissioned services you are responsible for is most used in assisting children in care?

(14) There are a number of services that are commissioned for children in care by various officers in the commissioning unit. For example, there is a 12 week programme in which intensive support is provided to prevent children going into care which is used to great effect this is provided by Core Assets. Another example is

providing an independent visitor services which aims to improve outcomes for children in care.

Q: We understand waiting times have improved, but what is the new target when the new service is up and running?

(15) Details of the specifications for the new services are still being discussed, at this time we have an outline proposal which is subject to change. Under the new service our target for waiting times for children in care is 2 weeks from referral to assessment. The new service will also address the delays that have been incurred by some groups of children that need specialist support e.g. children on the autistic spectrum.

Q: How well does CAMHS provide for 16-17 years old and care leavers who need support with mental health?

(16) If a child has ongoing issues which means they will need to continue to access mental health services after they reach adulthood there is a transition protocol. This will be used to move children smoothly into adult mental health services to meet their needs. This will normally be planned before they leave the children's mental health service which begins in the months prior to them turning 18. It includes a period of joint working and parallel care between the children's and adult mental health providers.

Q: After their first treatment how long usually is it until the following treatment?

(17) This is usually agreed with the young person and their carer. There is no definitive answer.

Q: Do you feel there are enough qualified professionals for this service?

(18) Yes, when considering the children in need service. The Trust, like other providers has sometimes found it difficult to recruit clinical staff with the right qualifications. When thinking more broadly about emotional wellbeing and mental health services there needs to be a range of staff with different professional disciplines.

Q: What is the nature of most of your complaints?

(19) Early on the complaints were focused around the delays in waiting times for assessment and treatment. This has been resolved by the far better waiting times that have been achieved. More recent challenges have been around the availability of tier 4 bed facilities.

Q: How many of Kent's Children in Care are being sent out of country to access tier 4 secure facilities, due to difficulties accommodating them within the county?

(20) NHSE are responsible for commissioning tier 4 beds.. In August 38 children needed a tier 4 bed, 1 was a child in care with a learning disability who needed specialist provision and therefore had to be placed out of the county

Q: How many children end up in a police cell following emotional problems for their own safety?

(21) I don't have those figures available. Young people may be in a police cell as a result of criminal activity, it should not be as a result of mental health issues. The Trust have a rapid response home treatment team which responds to emergency situations, the aim of the team is to prevent admission and support young people in the community

Q: Has Sussex Partnership Foundation Trusts service improved?

(22) Yes, they have improved significantly. They have focused on improving the waiting list and now have a good balance.

Q: What are the actual waiting times in each District? Do these vary?

(23) The data on waiting times haven't been recorded by district previously. The Trust has introduced a new system and will now be recording the children in care data by districts. This will be easier to provide in future. CCG data could also be supplied which may give some insight into any major difference in waiting times between the districts.

Q: What measures can we take to enable us as effective Corporate Parents?

(24) The best action to take is to keep abreast of developments at a national and local level, as well as performance information, stay up to date with relevant Government documents e.g. the Department of Health report 'Future in Mind'; changing legislation and continue to discuss strategy. Focusing on issues such as ease of access, timely access and initiatives designed to promote resilience.

Q: There is no reason why some of this service shouldn't be sub-contracted, are you keen on new models that include this?

(25) That's to come in future discussions, a procurement group is being set up to look at the procurement process and contracting arrangements.

(26) There were no other questions and the Chairman thanked Carol Infanti for her attendance at the Select Committee.

6. Interview with John Littlemore - Chief Housing Officer - Maidstone Borough Council
(Item 4)

(1) The Chairman welcomed Mr Littlemore to the meeting and invited him to outline his role and to answer questions from Members.

(2) Mr Littlemore stated that he was the Head of Housing and Community Services at Maidstone Borough Council, his remit included housing, community safety, environmental health and licensing. He confirmed that Maidstone had transferred its housing stock in 2004. He was the current Chair of the Kent Joint Policy and Planning Board which was a strategic partnership between health, housing and social care. He explained that the Board was involved with the development of a protocol for the housing of young people.

Q - What are the key challenges across districts in addressing housing issues for children in care (16-17 years old and care leavers)?

(3) Mr Littlemore stated that this was one area which housing officers struggled with. Legislation stated that a person had to be 18 years old to hold a tenancy. It was difficult for local authority and private landlords to grant a tenancy to a young person under 18 years old and in some cases these young people came from disturbed backgrounds and their maturity levels varied.

(4) Mr Littlemore explained that the provision for supported accommodation for young people was not uniform across Kent. There was the Trinity Foyer in Maidstone and a similar supported provision in Swale providing a holistic service for young people but little else across Kent.

(5) Mr Littlemore stated that there was an issue regarding the different service provided to young people by Social Services and Housing departments depending upon where they lived in Kent. He referred to a paper which had been considered by Kent Chief Executives and Kent Leaders regarding adopting the Dartford model across Kent which had found favour.

Q – What emergency housing services are available to 16/17 year olds? Can they turn to their local housing authority?

(6) Mr Littlemore explained that there was a difference between what should happen and what happened in practise. He referred to the Dartford model which attempted to prevent homelessness by reconciling the young person with their family. This required a joint Social Services and Housing approach. He emphasised that no one would want to see vulnerable young people on the street.

Q – What can a young person do if they find themselves "on the street" at 5.00pm?

(7) Mr Littlemore confirmed that all local authorities had a 24/7 out of hours service which would direct them to services that could provide assistance. If the young person was 16/17 years old then the first point of call was children's social services for an assessment to see what duty was owed to them under the Children Act. If the young person had been in care with Social Services then they should have a pathway plan, which ideally would start planning with Housing Services 6 months before the young person came out of Social Services care. If there was no duty to this young person under the Children Act then they would be referred to their local housing authority as potentially homeless.

Q – If a child is "kicked out" where do they turn for help?

(8) Mr Littlemore stated that this would vary depending on the young person's awareness. Some services are known to young people through advice agencies or the voluntary sector. Normally they would end up going to the Police, who then contact the relevant authority and may be placed in emergency Bed and Breakfast accommodation overnight.

Q – Is the housing authority's statutory responsibility to care leavers different to that to other young people?

(9) Mr Littlemore explained the difference between Parts 6 and 7 of the Housing Act 1996. Part 6 of the Act set out the regulations for entry onto the Housing Register and how priority is set between applicants. The local housing authority is required to adopt an "Allocation Scheme" that explains the criteria used by that authority. Part 6 does not expressly identify 'care leavers' as a characteristic to which the local authority should give 'preference' under the Allocation Scheme. He then explained that Part 7 dealt with homelessness and care leavers are expressed as a group who may have a priority need. This means that a young person may be entitled to a period of temporary accommodation under Part 7 but have no different priority on the Housing Register to any other young homeless person under Part 6.

Q – Care leavers are not necessarily homeless, but as an at-risk group, what preferential access do 16-17 years old children in care have to accommodation?

(10) Mr Littlemore restated that they were not included as a separate category under Part 6 of the Housing Act. He referred to the issue of young people's expectations and what might be offered via a housing service. There was a high demand for affordable housing and as social housing was in short supply it is not possible to house everyone into local authority or housing association accommodation. Local housing authorities try to assist these young people into supported accommodation and looked at all possible housing options open to them, including the private rented sector.

Q - What does the Kent Housing Strategy say about the housing needs of children in care (16-17 years old and care leavers) and how does this respond to other local authority children placed in Kent?

(11) Mr Littlemore explained that the current Strategy did not specifically refer to this group. However, the Kent and Medway Housing Strategy was in the process of being revised and he had asked for this to be included.

Q - How do housing authorities monitor the effectiveness of housing provision for children in care (16-17 years old and care leavers)?

(12) Mr Littlemore confirmed that there was no specific data relating to care leavers. Local Housing Authorities had to submit a quarterly return to Government on the number of homeless 16/17 year olds but not necessarily care leavers. However, he stated that this was something that could be looked at as part of the work being carried out with KCC on the Housing Strategy.

Q - What else could be done to increase the awareness and understanding of corporate parenting issues by Borough Council Members? Is there a need for a Member Champion at District level?

(13) Mr Littlemore expressed the view that there was no need to appoint a District Member Champion, as Kent benefits from mature partnership working through the JPPB and Kent Housing Group. The important issue was to progress the work identified through the Kent Leaders and Kent Chiefs meetings..

Q – Can you explain what the Dartford model is?

(14) Mr Littlemore explained that the Dartford model involved housing officers and social services Teams working together and the appointment of dedicated officers who were able to act when a young person was in crisis regarding housing. They made use of a crash pad at the YMCA hostel, which was clean, modern but sparse. This provided a safe breathing space, to enable negotiations with the family to facilitate the young person's return home, or to provide a support package for the young person to help them maintain a tenancy. This model needed a dedicated service which wasn't provided across Kent. The immediate challenge is the lack of emergency provision, which he suggested could be overcome by authorities "buddying up" with other authorities and the other factor was the changes to Social Services teams and waiting for the new Early Help teams to be established.

Q - What specific support do housing authorities provide to care leavers?

(15) Mr Littlemore confirmed that they tried not to abandon people and would attempt to offer support within their homeless responsibility. Previously support services of this specialism have been provided through the Supported People Programme.

Q – Just to clarify, is it the case that if a young person left care and had no were to live, they would be treated the same as any other young person on the housing list?

(16) Mr Littlemore stated that the social services team should be working with this young person to get them ready to leave care at 18, if appropriate. Social Service's responsibility to a young person in care did not end when they reached 18. The young person could go onto the waiting list, and each of the 12 districts had their own criteria. In some cases there were also approaches from Mental Health professionals to support the young person's housing application.

(17) He referred to the 2009 Southwark judgement and explained that this established whether the Children Act or the Homelessness legislation took precedence in relation to 16/17 year olds. The outcome of this was that in most cases the Children Act would take pre-eminence, as in most cases it was about the wider needs of the child rather than just providing accommodation.

Q – If a young person stayed in care until they were 21 years old did this improve their housing status?

(18) Mr Littlemore informed the Committee that there had been a 17% increase in homelessness in Kent since last year. There were a number of reasons for this including, the difficulty in obtaining a mortgage, the increase in house prices which was forcing people who would have been first time buyers to become renters. He stated that the proportion of people in Kent who were in rented accommodation had doubled over the past 5 years in Maidstone. Landlords were aware of the shortage of rented accommodation and therefore knew that they could charge more and be more choosy about who they would let to, often preferring those they see as less of a risk. These matters have combined to place greater pressure on housing lists for affordable housing. In addition not enough properties were being built across the

country to keep pace with the increasing population and there also was the unintended impact of welfare reforms.

Q – Do we utilise empty properties?

(19) Mr Littlemore stated that Maidstone BC had tried to return empty homes into use, but had found that in this area the effort that needed to be put in balanced against the small number of properties that they had been able bring back into use, was not an efficient use of resources. In Maidstone 353 units had been returned over a 3 year period. Other areas such as Thanet who have traditionally had a greater proportion of empty homes had experienced greater success in attracting external funding to bring empty properties back into the housing market.

(20) The Chairman thanked Mr Littlemore for attending the meeting and answering questions from Members.