Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **WEDNESDAY, 4 JANUARY 2017**
TIME: **5:30 pm**
PLACE: **Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Commission

Councillor Dempster (Chair)
Councillor Fonseca (Vice-Chair)

Councillors Cassidy, Chaplin, Cleaver, Sangster and Unsworth

I unallocated Non-Group place.

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester

G. J. Carey

For Monitoring Officer

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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information
If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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PUBLIC SESSION

AGENDA

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 9 November 2016 have been circulated and the Commission will be asked to confirm them as a correct record.

The minutes can be found on the Council's website at the following link:-

http://www.cabinet.leicester.gov.uk:8071/ieListMeetings.aspx?CId=737&Year=0

4. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures.

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

6. CHAIR'S UPDATE ON ACTIONS FROM PREVIOUS MEETINGS

7. PUBLIC HEALTH BUDGET **Appendix A (Pages 1 - 50)**

To receive the draft General Revenue Budget 2017-18. The Commission is asked to consider the Public Health elements of the budget. Comments made by the Commission will be considered by the Overview Select Committee on 2nd February 2017 prior to budget being approved by the Council on 22nd February 2017.

8. CQC INSPECTION OF LEICESTERSHIRE PARTNERSHIP TRUST **Appendix B (Pages 51 - 56)**

To receive a report from the Leicestershire Partnership Trust on the progress made to date in addressing the actions required after the inspection in March 2015 and the feedback received from the CQC following the re-inspection in November 2016.

9. SUSTAINABILITY AND TRANSFORMATION PLAN **Appendix C (Pages 57 - 132)**

To receive the draft Leicester, Leicestershire and Rutland Sustainability and Transformation Plan that was published on 21st November 2016. The Commission is asked to comment upon the proposals during the current engagement period. These comments will then be considered to determine whether any elements of the draft Plan need amendment prior to the formal consultation on those elements of the Plan which require it in early 2017.

At the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee on 14 December 2016 it was agreed that this Commission would take the lead on the scrutiny the new model of care for the primary care sector and the services reconfigurations for UHL acute hospital sites and Mental Health aspects.

Members are asked to focus on the new model for primary care at this meeting, as the other two aspects will be considered at separate meetings.

10. WORK PROGRAMME

The Scrutiny Policy Officer submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme for 2016/17. The Commission is asked to consider the Programme and make comments and/or amendments as it considers necessary.

11. ANY OTHER URGENT BUSINESS

Leicester City Council

Council **Date: 22nd February 2017**

General Fund Revenue Budget 2017/18 to 2019/20

Report of the Director of Finance

1. **Purpose**

1.1 The purpose of this report is to ask the Council to consider the City Mayor's proposed budget for 2017/18 to 2019/20.

1.2 The proposed budget is described in this report, subject to any amendments the City Mayor may wish to recommend when he makes a firm proposal to the Council.

1.3 This version of the report is a draft for consultation, and will be updated to reflect the local government finance settlement, any further information and comments from partners.

2. **Summary**

2.1 The Council is in the middle of the most severe period of spending cuts we have ever experienced.

2.2 The independent Institute for Fiscal Studies has recently (October 2016) reported that local authority budgets have fallen by 26% in real terms since 2009/10. The 10% of authorities most dependent on grant (generally, the least affluent areas) have cut spending by an average of 33% in real terms. The 10% least dependent on grant have cut spending by only 9%. Our own estimates, comparing cuts to the Index of Multiple Deprivation, point very strongly to the same conclusions.

2.3 Our government grant has fallen, on a like for like basis, from £289m in 2010/11 to £174m in 2017/18; and is projected to fall further, to £166m by 2019/20. Grant will have fallen by over 50%, after allowing for inflation, over ten years.

2.4 This has resulted in the Council's budget, again on a like for like basis, falling from £358m to an equivalent £277m by 2019/20. These figures, however, mask the fact that additional funding has been required to manage pressures

in statutory social care (both for adults and children). The amount available for all other services has consequently fallen by around 70% in real terms over the same period.

2.5 The Council's approach to achieving these substantial budget reductions is based on the following approach:-

(a) An in-depth review of discrete service areas (the "Spending Review Programme");

(b) The building up of reserves, in order to "buy time" to avoid crisis cuts and to manage the spending review programme effectively. This is termed the "Managed Reserves Strategy".

2.6 The spending review programme is a continuous process. When individual reviews conclude, an Executive decision is taken and the budget is reduced in-year, without waiting for the next annual budget report. Executive decisions are informed by consultation with the public (where appropriate) and the scrutiny function.

2.7 Since the 2016/17 budget was approved last February, a number of spending reviews have reported and budget reductions consequently made. Some of these have saved money in 2016/17 as well as later years.

2.8 Last February, it was anticipated that all reserves set aside for the managed reserves strategy would be used by 2017/18. However, additional reserves have become available, enabling the strategy to be extended:-

(a) Savings in 2016/17 arising from spending reviews approved after February have become available to support subsequent budgets;

(b) A review of earmarked reserves held by departments has taken place, with the result that £5m has become available for general purposes.

2.9 These measures, plus reductions in the annual budget, mean that a very limited level of reserves have now become available to support the 2018/19 budget. Spending reviews approved from now on will extend the strategy further.

2.10 Nonetheless, it is abundantly clear that the amount of work still required to achieve estimated savings of £41m by 2019/20 is enormous, notwithstanding the progress that has been made since last year. Even when the full spending review programme is complete, a gap will remain, and work will take place during early 2017 to bridge this. Some extremely difficult decisions will inevitably be required.

2.11 The budget provides for a council tax increase of 4%, which is the maximum available to us without a referendum. Half of this increase is for the "social care levy" – the Government has permitted social care authorities to increase tax by more than the 2% available to other authorities, in order to help meet

social care pressures. In practice, increasing our tax by 4% for 4 years will only meet a small proportion of the extra costs we are incurring.

2.12 In the exercise of its functions, the City Council (or City Mayor) must have due regard to the Council's duty to eliminate discrimination, to advance equality of opportunity for protected groups and to foster good relations between protected groups and others. The budget is, in effect, a snap-shot of the Council's current commitments and decisions taken during the course of 2016/17. There are no proposals for decisions on specific courses of action that could have an impact on different groups of people. Therefore, there are no proposals to carry out an equality impact assessment on the budget itself, apart from the proposed council tax increase (this is further explained in paragraph 11 and the legal implications at paragraph 21). Where required, the City Mayor has considered the equalities implications of decisions when they have been taken and will continue to do so for future spending review decisions.

3. Recommendations

3.1 Subject to any amendments recommended by the Mayor, the Council will be asked to:-

(a) approve the budget strategy described in this report, and the formal budget resolution for 2017/18 which will be circulated separately;

(b) note the outcome of the local government finance settlement for 2017/18 (once received);

(c) note any comments received on the draft budget from scrutiny committees, trade unions and other partners (once received);

(d) approve the budget ceilings for each service, as shown at Appendix One to this report;

(e) approve the scheme of virement described in Appendix Two to this report;

(f) note my view that reserves will be adequate during 2017/18, and that estimates used to prepare the budget are robust;

(g) note the equality implications arising from the proposed tax increase, as described in paragraph 11;

(h) approve the prudential indicators described in paragraph 18 of this report and Appendix Three;

(i) approve the proposed policy on minimum revenue provision described in paragraph 19 of this report and Appendix Four;

(j) agree that finance procedure rules applicable to trading organisations (4.9 to 4.14) shall be applicable only to City Catering, operational transport and highway maintenance.

4. **Budget Overview**

4.1 The table below summarises the proposed budget, and shows the forecast position for the following three years:-

	2017/18 £m	2018/19 £m	2019/20 £m
Service budget ceilings	262.9	258.7	260.6
Sums to be Allocated to Services			
Apprentice Levy	0.6	0.6	0.6
Corporate Budgets			
Capital Financing	13.8	13.7	13.4
Miscellaneous Central Budgets	(2.7)	(2.5)	(2.3)
Future Provisions			
Inflation		3.9	7.9
Education Funding Reform	3.0	3.0	3.0
Planning provision		3.0	6.0
Managed reserves Strategy	(20.7)	(4.6)	
TOTAL SPENDING	**256.9**	**275.8**	**289.1**
Resources – Grant			
Revenue Support Grant	48.1	38.4	28.4
*Business rates top-up grant	45.7	47.2	48.8
New Homes Bonus	9.2	5.8	5.5
Resources – Local Taxation			
Council Tax	99.5	104.2	109.1
*Business Rates	53.5	55.1	56.5
Collection Fund Surplus – Council Tax	0.8		
TOTAL RESOURCES	**256.9**	**250.6**	**248.3**

Projected tax increase	4.0%	4.0%	4.0%
Gap in resources		25.2	40.8
Underlying gap in resources	20.7	29.8	40.8

These figures will be revised following the local government finance settlement, once received.

*A revaluation of business rates will take effect from 2017/18. This will increase the amount of rates expected, but lead to a reduction in top-up grant (in theory, to ensure the effects of the revaluation are financially neutral but this is currently a risk). These figures will be revised once the settlement has been received.

4.2 Future forecasts are of course volatile and will change.

4.3 The forecast gap in 2019/20 makes no allowance for most inflation (other than for pay awards). In real terms, the gap for that year is some £5m higher.

5. Council Tax

5.1 The City Council's proposed tax for 2017/18 is £1,408.15 an increase of just below 4% compared to 2016/17.

5.2 The tax levied by the City Council constitutes only part of the tax Leicester citizens have to pay (albeit the major part). Separate taxes are raised by the police authority and the fire authority. These are added to the Council's tax, to constitute the total tax charged.

5.3 The total tax bill in 2016/17 for a Band D property was as follows:-

	£
City Council	1,354.01
Police	183.58
Fire	61.62
Total tax	**1,599.21**

5.4 The actual amounts people are paying in 2016/17, however, depend upon the valuation band their property is in and their entitlement to any discounts, exemptions or benefit. 80% of properties in the city are in band A or band B.

5.5 The formal resolution will set out the precepts issued for 2017/18 by the Police and Crime Commissioner and the fire authority, together with the total tax payable in the city.

6. Construction of the Budget

6.1 By law, the role of budget setting is for the Council to determine:-

(a) The level of council tax;

(b) The limits on the amount the City Mayor is entitled to spend on any service ("budget ceilings").

6.2 The proposed budget ceilings are shown at Appendix One to this report.

6.3 The ceilings for each service have been calculated as follows:-

(a) The starting point is last year's budget, subject to any changes made since then which are permitted by the constitution (e.g. virement);

(b) Decisions taken by the Executive in respect of spending reviews which are now being implemented have been deducted from the ceilings;

(c) Increases in pay costs, arising from the two year pay increase awarded in June 2016 (1% in each of 16/17 and 17/18).

6.4 Apart from the above, no inflation has been added to departments' budgets for running costs or income, except for an allowance for:-

(a) Independent sector adult care (1.5%);

(b) Foster care (1.5%);

(c) Costs arising from the waste PFI contract (2% - RPI).

6.5 The following spending review decisions have been formally taken since February 2016, and budgets reduced accordingly:-

	17/18 £000	**18/19 £000**	**19/20 £000**
Parks and Open Spaces	1,200	1,350	1,500
Substance Misuse	1,000	1,000	1,000
Transforming Neighbourhoods	486	647	647
Technical Services	3,407	5,870	6,970
Regulatory Services	150	150	150
	6,243	9,017	10,267

[This list will be added to as new reviews conclude before the budget is approved].

6.6 Additionally, management savings of £400,000 per year have arisen from a review of management in City Development and Neighbourhoods, and have been built into the budget.

6.7 A full schedule of reviews included in the programme is provided at Appendix Eight.

6.8 The budget ceiling of the Health and Wellbeing Division has been reduced to reflect Government cuts to the public health grant, amounting to £0.7m in 2017/18, and an estimated additional £0.7m in each of 2018/19 and 2019/20.

7. How Departments will live within their Budgets

7.1 The role of the Council is to determine the financial envelopes within which the City Mayor has authority to act. In some cases, changes to past spending patterns are required to enable departments to live within their budgets. Actions taken, or proposed by the City Mayor, to live within these budgets is described below.

Adult Social Care

7.2 In common with adult care services across the country, the department faces significant cost pressures. These principally arise from:-

(a) Demographic growth – an ageing population means the number of older people requiring care is increasing (which has been the pattern for many years);

(b) Increasing frailty and the impact of people having multiple health conditions that increase the level of care and support required (not just in older people, but also for adults of working age who are supported by the Department);

(c) The National Living Wage – this was introduced by the Government in April 2016, and is due to increase in stages to around £9 by 2020/21. These increases are creating substantial pressures for independent sector care providers, who are heavily dependent on a minimum wage workforce; and they will seek to pass on additional costs to local authorities.

7.3 The Government has partially recognised the difficulties facing adult social care, and has:-

(a) Permitted social care authorities to increase council tax by 2% per year over and above the referendum limit. This will raise around £1.9m per year, and will increase our total income by some £8m by 2019/20. This is well short of the sums required (as will be seen from the table below);

(b) Announced a further tranche of Better Care Fund monies, which will amount to £1.5bn nationally by 2020. However, the amount available will be minimal in 2017/18. This is discussed further at paragraph 12 below.

7.4 When the Council set the budget in February 2016, the budget for Adult Social Care had to be increased substantially to meet the cost of the living wage and increased need. Since then, in order to reduce the overall pressures facing the Council, the department has reviewed its budgets. The current position is shown below (which slightly reduces the growth previously approved). Estimates of the cost of the living wage have also been revised since 2016/17:-

	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000
National living wage	4,935	7,630	10,921	14,469
Other pressures	9,067	7,950	4,200	3,500
Net increase	**14,002**	**15,580**	**15,121**	**17,969**

7.5 Whilst the department believes it can live within these sums, the position is volatile. Key challenges facing the department are:-

(a) Managing demand for the service;

(b) The significant increase in costs of existing service users as their circumstances or conditions change. This is currently being analysed and monitored by the department.

7.6 The service also has to respond to a comparatively high level of working age adults requiring care due to problems of poor health, which have often built up over many years. The potential for prevention work in this area is being addressed by the Public Health Service (see below) and in joint working with the NHS, but the fruits of such work will not be seen for a considerable period of time.

7.7 Actions the department is taking to live within its resources include:-

(a) On-going review of the cost of existing user packages;

(b) Ensuring access to service is restricted to those with statutory entitlement;

(c) Transferring service users from residential care to supported living where possible, which is both cost effective and more popular than residential care. However, the Government has placed the future of Supported Living schemes in jeopardy by the proposed implementation of a housing benefit cap: such a cap would make schemes financially unviable. The Government has recently announced that the cap will not apply to supported living schemes until 2019/20. From this date, additional ringfenced grant funding will be provided to local authorities to address the shortfall between the rent cap and the actual rent (and service charges) paid. It is unclear whether the level of funding will be sufficient. A consultation paper was received on 21st November and is currently being studied.

(d) Substantial staffing savings which are designed to reduce our staffing complement to a level closer to that of comparative authorities (currently, our care staffing levels exceed those of similar authorities).

Education and Children's Services

7.8 Like adult care, the budget for Education and Children's Services was increased in 2016/17. This reflected substantial cost increases arising from:-

(a) Numbers of looked after children, where we had experienced significant growth in line with national trends;

(b) Extra staffing, arising from a national shortage of qualified social workers (and consequent reliance on more expensive agency staff).

7.9 However, measures to address these problems ("growing our own" social workers, and intensive family intervention to divert children from care) were expected to reduce these pressures over time. Consequently, unlike adult social care, the additional money required by the department was expected to reduce in years subsequent to 2016/17. The table below shows the position:-

	16/17 £000	**17/18 £000**	**18/19 £000**	**19/20 £000**
New monies	10,170	7,900	6,300	6,300
Less use of reserves	(6,962)			
	3,208			

7.10 All the department's services (other than social care) are subject to review as part of the Council's Spending Review Programme. Proposals have been made to save £4m per annum from Early Help, children's centres and adventure playgrounds. This includes reducing numbers of children's centres from 23 to 12.

7.11 The department is planning the following actions, to ensure it can live within its resources:-

(a) Continuing and expanding its new approach to preventing children being taken into care. There are currently 2 "Multi Systemic Therapy" (MST) teams – one predominantly for older children (11-17 years) with behavioural difficulties, and one for children aged 6-17 years who have suffered abuse and neglect. The former team has capacity to deal with 40-48 children per year, and the latter around 30 children per year. Subject to evaluation, it is planned to increase the size of the Child Abuse and Neglect Team. The department is also evaluating whether or not to expand the multi-systemic therapy interventions to include a team which will tackle those children already in care and try to return them to their parents. Additional resources are being provided to support a range of pre-proceedings work which will reduce the number of children aged 0-5 coming into care (the MST approach is not suitable for this age range). Funding to implement these measures has

been provided from the DfE, and the Council's own transformation fund;

(b) Results so far suggest that the strategy to "grow our own" social workers (which involves supporting and training them through their first years of work) is succeeding, and reliance on agency staffing can therefore decline in the coming years;

(c) Other areas of service are being considered in order to secure spending review savings of £5m in total (as the early help/children's centres/adventure playgrounds review is only targeting £4m);

(d) It is not clear yet how many of the 3,000 unaccompanied children who are being allowed to enter the UK under the "Dubs amendment" will ultimately need to be placed by the Council, and at what cost. This is a critical issue given the potential costs involved: the Government is being asked to ensure these costs are fully funded.

7.12 As members will be aware, schools' funding is provided by the Dedicated Schools Grant (DSG), and is outside the scope of the general fund. Funding for individual schools is calculated by reference to a locally determined formula, which is approved by the Schools' Forum. There is also scope to provide some (tightly prescribed) services which support schools from DSG.

7.13 The Government has consulted on sweeping changes to the arrangements for schools' funding. This will include replacement of the local funding formula with a national funding formula, and overhaul of the arrangements for using DSG on anything other than schools' individual budgets.

7.14 In addition to these proposals, the Government proposes to substantially reduce the amount of Education Services Grant paid to local authorities. This change will take effect in 2017/18. The reduction will be accompanied by certain changes in LEA duties.

7.15 No Government response to the consultation has yet been published, although the bulk of the changes have now been deferred until 2018/19.

7.16 Taken together, these changes will have knock-on implications for the general fund, and for the time being a provision has been made in corporate budgets (see paragraph 9 below).

City Development and Neighbourhoods

7.17 The department provides a wide range of statutory and non-statutory services which contribute to the well-being and civic life of the city. It brings together divisions responsible for local services in neighbourhoods and communities, economic strategy, tourism, regeneration, the environment, culture, heritage, sport, libraries, housing and property management.

7.18 The department is able to live within its budget for 2017/18. It is also contributing to the savings required by the Council from the Spending Review Programme (in fact, the majority of reviews in the programme are the responsibility of this department). Projects include:-

(a) Transforming Neighbourhood Services (TNS), which is reviewing local services in the city area by area. In the areas that have been reviewed to date, this has resulted in the relocation of services into a reduced number of buildings, thus saving money on maintaining facilities. Community engagement has been paramount throughout. TNS has also enabled staffing savings to be made, through our organisational review process;

(b) A review of technical services (facilities management, operational property services, traffic and transport, buildings repairs and maintenance, fleet, stores, energy and environment services). Savings of £10m per annum have been identified and approved, and are in the process of implementation;

(c) Using Buildings Better, which is an extension of TNS and is reviewing building use throughout the city. In addition to customer facing buildings reviewed by TNS, this programme is looking at operational buildings such as offices and depots, and seeking to reduce the cost of customer contact by means of "channel shift";

(d) A review of sports and leisure provision, which is examining how these services can best be run in the future;

(e) Reviews of Cleansing, Regulatory Services, Arts, Festivals and Museums.

7.19 The main budget pressures facing the department are:-

(a) Delivering the savings arising from the Technical Services Review, which is a substantial remodelling exercise involving the rationalisation of both staffing structures and occupation of buildings. The savings from this review have already been built into the budget, but close monitoring will be required to ensure it achieves its aims and makes the intended savings;

(b) Additional landfill tax, arising from a change in legislation relating to the organic content of sand;

(c) Loss of car park income, arising from sale of the former Granby Halls site.

7.20 These pressures are being addressed through management action.

Corporate Resources and Support

7.21 The key challenge facing the department is to be as cost effective as possible, in order to maximise the amount of money available to run public facing services.

7.22 Two substantial spending reviews were completed prior to approval of the 2016/17 budget. These were:-

(a) A review of support services, which is now saving £3.9m per year. Savings have principally come from the Finance Division; and the Delivery, Communications and Political Governance Division;

(b) A review of IT, which has saved £1.2m in 2016/17. Further work is taking place to ensure the full savings of £2.4m per year will be achieved, on time, by 2017/18.

7.23 The department is able to manage within its budget ceilings for 2016/17, having absorbed new spending pressures. These pressures include reductions in the housing benefit administration grant, which now amount to £2m per year compared to 2010/11, despite a largely similar caseload.

7.24 The main budget pressures facing the department are:-

(a) Pressures in the Revenues and Benefits Service, as benefit claimants are gradually transferred to Universal Credit. Universal Credit will replace a number of current benefits with a single monthly payment. The new payment will be administered by the DWP, who have different systems to us, and transitional problems (and workload) are envisaged. The transfer is also likely to adversely affect our ability to collect overpaid housing benefit, as DWP will prioritise other debts when making deductions from continuing benefit;

(b) Pressures arising from welfare reform, and an expected increase in numbers of residents requiring emergency support (this used to be funded by a DWP grant, which has now ceased);

(c) Difficulties in recruiting and retaining qualified legal staff, in the face of additional workload arising from spending reviews and regeneration projects. In particular, there are concerns about our ability to recruit and retain experienced childcare lawyers;

(d) An increasing number of cyber-attacks are being experienced by our IT network, requiring additional expenditure to safeguard our systems and data.

7.25 These pressures are being addressed through management action.

Public Health

7.26 The budget ceiling of the Health and Well Being Division has been reduced to reflect government cuts to specific grant (the Public Health Grant), as described at paragraph 6 above. A reduction of £0.7m is expected in 2017/18, followed by an estimated £0.7m per year in each of 2018/19 and 2019/20.

7.27 Spending reductions will be achieved by:-

(a) Consolidation of a range of children's public health services (school nurses, health visiting and healthy child programme) into a single contract, which will save an estimated £1.3m per year;

(b) A review of lifestyle services to develop a single integrated service, focussing predominantly on high risk working age adults. NHS monies to co-fund this service are being sought.

8. Sums to be Allocated to Services

8.1 The budget for the **apprentice levy** will meet the cost of a new tax imposed on large employers, which the Government will ringfence for apprentice training. Precise sums will be allocated to departments in due course. This tax amounts to 0.5% of pay costs; sums will also be required from the HRA and individual schools. The Council will have a digital account, out of which we can pay for any training we provide for our apprentices. Work is taking place to establish how we can best utilise this account to help move towards the Government's apprenticeship targets, and to offset the costs of the levy.

9. Corporately held Budgets

9.1 In addition to the service budget ceilings, some budgets are held corporately. These are described below (and shown in the table at paragraph 4).

9.2 The budget for **capital financing** represents the cost of interest and debt repayment on past years' capital spending. This budget is not controlled to a cash ceiling, and is managed by the Director of Finance. Costs which fall to be met by this budget are driven by the Council's approved treasury management strategy, which will be approved by the Council in January. This budget is declining over time, as the Government now provides grant in support of capital expenditure instead of its previous practice of providing revenue funding to service debt.

9.3 **Miscellaneous central budgets** include external audit fees, pensions costs of some former staff, levy payments to the Environment Agency, bank charges, the carbon reduction levy, monies set aside to assist council taxpayers suffering hardship and other sums it is not appropriate to include in service budgets. These budgets are offset by the effect of charges from the general fund to other statutory accounts of the Council.

10. Future Provisions

10.1 This section of the report describes the future provisions shown in the table at paragraph 4 above. These are all indicative figures – budgets for these years will be set in February prior to the year in question.

10.2 The provision for **inflation** includes money for:-

(a) An assumed 1% pay award each year in 2018/19 and 19/20;

(b) A contingency for inflation on running costs for services unable to bear the costs themselves. These are: waste disposal, independent sector residential and domiciliary care, and foster payments.

10.3 Paragraph 7 above describes the Government's proposals for **education funding reform**. Whilst details remain unclear, and the major aspects will not be implemented until 2018/19, there will be knock on implications for general fund services: cuts will be made to Education Services Grant (ESG) and some services currently paid for by Dedicated Schools Grant will need to be traded with schools or cease altogether. The ESG cuts will take effect in 2017/18. Whilst the Education and Children's Services Department will make some cuts to mitigate these changes, there will be some resultant cost – the Government is unwinding the current framework which enables us to share some school support costs with the schools themselves. A provision has thus been made for any funding reductions which the department will be unable to mitigate.

10.4 A **planning provision** has been set aside to manage uncertainty. Our general policy is to set aside a cumulative £3m per year, each year for the duration of the strategy. This can then be removed in subsequent budget reports, to the extent that it has not been utilised elsewhere (the sum set aside in the 16/17 budget, for instance, has now been used as a provision for the costs of education funding reform).

11. Budget and Equalities (Irene Kszyk)

11.1 The Council is committed to promoting equality of opportunity for its local residents; both through its policies aimed at reducing inequality of outcomes, and through its practices aimed at ensuring fair treatment for all and the provision of appropriate and culturally sensitive services that meet local people's needs.

11.2 In accordance with section 149 of the Equality Act, the Council must "have due regard", when making decisions, to the need to meet the following aims of our Public Sector Equality Duty:-

(a) eliminate discrimination;

(b) advance equality of opportunity between protected groups and others;

(c) foster good relations between protected groups and others.

11.3 Protected groups under the public sector equality duty are characterised by age, disability, gender re-assignment, pregnancy/maternity, race, religion or belief, sex and sexual orientation.

11.4 When making decisions, the Council (or City Mayor) must be clear about any equalities implications of the course of action proposed. In doing so, it must consider the likely impact on those likely to be affected by the recommendation; their protected characteristics; and (where negative impacts are anticipated) mitigating actions that can be taken to reduce or remove that negative impact.

11.5 This report seeks the Council's approval to the proposed budget strategy. The report sets out financial ceilings for each service which act as maxima above which the City Mayor cannot spend (subject to his power of virement). However, decisions on services to be provided within the budget ceilings are taken by managers or the City Mayor separately from the decision regarding the budget strategy. Therefore, the report does not contain details of specific service proposals. However, the budget strategy does recommend a proposed council tax increase for the city's residents. As the recommended increase could have an impact on those required to pay it, an assessment has been carried out to inform decision makers of the potential equalities implications. This is provided at Appendix Five.

11.6 In a nutshell, the likely impact on a household depends on whether or not the household is reliant on social security benefits.

11.7 The assessment suggests a very limited impact on the household finances of council tax payers who are not dependent on social security benefits: the increase will be readily mitigated by increased levels of household discretionary income which have been seen nationally (assuming these levels continue). However, the country may face a more uncertain economic future as a result of the referendum to leave the European Union. Future negative impacts on household incomes could undermine the premise this equality impact assessment is based on. However, these are as yet unknown, and the EIA sets out the known potential impacts and the sources used to identify these.

11.8 Some households reliant on social security benefits are likely to be adversely affected. This follows from a forecast increase in inflation (2.7% according to the Bank of England) and further implementation of the Government's welfare reforms. That said, the increase in tax alone contributes only a small increase in weekly costs for many benefit dependent households. The Council also has a number of mitigating actions in place to provide support in instances of short term financial crisis.

11.9 Locally, Council services provide (or fund) a holistic safety net including the provision of advice, personal budgeting support, and signposting provision of necessary household items. It is important to note that these mitigating

actions are now the sole form of safety net support available to households in the city. A House of Commons Works and Pensions Committee report in January ('The local welfare safety net') describes this devolution of discretionary support to those in short term financial crisis to local government. There is now no other source of Government support available.

11.10 Leicester is ranked as the 21st most deprived local authority in the country. In addition to provision of a 'local welfare safety net', council services seek to address inequalities of opportunity that contribute to this deprivation. They do this by seeking to improve equality of outcomes for those residents that we can directly support. The role of Adult Social Care is crucial in this context, and the approval of the additional 2% of council tax to maintain this service provision for a growing number of elderly people will directly contribute to improved outcomes related to health; personal safety; and personal identity, independence and participation in community life.

11.11 Our public sector equality duty is a continuing duty, even after decisions have been made and proposals have been implemented. Periodically we review the outcomes of earlier decisions to establish whether mitigating actions have been carried out and the impact they have had. The spending review programme enables us to assess our service provision from the perspective of the needs of individual residents. This "person centred" approach to our decision making ensures that the way we meet residents' needs with reducing resources can be kept under continuous review – in keeping with our Public Sector Equality Duty.

12. Government Grant

12.1 As can be seen from the table at paragraph 4, Government grant is a major component of the Council's budget.

12.2 Funding of local authorities changed in 2013/14, when we started to keep 50% of business rates. (Prior to 2013/14, business rates were handed over in their entirety to the Government, and recycled to local authorities on the basis of a formula). Government grant support now principally consists of:-

(a) **Revenue Support Grant** (RSG). This is the main grant which the Government has available to allocate at its own discretion. Consequently, cuts to local authority funding are substantially delivered through reductions in RSG (and the methodology for doing this has disproportionately disadvantaged deprived authorities). The impact on the city has been dramatic (RSG is reducing from £133m in 2013/14, to an estimated £28m in 2019/20). In 2016/17, the Government offered, and we accepted, a four year certainty deal which means the grant figures for 2017/18 to 2019/20 are fixed, "barring exceptional circumstances." As part of the four year certainty offer, the Council published an efficiency plan which can be found on the City Mayor's website;

(b) A **top-up to local business rates**. The local authority sector keeps 50% of business rates collected, with the balance paid to the Government. In recognition of the fact that different authorities' ability to raise rates does not correspond to needs, a top-up is paid to less affluent authorities (authorities with substantial numbers of highly rated businesses pay a tariff into the system, which funds these top-ups). The amount of our top-up grant was first calculated in 2013/14, and has not changed since, except for inflation. The grant will, however, be re-calculated as part of the 2017/18 settlement. As part of a regular cycle of revaluations, the rates of individual businesses have been re-assessed and will change with effect from April. The Government's intention is that local authorities should neither lose nor gain from the revaluation, and the top-up will be re-calculated as a consequence (the revaluation will see rates in Leicester increase by more than the national average, so our top-up grant will be reduced). [Once we have the final settlement, this report will be amended accordingly.] It should be added that the Government lacks the data to properly calculate the impact of the revaluation on top-up grant, so proxies will be used – we do not yet know how much difference this will make. More importantly, however, the calculation of the top-up grant needs to allow for an expected substantial number of appeals by businesses against the new values. Whether this allowance is adequate or not also remains to be seen, but will be a significant risk for the future (in the first two years of business rates retention, appeals cost local authorities almost twice the amount Government had assumed);

(c) **New Homes Bonus (NHB)**. This is a grant paid to authorities which roughly matches the council tax payable on new homes, and homes which have ceased to be empty on a long term basis. The system of New Homes Bonus is expected to change, and the Government wishes to reduce the amount it pays by £800m per year. Until now, the grant for each new house has been paid for six years, and the Government has proposed to reduce this to four. More detail about this may be available as part of the local government finance settlement.

12.3 The Government also controls **specific grants** which are given for specific rather than general purposes. These grants are not shown in the table at paragraph 4.1, as they are treated as income to departments (departmental budgets are consequently lower than they would have been).

12.4 Some specific grants are subject to change:-

(a) The **Education Services Grant** is being cut as part of education funding reforms, as described at paragraphs 7 and 10 above;

(b) The **Better Care Fund** is being increased by £1.5bn per year. This increase is not new money: around half the cost is being met from the proposed cuts to New Homes Bonus (described above); the remainder is reflected in the amount available for Revenue Support Grant. Only £100m of this money is expected to be made available in 2017/18.

Details of how much Leicester will receive are not yet known, although the Government intends to skew distribution towards deprived authorities (recognising that the extra 2% tax rise skews resources towards affluent authorities). Notwithstanding this, the total BCF on offer is insufficient to fully redress the imbalance of additional social care support in favour of more affluent authorities. Unlike previous rounds of BCF, the new tranche will be made available as a grant to local government. It is vital that the full amount is made available for adult social care, which we believe is the Government's intent (previous rounds have involved projects sponsored by both local authorities and the NHS).

12.5 The Institute for Fiscal Studies (IfS) has calculated the disproportionate impact of funding cuts on deprived authorities. Since 2009/10, the 10% of authorities most reliant on grant have seen budget cuts averaging 33% in real terms. The 10% of authorities least reliant on grant have seen cuts averaging 9%. This is a consequence of various changes in the funding regime which have had different impacts, and (to some extent) contravened the Government's stated intentions. The IfS states that "the overall impression is of rather confused, inconsistent and opaque policymaking."

12.6 Paradoxically, the local government finance settlement for 2016/17 provided some extra, transitional money to authorities who unexpectedly lost out from a change to the way RSG cuts were calculated in 2016/17. This transitional money has generally been made available to more affluent authorities, and the final payment will be made in 2017/18. The Government has refused requests for information on how these allocations have been calculated.

13. Local Taxation Income

13.1 Local tax income consists of three elements:-

(a) The retained proportion of business rates;

(b) Council tax;

(c) Surpluses or deficits arising from previous collection of council tax and business rates (collection fund surpluses/deficits).

Business Rates

13.2 Local government retains 50% of the rates collected locally, with the other 50% being paid to central government. In Leicester, 1% is paid to the fire authority, and 49% is retained by the Council. This is known as the "Business Rate Retention Scheme".

13.3 Rates due from individual businesses are calculated with reference to "rateable value" (RV). This is a sum calculated for each business by the Valuation Office Agency (a government agency), and for most properties the main driver of RV is rental values. Rateable value is multiplied by a nationally

set “multiplier”, to calculate gross rates due from which any exemptions or reliefs are deducted.

13.4 The Government asks the Valuation Office Agency to recalculate RVs every five years (although the revaluation due in 2015 was deferred). The next revaluation will take effect in 2017/18, and provisional lists of values are available now. Total RV in Leicester will increase by 17%, considerably higher than the national average of 10% and the East Midlands average of 7%. To a large extent, this reflects changes in rental values arising from successful regeneration of the city – we are by this measure a victim of our own success.

13.5 Business rates payable by Leicester businesses will be based on the new rateable values, although the multiplier will be lower than it otherwise would have been (the Government seeks to ensure that the total national yield does not increase as a result of revaluation). There will also be a transitional scheme which will phase in increases and decreases over time. Nonetheless, many Leicester businesses will see substantial increases in due course.

13.6 In advance of the local government finance settlement, we have estimated rates income based on the old rateable values. These will be reviewed prior to the final report being presented to Council, although (as discussed at paragraph 12 above) we would expect any increase in rates to be offset by reductions in top-up grant.

13.7 Our estimates of rates income will also require us to forecast the amount of income we will lose as a consequence of successful appeals: this is likely to be significant, and difficult to estimate (particularly given the scale of increases in RV). The cost ought to be allowed for in our top-up grant, but there is a real risk that this will be insufficient. This has been reflected in current estimates.

13.8 The Council is part of a “business rates pool” with other authorities in Leicestershire. Pools are beneficial in cases where shire district councils’ rates are expected to grow, as pooling increases the amount of rates which can be retained in those areas. Conversely, if district councils’ rates decline, this transfers risk to the pool authorities. (Oddly, our own rates do not affect the pool). In 2015/16, the pool made a substantial surplus of £2.7m: £0.7m of this was retained as a contingency, and £2m was paid to the LEP for area wide regeneration projects. A surplus of £4m is also forecast for 2016/17. Forecasting the pool surplus in 2017/18 is extremely difficult, given the impact of revaluation, and the impact of future appeals adds a new level of risk. A decision can be taken to disband the pool if the finance settlement suggests that the risk in 2017/18 would be too great.

13.9 The Government is planning to introduce 100% business rates “by 2020” (which could be 19/20 or 20/21). 100% business rates retention means local government will keep 100% of rates, not just the current 50%. As a consequence, RSG will cease. By 2019/20, 50% of national rates will exceed forecast RSG. This does not, however, mean that authorities will be better

off. The Government will ensure that the changes are "fiscally neutral" at national level by adding to the responsibilities which authorities must pay for. How the change will affect us locally is not known – the Government plans to carry out a re-assessment of need which may be to our benefit (depending on how it is done). The City Mayor has responded to a consultation on 100% business rates retention, which took place over the summer. The table at paragraph 4.1 shows forecast RSG in 2019/20, thereby assuming that 100% business rates retention (if implemented) will be neutral.

Council Tax

13.10 Council tax income is estimated at £99.5m in 2017/18, based on a tax increase of just below 4%. For planning purposes, a tax increase of just below 4% has also been assumed in 2018/19 and 2019/20.

13.11 The Council is unable to increase tax by 4% or more without first seeking endorsement by means of a local referendum. The "referendum limit" is 2% higher than it is for authorities generally: this concession is only available to social care authorities, and is designed to help mitigate the growing costs of social care (including the national living wage). Over 4 years, the extra income amounts to some £8m, which (as can be seen from paragraph 7 above) falls well short of meeting the estimated additional costs. The policy of allowing increases in council tax, as opposed to providing more central funding, also exacerbates the disproportionate impact Government policy has had on deprived authorities. The Government will partially address this in the way it distributes the proposed additional BCF monies. However, a comparison of the amount the Council will receive over 3 years from the combined 2% and additional BCF has been carried out by Sigoma. This suggests the Council will receive £1.7m less than it would have done compared to the needs formula for adult social care. Deprived authorities generally are in the same position. Surrey, by contrast, will be £18m better off.

Collection Fund Surpluses/Deficits

13.12 Collection fund surpluses arise when more tax is collected than assumed in previous budgets. Deficits arise when the converse is true.

13.13 The Council has a **council tax collection fund surplus** of £0.8m, after allowing for shares paid to the police and fire authorities.

13.14 No surplus or deficit is currently forecast in respect of business rates.

14. General Reserves and the Managed Reserves Strategy

14.1 In the current climate, it is essential that the Council maintains reserves to deal with the unexpected. This might include continued spending pressures in demand led services, or further unexpected Government grant cuts.

14.2 The Council has agreed to maintain a minimum balance of £15m of reserves. The Council also has a number of earmarked reserves, which are further discussed in section 15 below.

14.3 In the 2013/14 budget strategy, the Council approved the adoption of a managed reserves strategy. This involved contributing money to reserves in 2013/14 to 2015/16, and drawing down reserves in later years. This policy has bought time to more fully consider how to make the substantial cuts which are necessary. The 2016/17 budget was heavily dependent on the use of reserves, although some remain to support 2017/18 and 2018/19.

14.4 The managed reserves strategy will be extended as far as we can:-

(a) Following a review of earmarked reserves during 2016/17, £4.9m has been identified as no longer required and added to the monies set aside for the managed reserves strategy;

(b) The rolling programme of spending reviews enables any in-year savings to extend the strategy. Additional money has been made available since the 2016/17 budget was set, and future reviews should enable further contributions to be made.

14.5 The table below shows the forecast reserves available to support the managed reserves strategy:-

	2016/17	**2017/18**	**2018/19**
	£m	**£m**	**£m**
Brought forward	40.9	25.2	4.6
Additional spending review savings	3.3		
Earmarked reserves review	4.9		
Planned use	(23.9)	(20.7)	(4.6)
Carried forward	**25.2**	**4.6**	**NIL**

15. Earmarked Reserves

15.1 Appendix Six shows the Council's earmarked revenue reserves. These are set aside for specific purposes.

15.2 As stated above, departmental earmarked reserves have been reviewed; the purposes for which each was held have been challenged, and consequently £4.9m has been made available to support the managed reserves strategy. Appendix Six shows the estimated year end balances of departmental reserves as at period 6 in 2016/17.

15.3 Appendix Six also shows the Council's non-departmental earmarked reserves, and reserves which are ringfenced by law.

15.4 The appendix repeats the information shown in the Revenue Monitoring report for period 6, considered by Overview Select Committee in December, 2016.

16. **Risk Assessment and Adequacy of Estimates**

16.1 Best practice requires me to identify any risks associated with the budget, and section 25 of the Local Government Act 2003 requires me to report on the adequacy of reserves and the robustness of estimates.

16.2 In the current climate, it is inevitable that the budget carries significant risk.

16.3 In my view, although very difficult, the budget for 2017/18 is achievable subject to the risks and issues described below.

16.4 The most substantial risks are in social care, specifically the risks of further growth in the cost of care packages, and inability to contain the costs of looked after children. These risks are the ones which will require the most focussed management attention in 2017/18.

16.5 There are also risks in the 2017/18 budget arising from:-

(a) Ensuring spending reviews which have already been approved, but not yet implemented, deliver the required savings. The most significant of these is the Technical Services review, which is discussed further at paragraph 7 above;

(b) Achievability of estimated rates income (although technically any shortfall will appear as a collection fund deficit in the 2018/19 budget). The key concern is the extent to which ratepayers will successfully appeal their new valuations, although there are still appeals outstanding from the previous revaluation which would result in backdated reductions if successful.

16.6 In the longer term, the risks to the budget strategy arise from:-

(a) Non-achievement, or delayed achievement, of the remaining spending review savings;

(b) Failure to achieve sufficient savings over and above the spending review programme;

(c) Loss of future resources, particularly in the transition to 100% business rates retention;

(d) Costs arising from the education funding reforms, over and above those for which provision has already been made.

16.7 A further risk arises from the implementation of the National Living Wage. This has effectively removed bands 1 and 2 from our pay structure, meaning differentials have ceased to be meaningful at the lower ends of the pay scale.

The LGA is currently reviewing the pay spine, with a view to making it fit for purpose again: recommendations have not yet been made, although it is hard to see what could be recommended other than wage increases to pay bands just above the national living wage.

16.8 Further risk is economic downturn, nationally or locally. This could result in new cuts to Revenue Support Grant (the Government has reserved its position over 4 year certainty, in the event of a substantial downturn); falling business rate income; and increased cost of council tax reductions for taxpayers on low incomes. It could also lead to a growing need for council services and an increase in bad debts. The decision to leave the EU may have increased this risk.

16.9 The budget seeks to manage these risks as follows:-

(a) A minimum balance of £15m reserves will be maintained;

(b) A planning contingency is included in the budget from 2018/19 onwards (£3m per annum accumulating);

(c) Savings from the Council's minimum revenue provision policy are being saved until they are required (see paragraph 19).

16.10 Subject to the above comments, I believe the Council's general and earmarked reserves to be adequate. I also believe estimates made in preparing the budget are robust. (Whilst no inflation is provided for the generality of running costs in 2017/18, some exceptions are made, and it is believed that services will be able to manage without an allocation).

17. Consultation on the Draft Budget

17.1 Comments on the draft budget will be sought from:-

(a) Business community representatives (a statutory consultee);

(b) The Council's scrutiny function;

(c) The Council's trade unions;

(d) Key partners and other representatives of communities of interest.

17.2 Comments received will be included in the final version of this report.

18. Borrowing

18.1 Local authority capital expenditure is self-regulated, based upon a code of practice (the "prudential code").

18.2 The Council complies with the code of practice, which requires us to demonstrate that any borrowing is affordable, sustainable and prudent. To

comply with the code, the Council must approve a set of indicators at the same time as it agrees the budget. The substance of the code pre-dates the recent huge cutbacks in public spending, and the indicators are of limited value.

18.3 Since 2011/12, the Government has been supporting all new general fund capital schemes by grant. Consequently, any new borrowing has to be paid for ourselves and is therefore minimal.

18.4 Attached at Appendix Three are the prudential indicators which would result from the proposed budget. A limit on total borrowing, which the Council is required to set by law, is approved separately as part of the Council's treasury strategy.

18.5 The Council will continue to use borrowing for "spend to save" investment which generates savings to meet borrowing costs.

19. Minimum Revenue Provision

19.1 By law, the Council is required to charge to its budget each year an amount for the repayment of debt. This is known as "minimum revenue provision" (MRP). The Council approved a new approach in November, 2015, and the proposed policy for 2017/18 is shown at Appendix Four.

19.2 The proposed MRP policy results in revenue account savings when compared to the old approach, although these are paper rather than real savings – they result from a slower repayment of historic debt.

19.3 The proposed budget for 2017/18 would use the savings made in that year to set aside additional monies for debt repayment (voluntarily). This creates a "virtuous circle", i.e. it increases the savings in later years when we will need them more.

19.4 The approach to savings in 2018/19 and later years will be considered when the budgets for those years are prepared. At present, the capital financing estimates assume that the previous policy continues to apply.

19.5 Members are asked to note that the extent of savings available from the policy change will tail off in the years after they are fully brought into account.

20. Financial Implications

20.1 This report is exclusively concerned with financial issues.

20.2 Section 106 of the Local Government Finance Act 1992 makes it a criminal offence for any member with arrears of council tax which have been outstanding for two months or more to attend any meeting at which a decision affecting the budget is to be made unless the member concerned declares the arrears at the outset of the meeting and that as a result s/he will not be voting. The member can, however, still speak. The rules are more circumscribed for

the City Mayor and Executive. Any executive member who has arrears outstanding for 2 months or more cannot take part at all.

21. **Legal Implications (Kamal Adatia/Emma Horton)**

21.1 The budget preparations have been in accordance with the Council's Budget and Policy Framework Procedure Rules – Council's Constitution – Part 4C. The decision with regard to the setting of the Council's budget is a function under the constitution which is the responsibility of the full Council.

21.2 At the budget-setting stage, Council is estimating, not determining, what will happen as a means to the end of setting the budget and therefore the council tax. Setting a budget is not the same as deciding what expenditure will be incurred. The Local Government Finance Act, 1992, requires an authority, through the full Council, to calculate the aggregate of various estimated amounts, in order to find the shortfall to which its council tax base has to be applied. The Council can allocate more or less funds than are requested by the Mayor in his proposed budget.

21.3 As well as detailing the recommended council tax increase for 2017/18, the report also complies with the following statutory requirements:-

(a) Robustness of the estimates made for the purposes of the calculations;

(b) Adequacy of reserves;

(c) The requirement to set a balanced budget.

21.4 Section 65 of the Local Government Finance Act, 1992, places upon local authorities a duty to consult representatives of non-domestic ratepayers before setting a budget. There are no specific statutory requirements to consult residents, although in the preparation of this budget the Council will undertake tailored consultation exercises with wider stakeholders.

21.5 As set out at paragraph 2.12, the discharge of the 'function' of setting a budget triggers the duty in s.149 of the Equality Act, 2010, for the Council to have "due regard" to its public sector equality duties. These are set out in paragraph 11. There are considered to be no specific proposals within this year's budget that could result in new changes of provision that could affect different groups of people sharing protected characteristics. As a consequence, there are no service-specific 'impact assessments' that accompany the budget. There is no requirement in law to undertake equality impact assessments as the only means to discharge the s.149 duty to have "due regard". The discharge of the duty is not achieved by pointing to one document looking at a snapshot in time, and the report evidences that the Council treats the duty as a live and enduring one. Indeed case law is clear that undertaking an EIA on an 'envelope-setting' budget is of limited value, and that it is at the point in time when policies are developed which reconfigure services to live within the budgetary constraint when impact is best assessed. However, an analysis of equality impacts has been prepared

in respect of the proposed increase in council tax, and this is set out in Appendix Five.

21.6 Judicial review is the mechanism by which the lawfulness of Council budget-setting exercises are most likely to be challenged. There is no sensible way to provide an assurance that a process of budget setting has been undertaken in a manner which is immune from challenge. Nevertheless the approach taken with regard to due process and equality impacts is regarded by the City Barrister to be robust in law.

22. **Other Implications**

Other Implications	**Yes/ No**	**Paragraph References within the report**
Equal Opportunities	Y	Paragraph 11
Policy	Y	The budget sets financial envelopes within which Council policy is delivered
Sustainable and Environmental	N	The budget is a set of financial envelopes within which service policy decisions are taken. The proposed 2016/17 budget reflects existing service policy.
Crime & Disorder	N	
Human Rights Act	N	
Elderly People/People on Low Income	N	

23. **Report Author**

Mark Noble
Head of Financial Strategy

30th November 2016

Appendix One

Budget Ceilings

1. City Development & Neighbourhoods

1.1 Local Services and Enforcement					
Divisional Management	202.7	0.0		1.7	204.4
Regulatory Services	4,398.5	(50.0)		55.2	4,403.7
Waste Management	15,248.4	0.0		285.9	15,534.3
Parks & Open Spaces	4,122.9	(430.0)		102.4	3,795.3
Neighbourhood Services	5,910.5	(111.0)		40.4	5,839.9
Standards & Development	715.9	0.0		11.3	727.2
Divisional sub-total	**30,598.9**	**(591.0)**	**0.0**	**496.9**	**30,504.8**
1.2 Tourism, Culture & Inward Investment					
Arts & Museums	4,985.0	0.0		25.9	5,010.9
De Montfort Hall	969.7	0.0		18.9	988.6
City Centre	324.5	0.0		1.8	326.3
Inward Investment	192.7	0.0		1.9	194.6
Economic Development	457.2	0.0		10.5	467.7
Markets	(388.1)	0.0		6.6	(381.5)
Management - TCII	55.0	0.0		1.8	56.8
Divisional sub-total	**6,596.0**	**0.0**	**0.0**	**67.4**	**6,663.4**
1.3 Planning, Transportation & Economic Development					
Transport Strategy	8,403.5	0.0		29.6	8,433.1
Traffic Management	1,526.4	0.0		35.2	1,561.6
Highways Design & Maintenance	6,199.5	(50.0)		2.2	6,151.7
Planning	1,057.1	0.0		21.5	1,078.6
Divisional Management	194.5	0.0		2.0	196.5
Divisional sub-total	**17,381.0**	**(50.0)**	**0.0**	**90.5**	**17,421.5**
1.5 Investment					
Property Management	6,813.5	0.0		68.6	6,882.1
Environment team	329.4	0.0		3.0	332.4
Energy Management	635.9	0.0		7.0	642.9
Divisional sub-total	**7,778.8**	**0.0**	**0.0**	**78.6**	**7,857.4**
1.6 Housing Services	**4,414.7**	**0.0**	**0.0**	**61.2**	**4,475.9**
1.7 Departmental Overheads	**657.0**	**0.0**	**0.0**	**1.6**	**658.6**
1.8 Fleet Management	**111.8**	**(103.0)**	**0.0**	**1.8**	**10.6**
Savings to be allocated	**0.0**	**(1,816.5)**	**0.0**	**0.0**	**(1,816.5)**
DEPARTMENTAL TOTAL	**67,538.2**	**(2,560.5)**	**0.0**	**798.0**	**65,775.7**

	2016/17 budget £'000s	Spending Review savings £'000s	Social care pressures £'000s	Inflation £'000s	Budget 2017/18 £'000s
2.Adults					
2.1 Adult Social Care & Safeguarding					
Other Management & support	1,752.7	0.0		13.9	1,766.6
Safeguarding	543.0	0.0		6.9	549.9
Preventative Services	7,914.0	0.0		72.6	7,986.6
Independent Sector Care Package Costs	75,522.0	0.0		1,179.8	76,701.8
Care Management (Localities)	7,274.2	0.0		74.7	7,348.9
Divisional sub-total	**93,005.9**	**0.0**	**0.0**	**1,347.9**	**94,353.8**
2.2 Adult Social Care & Commissioning					
Enablement &Day Care	4,723.7	0.0		48.2	4,771.9
Care Management (LD & AMH)	5,426.0	0.0		53.7	5,479.7
Preventative Services	3,746.3	0.0		2.1	3,748.4
Contracts,Commissioning & Other Support	2,695.3	0.0		30.0	2,725.3
Substance Misuse	5,282.7	0.0		0.0	5,282.7
Departmental	(12,396.0)	0.0	1,578.0	4.8	(10,813.2)
Divisional sub-total	**9,478.0**	**0.0**	**1,578.0**	**138.8**	**11,194.8**
2.3 City Public Health & Health Improvement					
Sexual Health	4,390.6	0.0		0.0	4,390.6
NHS Health Checks	521.0	0.0		0.0	521.0
Children 0-19	10,367.5	0.0		0.0	10,367.5
Smoking & Tobacco	972.0	0.0		0.0	972.0
Substance Misuse	327.0	0.0		0.0	327.0
Physical Activity	1,623.2	0.0		0.0	1,623.2
Health Protection	55.0	0.0		0.0	55.0
Public Mental Health	234.0	0.0		0.0	234.0
Public Health Advice & Intelligence	90.0	0.0		0.0	90.0
Staffing & Infrastructure	1,288.7	0.0		0.0	1,288.7
Sports Services	3,491.8	0.0		54.0	3,545.8
Divisional sub-total	**23,360.8**	**0.0**	**0.0**	**54.0**	**23,414.8**
2.4 Public Health grant income	**(28,214.0)**	**0.0**	**0.0**	**0.0**	**(28,214.0)**
DEPARTMENT TOTAL	**97,630.7**	**0.0**	**1,578.0**	**1,540.7**	**100,749.4**

	2016/17 budget £'000s	Spending Review savings £'000s	Social care pressures £'000s	Inflation £'000s	Budget 2017/18 £'000s
3. Education & Children's Services					
3.1 Strategic Commissioning & Business Support					
Divisional Budgets	640.9	0.0		7.3	648.2
Operational Transport	(111.6)	0.0		0.0	(111.6)
Divisional sub-total	**529.3**	**0.0**	**0.0**	**7.3**	**536.6**
3.2 Learning Quality & Performance					
Raising Achievement	1,872.4	0.0		17.8	1,890.2
Adult Skills	(870.4)	0.0		0.0	(870.4)
School Organisation & Admissions	794.8	0.0		5.0	799.8
Special Education Needs and Disabilities	6,783.5	0.0		27.2	6,810.7
Divisional sub-total	**8,580.3**	**0.0**	**0.0**	**50.0**	**8,630.3**
3.3 Children, Young People and Families					
Children In Need	9,490.1	0.0		58.9	9,549.0
Looked After Children	33,448.7	0.0	4,692.0	221.1	38,361.8
Safeguarding & QA	2,128.5	0.0		21.0	2,149.5
Early Help Targeted Services	8,948.7	0.0		86.5	9,035.2
Early Help Specialist Services	5,266.4	0.0		56.6	5,323.0
Divisional sub-total	**59,282.4**	**0.0**	**4,692.0**	**444.1**	**64,418.5**
3.4 Departmental Resources					
Departmental Resources	(5,677.7)	0.0		6.7	(5,671.0)
Education Services Grant	(4,468.1)	0.0		0.0	(4,468.1)
Divisional sub-total	**(10,145.8)**	**0.0**	**0.0**	**6.7**	**(10,139.1)**
DEPARTMENTAL TOTAL	**58,246.2**	**0.0**	**4,692.0**	**508.1**	**63,446.3**
4. Corporate Resources Department					
4.1 Delivery, Communications & Political Gover	**5,685.6**	**0.0**	**0.0**	**33.8**	**5,719.4**
4.2 Financial Services					
Financial Support	6,218.9	0.0		70.6	6,289.5
Revenues & Benefits	5,767.9	0.0		81.1	5,849.0
Divisional sub-total	**11,986.8**	**0.0**	**0.0**	**151.7**	**12,138.5**
4.3 Human Resources	**3,963.2**	**0.0**	**0.0**	**42.2**	**4,005.4**
4.4 Information Services	**10,084.6**	**(1,200.0)**	**0.0**	**64.0**	**8,948.6**
4.5 Legal Services	**2,017.1**	**0.0**	**0.0**	**38.0**	**2,055.1**
DEPARTMENTAL TOTAL	**33,737.3**	**(1,200.0)**	**0.0**	**329.7**	**32,867.0**
GRAND TOTAL -Service Budget Ceilings	**257,152.4**	**(3,760.5)**	**6,270.0**	**3,176.5**	**262,838.4**

Appendix Two

Scheme of Virement

1. This appendix explains the scheme of virement which will apply to the budget, if it is approved by the Council.

Budget Ceilings

2. Strategic directors are authorised to vire sums within budget ceilings without limit, providing such virement does not give rise to a change of Council policy.

3. Strategic directors are authorised to vire money between any two budget ceilings within their departmental budgets, provided such virement does not give rise to a change of Council policy. The maximum amount by which any budget ceiling can be increased or reduced during the course of a year is £500,000. This money can be vired on a one-off or permanent basis.

4. Strategic directors are responsible, in consultation with the appropriate Assistant Mayor if necessary, for determining whether a proposed virement would give rise to a change of Council policy.

5. Movement of money between budget ceilings is not virement to the extent that it reflects changes in management responsibility for the delivery of services.

6. The City Mayor is authorised to increase or reduce any budget ceiling. The maximum amount by which any budget ceiling can be increased during the course of a year is £5m. Increases or reductions can be carried out on a one-off or permanent basis.

7. The Director of Finance may vire money between budget ceilings where such movements represent changes in accounting policy, or other changes which do not affect the amounts available for service provision.

8. Nothing above requires the City Mayor or any director to spend up to the budget ceiling for any service.

Corporate Budgets

9. The following authorities are granted in respect of corporate budgets:

   (a) the Director of Finance may incur costs for which there is provision in miscellaneous corporate budgets, except that any policy decision requires the approval of the City Mayor;

   (b) the City Mayor may determine the use of the provision for Education Funding reform.

Earmarked Reserves

10. Earmarked reserves may be created or dissolved by the City Mayor. In creating a reserve, the purpose of the reserve must be clear.

11. Strategic directors may add sums to an earmarked reserve, from:

    (a) a budget ceiling, if the purposes of the reserve are within the scope of the service budget;
    (b) a carry forward reserve, subject to the usual requirement for a business case.

12. Strategic directors may spend earmarked reserves on the purpose for which they have been created.

13. When an earmarked reserve is dissolved, the City Mayor shall determine the use of any remaining balance.

Appendix Three

Recommended Prudential Indicators

1. Introduction

1.1 This appendix details the recommended prudential indicators for general fund borrowing and HRA borrowing.

2. Proposed Indicators of Affordability

2.1 The ratio of financing costs to net revenue budget:

	2017/18 Estimate %	2018/19 Estimate %	2019/20 Estimate %
General Fund	5.4	5.5	5.4
HRA	11.4	11.9	12.3

2.2 The estimated incremental impact on council tax and average weekly rents of capital investment decisions proposed in the general fund budget and HRA budget reports over and above capital investment decisions that have previously been taken by the Council are:

	2017/18 Estimate £	2018/19 Estimate £
Band D council tax	0.0	0.0
HRA rent	0.0	0.0

3. Indicators of Prudence

3.1 The forecast level of capital expenditure to be incurred for the years 2016/17 and 2017/18 (based upon the Council capital programme, and the proposed budget and estimates for 2017/18) are:

Area of expenditure	**2016/17 Estimate £000s**	**2017/18 Estimate £000s**
Children's services	20,467	41,310
Young People	438	1,097
Resources ICT	951	1,880
Transport	15,271	45,333
Cultural & Neighbourhood Services	7,350	1,298
Environmental Services	2,375	284
Economic Regeneration	41,679	28,864
Adult Care	934	15,571
Public Health	390	120
Property	7,769	2,715
Vehicles	501	3,100
Housing Strategy & Options	2,121	3,600
Corporate Loans	1,000	-
Total General Fund	101,246	145,172
Housing Revenue Account	22,080	17,130
Total	123,326	162,302

3.2 The capital financing requirement measures the authority's underlying need to borrow for a capital purpose is shown below. This includes PFI recognised on the balance sheet.

	2016/17 Estimate £m	**2017/18 Estimate £m**	**2018/19 Estimate £m**	**2019/20 Estimate £m**
General Fund	364	347	330	313
HRA	213	212	211	211

4. Treasury Limits for 2017/2018

4.1 The Treasury Strategy which includes a number of prudential indicators required by CIPFA's prudential code for capital finance has been included as part of a separate report to Council.

Appendix Four

Minimum Revenue Provision Policy

1. Introduction

1.1 This policy sets out how the Council will calculate the minimum revenue provision chargeable to the General Fund in respect of previous years' capital expenditure, where such expenditure has been financed by borrowing.

2. Basis of Charge

2.1 Where borrowing pays for an asset, the debt repayment calculation will be based on the life of the asset.

2.2 Where borrowing funds a grant or investment, the debt repayment will be based upon the length of the Council's interest in the asset financed (which may be the asset life, or may be lower if the grantee's interest is subject to time limited restrictions).

2.3 Where borrowing funds a loan to a third party, the basis of charge will normally be the period of the loan (and will never exceed this). The charge would normally be based on an equal instalment of principal, but could be set on an annuity basis where the Director of Finance deems appropriate.

3. Commencement of Charge

3.1 Debt repayment will normally commence in the year following the year in which the expenditure was incurred. However, in the case of expenditure relating to the construction of an asset, the charge will commence in the year in which the asset becomes operational. Where expenditure will be recouped from future income, and the receipt of that income can be forecast with reasonable certainty, the charge may commence when the income streams arise.

4. Asset Lives

4.1 The following maximum asset lives are proposed:-

- Land – 50 years;
- Buildings – 50 years;
- Infrastructure – 40 years;
- Plant and equipment – 20 years;
- Vehicles – 10 years;
- Loan premia – the higher of the residual period of loan repaid and the period of the replacement loan;

5. **Voluntary Set Aside**

5.1 Authority is given to the Director of Finance to set aside sums voluntarily for debt repayment, where she believes the standard depreciation charge to be insufficient, or in order to reduce the future debt burden to the authority.

6. **Other**

6.1 In circumstances where the treasury strategy permits use of investment balances to support investment projects which achieve a return, the Director of Finance may adopt a different approach to reflect the financing costs of such schemes. A different approach may also be adopted for other projects which aim to achieve a return.

Appendix Five

Equality Impact Assessment

1. The purpose of this appendix is to present the equalities impact of the proposed 3.99% council tax increase.

2. **Purpose of the increase**

2.1 There are two elements to the proposed tax increase:

(a) A 2% increase to address Adult Social Care funding needs outlined in the budget strategy;

(b) A 1.99% increase in council tax to enable the council to maintain its budgeted policy commitments.

3. **Who is affected by the proposal?**

3.1 Since April 2013, as a consequence of the Government's welfare reforms, all working age households in Leicester have been required to contribute towards their council tax bill. Our current council tax reduction scheme (CTRS) requires working age households to pay at least 20% of their council tax bill, and sets out to ensure that the most vulnerable householders are given some relief in response to financial hardship they may experience.

3.2 NOMIS[1] figures for the city's working age population (June 2016) indicated that there are 159,000 economically active residents in the city, of whom 6.6% are unemployed. As of February 2016, there were 32,000 working age benefit claimants (14.0% of the city's working age population of 229,000), with 25,000 of these in receipt of out of work benefits. The working age population is inclusive of all protected characteristics.

4. **How are they affected?**

4.1 The chart below sets out the financial impact of the proposed council tax increase on different properties, before any discounts or reliefs are applied. It shows the weekly increase in each band, and the minimum weekly increase for those in receipt of a reduction under the CTRS.

4.2 For band B properties (80% of the city's properties are in bands A or B), the proposed annual increase in council tax is £42.11; the minimum annual increase for households eligible under the CTRS would be £8.42.

[1] NOMIS is an Office for National Statistics web based service that provides free UK labour market statistics from official sources.

Band	No. of Households	Weekly Increase	Maximum Relief (80%)	Minimum Weekly Increase
A-	243	£0.58	£0.46	£0.12
A	80066	£0.69	£0.55	£0.14
B	26153	£0.81	£0.65	£0.16
C	15485	£0.92	£0.65	£0.27
D	6732	£1.04	£0.65	£0.39
E	3279	£1.27	£0.65	£0.62
F	1459	£1.50	£0.65	£0.85
G	597	£1.73	£0.65	£1.08
H	39	£2.08	£0.65	£1.43
Total	**134053**			

5. **Risks over the coming year:**

5.1 One of the main risks to household income over the coming year is increased inflation. The November 2016 forecast by the Bank of England anticipates a CPI inflation rate of 2.7% in the third quarter of 2018, arising from the drop in value of the pound. Some industry sources expect an increase of up to 5% in food prices over the next year. Because food takes up a larger proportion of low income household expenditure, and their income levels have been squeezed by the Government's welfare reforms (ASDA tracker, June 2016), increases in food prices will have the most significant impact on these households.

5.2 Another area of cost increase could be fuel and oil, as a result of the decision by OPEC to reduce its supplies to the energy markets. Costs rose by 6% in September 2016 as result of this decision alone. It is likely we will see increases in fuel and energy costs over time as a result of this OPEC decision.

5.3 Incomes of households reliant on social security benefits continue to be squeezed with the Government's continued implementation of the welfare reform programme. There are a range of specific reductions alongside the far ranging freeze in the level of benefits until 2020. This will reduce the ability of low income households to respond to the above anticipated inflationary

pressures, particularly in regard to the cost of food. The chart below gives an indication of anticipated decreases in household incomes by 2020/21, as a consequence of post 2015 welfare reforms:-

Couple – one dependent child	£900 p.a.
Couple – two or more dependent children	£1,450 p.a.
Lone parent – one dependent child	£1,400 p.a.
Lone parent – two or more dependent children	£1,750 p.a.
Single person working age household	£250 p.a.

Source: Centre for Regional Economic and Social Research/Sheffield Hallam University report: "The uneven impact of welfare reform – the financial losses to places and people" (March 2016).

6. **Offset by current trends:**

6.1 There has been a continuing decrease in the percentage of the working age population unemployed in Leicester (NOMIS): June 2016, 6.6%, (down from June 2015, 7.7%; June 2014, 11.8%; and June 2013, 13.9%).

6.2 The supermarket ASDA tracks household expenditure. The tracker for June 2016 indicated that the national increase in average household discretionary income was £10 per week compared to June 2015. However, the level of increase is starting to be affected by inflationary rises for essential household items. The tracker nonetheless found that wage growth remains well about the inflation rate.

6.3 The Joseph Rowntree Foundation's annual "Minimum Income Standard" for 2016 highlighted the emerging trend of families seeking more economical ways of maintaining their standard of living, by shopping around and using the internet for price comparisons. They cited weekly savings of £7 in fuel costs for a family with children by switching suppliers. The Minimum Income Standard also observed that a significant proportion of childcare costs for families in receipt of Universal Credit and tax credits were being covered for them (by 85% and 70% respectively); and that the introduction by the Government of free childcare for 3 and 4 year olds will further ease pressures on household incomes for those with young children.

7. **Overall impact:**

7.1 Any increased costs will be a problem for some households with limited incomes, as they will be squeezed by the next round of welfare reforms alongside anticipated inflationary increases of many basic household items such as food and fuel.

7.2 The weekly increase in council tax, however, is small for many of these households, as can be seen from the table above.

8. **Mitigating actions:**

8.1 For residents likely to experience short term financial crises as a result of the cumulative impacts of the above risks, the Council has a range of mitigating actions. These include: funding through Discretionary Housing Payments; the council's work with voluntary and community sector organisations to provide food to local people where it is required – through the council's or partners' food banks; and through schemes which support people getting into work (and include cost reducing initiatives that address high transport costs such as providing recycled bicycles).

9. **What protected characteristics are affected?**

9.1 The chart below, describes how each protected characteristic is likely to be affected by the proposed council tax increase. The chart sets out known trends, anticipated impacts and risks; along with mitigating actions available to reduce negative impacts.

9.2 Some protected characteristics are not (as far as we can tell) disproportionately affected (as will be seen from the table) because there is no evidence to suggest they are affected differently from the population at large. They may, of course, be disadvantaged if they also have other protected characteristics that are likely to be affected, as indicated in the following analysis of impact based on protected characteristic.

Analysis of impact based on protected characteristic

Protected characteristic	Impact of proposal:	Risk of negative impact:	Mitigating actions:
Age	Older people are least affected – they receive protection from inflation in the uprating of state pensions; and 100% reductions are available under the CTRS. Working age people bear the impacts of welfare reform reductions – particularly those with children. Whilst an increasing proportion of working age residents are in work, national research indicates that those on low wages are failing to get the anticipated uplift of the National Living Wage. The tax increase could have an impact on such household incomes.	Working age households – incomes squeezed through low wages and reducing levels of benefit income, along with anticipated inflation.	Access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on better managing household budgets.
Disability	Disability benefits have been reduced over time as thresholds for support have increased. The tax increase could have an impact on such household incomes.	Further erode quality of life being experienced by disabled people as their household incomes are squeezed further by anticipated inflation.	Disability benefits are disregarded in the assessment of need for CTRS purposes. Access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on better managing budgets.

Protected characteristic	Impact of proposal:	Risk of negative impact:	Mitigating actions:
Gender Reassignment	No disproportionate impact is attributable specifically to this characteristic.		
Marriage and Civil Partnership	Couples receive benefits if in need, irrespective of their legal marriage or civil partnership status. No disproportionate impact is attributable specifically to this characteristic.		
Pregnancy and Maternity	Maternity benefits will not be frozen and therefore kept in line with inflation. However, other social security benefits will be frozen, but without disproportionate impact arising for this protected characteristic.		
Race	Those with white backgrounds are disproportionately on low incomes (indices of multiple deprivation) and in receipt of social security benefits. Some BME are also low income and on benefits. The tax increase could have an impact on such household incomes.	Household income being further squeezed through low wages and reducing levels of benefit income, along with anticipated inflation.	Access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on better managing household budgets.

Protected characteristic	Impact of proposal:	Risk of negative impact:	Mitigating actions:
Religion or Belief	No disproportionate impact is attributable specifically to this characteristic.		
Sex	Disproportionate impact on women who tend to manage household budgets and are responsible for childcare costs. Women are disproportionately lone parents.	Incomes squeezed through low wages and reducing levels of benefit income, along with anticipated inflation.	If in receipt of Universal Credit or tax credits, a significant proportion of childcare costs are met by these sources. Access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on better managing household budgets.
Sexual Orientation	No disproportionate impact is attributable specifically to this characteristic.		

Earmarked Reserves — Appendix Six

Earmarked Revenue Reserves-Departmental	Balance at 1st April 2016 {£000}	Forecast Balance 31-3-2017 {£000}
Adult Care		
Adult and Children's Social Care IT System (Liquidlogic)	354	193
Amount required to balance 16/17 budget	331	-
Children's		
Amount required to balance 16/17 budget	5,005	-
City Development (excluding Housing)		
Strategic Reserve	1,139	954
Central Maintenance Fund	436	-
On Street Parking - commitments	432	-
Other CDN	1,078	637
Housing		
Provision for Bed & Breakfast Costs	400	400
Other Housing	966	829
Public Health		
Outdoor Gyms Reserve	727	-
Provision for Severance Costs	910	410
Food Growing Hubs Initiative (17/18)	93	93
Corporate Resources		
Replacement of Finance System	1,250	1,250
Service Analysis Team	624	624
Channel Shift Reserve	1,702	1,702
ICT Development Fund	2,156	2,156
PC Replacement Fund	939	939
Surplus Property Disposal Costs	1,000	1,000
Electoral Services	619	619
Legal Services Divisional Reserve	521	521
Election Fund	1,020	1,020
Strategic Initiatives	500	500
Other Corporate Resources	2,339	1,800
TOTAL DEPARTMENTAL RESERVES	**24,541**	**15,647**

	Balance at 1st April 2016 *{£000}*
Corporate Reserves	
Earmarked Reserves Declared Surplus	4,914
Managed Reserves Strategy	40,936
BSF Financing	24,812
Capital Programme Reserve	17,125
Severance Fund	8,094
Insurance Fund	11,121
Service Transformation Fund	6,135
Welfare Reform Reserve	4,533
Other Corporate Reserves	2,249
Total Corporate Reserves	**119,919**
Ringfenced Monies	
NHS Joint Working Projects	5,275
DSG not delegated to schools	16,705
School Capital Fund	2,829
Schools Buy Back	923
Primary PRU Year-End Balance	71
Secondary PRU Year-End Balance	175
Schools' Balances	19,583
Total Ringfenced Monies	**45,561**

Appendix Seven

Comments from Partners

[To complete later]

Appendix Eight

Spending Review Programme

	Review	Summary	Savings Reported (£m)	Outstanding Savings (£m)
1.	Corporate Resources	In implementation.	3.9	Nil
2.	Transforming Neighbourhood Services	Reviewing community use buildings on an area by area basis (libraries, community centres, adult skills, customer service centres).	0.9	0.8
3.	Voluntary and Community Services	Complete.	0.1	Nil
4.	HRA Charging	Complete (decisions taken).	4.0	Nil
5.	Sports and Leisure	Review of Council's direct sports provision and sports development.		2.0
6.	Parks and Open Spaces	In implementation.	1.5	Nil
7.	Park and Ride	Service expected to become self-financing.		0.2
8.	External Communications	Complete.	0.1	Nil
9.	Substance Misuse	Complete.	1.0	Nil
10.	Welfare Advice	Decision taken.	0.2	Nil
11.	Investment Property.	Review of property assets held for investment income.		0.6
12.	IT	Complete, in implementation.	2.4	Nil
13.	Homelessness Services	Review of services to prevent homelessness. Service already restructured to focus on prevention; savings of £0.8m achieved.	0.8	0.7
14.	Technical Services	Covers facilities management, operational property services, traffic and transport, repairs and maintenance of all buildings (including housing), fleet management, stores, energy, environment team. In implementation.	10.1	0
16.	Children's Services	All services provided by Education and Children's Services, other than schools and social care.		5.0
17.	Regulatory Services	Protective services including neighbourhood protection, business regulation, pest control, licensing and community safety.	0.2	0.8
18.	Cleansing and Waste	City and neighbourhood cleansing, litter disposal, waste collection and disposal (including PFI arrangements).		2.5
19.	City Centre	Services provided by City Centre Division, including tourism.	0.1	

	Review	Summary	Savings Reported £m	Savings Outstanding (£m)
20.	Using Buildings Better	Extends scope of Transforming Neighbourhoods to review other neighbourhood buildings (depots and local non-customer facing offices). Revenue savings will arise from channel shift and staff accommodation.		2.0
21.	Arts Organisations	De Montfort Hall and grants to Curve/Phoenix.		0.7
22.	Museums	Cost of managing and running buildings and collections. Scope does not include removal of free admission.		0.7
23.	Car Parking and Highways Maintenance	Maximise net income and reduce cost of operating car parks; and increase available surplus from on-street parking. Review options for savings in highways division.		0.7
24.	Festivals	Review of Council support to festivals.		0.1
25.	Community and Voluntary Organisations	Review support to a number of VCS bodies supported by Community Services.		TBD
26.	Parks standards and development	Efficiency savings.		0.2
27.	Community Capacity Building	Revisit current arrangements with Voluntary Action Leicester and other projects.		0.2
28.	Civic and Democratic Services	Democratic and civic functions.		0.2
29.	Departmental Administration	Review of departmental administrative services with view to rationalisation, automation, management of admin and removal of duplication.		1.0
30.	Adult Learning	Aim to increase the £0.8m currently contributing to Council support. Service is entirely grant funded, and finance input will be required to ensure grant conditions are complied with.		0.4
31.	Advice Services (follow up)	Review of internal and external advice services provided by internal Welfare Rights Service, STAR service and external organisations. Aims to eliminate duplicate provision.		0.5

	Review	Summary	Savings Reported £m	Savings Outstanding (£m)
32.	Health Services	Ongoing review of services promoting health, including Health and Wellbeing Division; and services contributing to healthy lifestyles. Savings cannot be made to extent that service is funded by ringfenced public health grant.		TBD
Total			**25.2**	**19.4**

NB: This appendix will be brought up to date for any new approvals between now and February 2017.

Appendix B

Leicestershire Partnership NHS
NHS Trust

HEALTH AND WELLBEING SCRUTINY COMMISSION – 4TH JANUARY 2017

2015 CQC INSPECTION ACTION PLAN PROGRESS REPORT AND FEEDBACK FROM 2016 INSPECTION

Introduction/Background

Following the Care Quality Commission (CQC) comprehensive inspection in March 2015 the Trust has responded to both the initial concerns raised shortly after the inspection, as well as the comprehensive inspection reports published in July 2015 with a range of improvement measures collated as formal action plans.

CQC subsequently re-inspected the Trust in November 2016.

Aim

This paper provides an overview of the progress made to date in addressing the CQC 'Requirement Actions' as well as describing systems in place for governance of those actions. CQC re-inspected the Trust in November 2016, this paper outlines summary feedback received to date from CQC.

Discussion

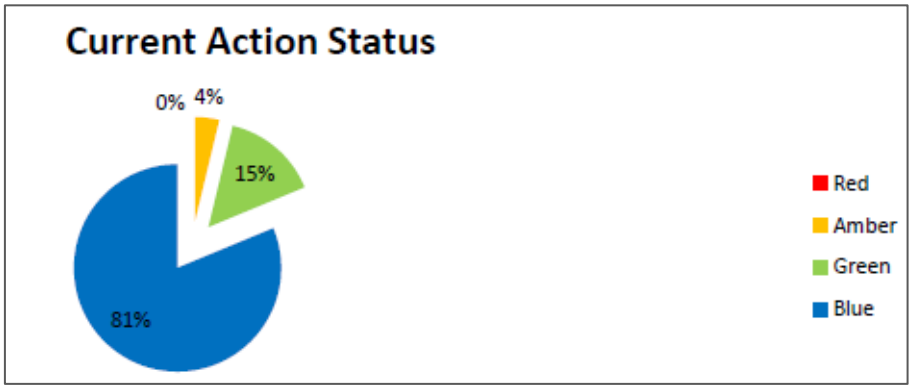
The CQC Comprehensive Inspection commenced on 9th March 2015, followed by initial verbal feedback on Friday 13th March 2015.

The CQC published 16 Core Service Reports, plus the overall provider-level report on Friday July 10th 2015.

Overall Compass has received and accepted evidence of completion for 54 actions (Blue), 22 actions remain on track for completion with an additional four rated as potentially slipping their target date with assurance that a robust remedial plan is in place to deliver (amber) there are no actions past their deadline with delivery concerns (red).

Summary Position and Progress

RAG Colour	Actions THIS Month November	Movement from last update	November RAG	August RAG	July RAG	June RAG	May RAG	April RAG	March RAG	February RAG	January RAG	December RAG	November RAG
Red	0	0		0	0	1	1	1	1	5	1	1	4
Amber	3	0	3	4	3	17	22	23	25	20	26	22	12
Green	12	-1	13	22	31	31	30	33	35	44	44	53	61
Blue	65	1	64	54	46	31	27	23	19	11	9	4	3
	80												



Further action, mitigation and risk

CQC Action Plan Ref.	Current RAG Rating	Summary of Action	Assurance discharged to	Lead Director
Actions 13.1-13.3	Amber	clinical risk assessment and care planning	Lead Nurses Group via CEG	Chief Nurse
The November 2016 Clinical Effectiveness Group (CEG) received a record keeping and care planning update covering details from each directorate for triangulation against the requirements of CQC action plan items 13.1-13.3. The directorates continue to complete regular record keeping and care planning audits; these will be reported on a quarterly basis. A communication campaign is underway reinforce the importance of effective care planning and record keeping.				
Actions 14.1-14.10	Amber	ensuring that assessment of capacity is both undertaken and recorded within patient notes	Safeguarding Committee	Chief Nurse
A trust wide case note audit has been completed identifying that MCA and DoLS is a significant area for improvement. A corporate risk has been identified and this will be reviewed at the MCA Clinical Forum for clarification of controls and actions. Directorates are requested to consider the development of T1 and T2 risks. *Evidence has been received against all actions in preparation for approval and closure.*				
Action 20.1	Amber	the development of a Trustwide Mental Capacity Act assurance framework	Safeguarding Committee	Chief Nurse
A Mental Capacity Act Clinical Forum (MCA Forum) and Mental Capacity groups have been established. The MCA Clinical Forum reports to the Safeguard Committee on a bi-monthly basis. *The MCA Clinical Forum is responsible for the trust wide case note audit; findings to be reported to the Safeguarding Committee in November 2016.* *MCA Champions have received an interactive training session on MCA.*				

CQC Action Plan Ref.	Current RAG Rating	Summary of Action	Assurance discharged to	Lead Director
The training for MCA and DoLS has been reviewed. An e-learning module via ULearn for DoLS application has been created. Programmes of review have commenced to ensure that mandatory and clinical specific training include the principles of MCA. This will enhance the practical application of the MCA principles.				
Actions 23.1-23.4	Green	review of record keeping procedures	Records and Information Governance	Chief Nurse
One remaining action remains under 23.1-23.4 – the production of a Trustwide Electronic Patient Records Policy – this is on track for delivery in November 2016 – a draft version of this new policy will begin a short consultation at the beginning of November 2016 with a review at Records and Information Governance Group (RIGG) on 8th November. Anticipated to be with Policy Review Team after this and virtual approval of RIGG soon after.				
Action 26.1	Green	Provision of a CAMHS Crisis Service	FYPC Full Business Day Meeting	Director FYPC
Crisis development is as follows; 1. *Service Specs being agreed between LPT and Commissioners* - *Service Spec was received by the service w/c 31st October 2016. It is being reviewed by Clinical Leads and Managers and comments will be with Commissioners by the end of October 2016.* - *Commissioners need to sign off any changes and have indicated that, assuming there is no disagreement, specs were to be signed off by the end of November 2016 and full monies CV'd into the contract by end of March 2017 however this timeline has slipped as changes were requested to the KPI's within the service spec by the FYPC Business team, commissioners are considering these proposals Timeline for sign off now End of December 2016.* 2. *Accelerator Funding released to recruit to Crisis element of the team (x1 Band 7 and x3 band 6 practitioners recruited with a further x4 band 6 practitioners being interviewed this week.)* - *Accelerator funding has enabled recruitment of x 8 practitioners (all complete)* - *X1 Team Leader took up post 1st October 2016* - *X3 practitioners took up post 1st October 2016* - *X4 practitioners have start dates for end of December 2016* 3. *Full home treatment team (plus consultant) will be released when service specs are agreed..* - *Due for End of March 2017*			

2016 Inspection – feedback to date

The November 2016 inspection saw 86 inspectors across four teams – Community Health Service, End of Life, Mental Health – community and Inpatient. CQC inspectors visited in excess of 79 wards, teams and services, inspecting the same 15 "Core Services" as they did in 2015.

During the week CQC facilitated 17 focus groups with our staff, asking their opinion on such things as safety, culture, leadership and Trust values, as well as asking them what had changed in the Trust since the 2015 inspection.

CQC also held 36 formal interviews with clinical leads, Heads of clinical and corporate services as well as Directors. Questions ranged from 'How are you personally assured?' to ' what are relationships with partner organisations like?' and 'How would a staff member escalate their concerns?'

Formal requests for Information:-

	2015	2016
Pre-Inspection Request 1	11	14
Pre-Inspection Request 2	17	56
Inspection Enquiries	85	278 (at 30/11/2016)

A change of note since the last inspection was the volume of telephone contacts with patients and carers – CQC requested contact lists for a range of services including End of Life, MHSOP community and AMH community. There was significant scrutiny on Mental Health Act with two reviewers based on the Bradgate wards most of the week with a whole day spent in the MHA Office reviewing records.

At the feedback meeting on Friday November 18th CQC were very positive about our staff, noting the warm welcome received across the Trust. CQC commented that there is evidence of much positive practice across the Trust, and it was clear that much had been done since the 2015 inspection, and there had been a lot of hard work.

CQC recognised that all staff across the Trust are very busy and working under a lot of pressure, they noted this from ward staff to administrators and domestic staff, right up to the senior leadership of the Trust.

CQC noted some positive practice across the organisation citing examples from each clinical directorate to evidence their observations as well as from some enabling functions.

There were however some concerns noted across the Trust; some of these relate to very specific services and issues, others are more wide ranging.

LPT Next-steps

The Regulation and Assurance Team continue to gather feedback from services and triangulate all intelligence ahead of receipt of the inspection reports.

We have responded to the initial concerns letter outlining actions underway to address where possible the CQCs immediate concerns

Preparatory work for a 2016 comprehensive inspection action plan is underway, this will be;

- Locally –led with corporate facilitation
- triangulated with 2015 and 2016 intelligence
- locally governed with corporate oversight

A proposed governance framework to monitor progress against the 2016 inspection reports will be established in the New Year once the reports have been received, QAC (Quality Assurance Committee) will retain oversight on behalf of the Trust Board.

CQC Next-steps:

- Draft reports are expected in early January 2017
- LPT will have 10 days for factual accuracy checking the draft reports before CQC publish during the first week of February 2017
- CQC will convene a Quality Summit with key stakeholders in early March 2017

Conclusions

This paper provides assurance that systems and processes are in place to respond to the CQC Inspection of March 2015 and provides the available feedback on the November 2016 Inspection. The establishment of a task and finish group to internally govern this process has provided QAC with assurance via a monthly highlight report.

Dr Peter Miller
Chief Executive

December 2016

Better care together
Leicester, Leicestershire & Rutland health and social care

Leicester, Leicestershire and Rutland

(No.15)

Sustainability and Transformation Plan

Latest Draft at 21st November 2016

"It's about our life, our health, our care, our family and our community"

University Hospitals of Leicester
Leicestershire Partnership Trust
East Midlands Ambulance Service
East Leicestershire and Rutland Clinical Commissioning Group
Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group

NHS

Contents

Foreward

Our organisations commission and provide health and care services for over a million people in Leicester, Leicestershire and Rutland. Every day our services support people to stay healthy and lead independent lives. And when people are ill our services are there for them, their carers and families. Over the next five years, the services we are accountable for will need to adapt and transform in order to ensure that they remain clinically and financially sustainable. This latest version of our Plan sets out the actions that we will need to take in order to balance the various pressures of continued growth in patient demand from an ageing and growing population, a requirement to recover and maintain delivery against national access and quality standards, at a time of historically low levels of financial growth in the NHS and substantial pressures on social care funding.

The financial challenge facing the NHS nationally over the next five years is well recognised, with 2018/19 set to be the most pressurised year where the NHS is set to have negative per person NHS funding growth. Locally, the requirement set against this national backdrop to make more rapid progress in the early years of the Plan to move the provider sector back into financial surplus is going to be incredibly challenging.

Our STP builds on the work of our Better Care Together programme, the plans of which were already well advanced and articulated in many areas, particularly around proposals for reconfiguring acute hospital services to address long standing issues around the condition of our premises and how these are utilised.

It is a Plan that in many areas will take time to deliver. In part because some of the proposed service changes will require formal public consultation before final decisions can be taken. But equally because many of the new models of care set out will require our front line staff to work together in new roles and ways.

Reflecting this, the progression of this Plan over the coming weeks and months will be an iterative one. This latest version will continue to be refined ahead of target publication in November.

Our commitment to the people our organisations serve is to work together to deliver this through shared endeavour and collective accountability.

Toby Sanders
STP Lead for LLR and
Managing Director
West Leicestershire CCG

Sue Lock
Managing Director
Leicester City CCG

Karen English
Managing Director
East Leicestershire and Rutland CCG

John Adler
Chief Executive
University Hospitals Leicester

Peter Miller
Chief Executive
Leicestershire Partnership Trust

Local authority officers from the three upper tier local authorities (Leicester City, Leicestershire County and Rutland County) have been part of the discussions responding to the challenges facing health and adult and children social care services across LLR that have shaped the development of this draft STP. This involvement has focused on two particular areas. Firstly, the two way relationship between demand for local authority adults and children's social care services and local NHS provision, including the proposals to develop more integrated community teams. Secondly, the

contribution to the prevention and inequalities agenda from the local government responsibility for commissioning public health services. In addition, as community representatives the local authorities have a special interest in the configuration and availability of NHS primary and secondary care services.

The local authorities are committed to ensuring an open public discussion on the proposals in the draft STP through their executives, health and wellbeing boards and health overview and scrutiny committees in order to reach their own formal position during the engagement period on the overall plan and specific proposals. The local authorities will wish to apply the same principles of openness and engagement in the implementation of the approved STP.

Plan on a Page - Leicester, Leicestershire and Rutland Sustainability and Transformation Plan

- The Leicester, Leicestershire and Rutland system footprint has a population of 1,061,800. We start our transformation journey from a good point through our Better Care Together Programme which has been developing proposals for transformation and financial sustainability since 2014.
- The system is experiencing increasing pressure and our modelling of the demography and financial challenges clearly shows that we need to respond with much greater transformation if we are to address our do nothing gap of £399.3m by 2020/21.
- We have identified five key strands for change which taken together will help us to eliminate our financial gap by 2020/21 and contribute to closing the health and wellbeing and care and quality gaps.
- All of our plans are built on collaborative relationships and consensus amongst our system leaders which we will continue to develop through our new governance arrangements to ensure the success of our STP, and which provide the foundations for an integrated health and social care system. All of our plans will ensure compliance with statutory safeguarding legislation and the Local Safeguarding Boards: Safeguarding Children and Safeguarding Adults procedures.

Our priorities for the next five years

Strand 1: New models of care focused on prevention, moderating demand growth – including place based integrated teams, a new model for primary care, effective and efficient planned care and an integrated urgent care offer.

Strand 2: Service configuration to ensure clinical and financial sustainability – including, subject to consultation, consolidating care onto two acute hospital sites, consolidaiton maternity provision onto one site and moving from eight community hospitals with inpatient beds to six.

Strand 3: **Redesign pathways to deliver improved outcomes for patients and deliver core access and quality** – including actions to improve long term conditions, improve wellbeing, increase prevention, self-care and harnessing community assets, as wellas our work to improve cancer; mental health and learning disabilites.

Strand 4: Operational efficiencies - to reduce variation and waste, provide more efficienent interventions and support financial sustainability - the Carter recommendations; provider cost improvement plans, medicines optimisation and back office efficiencies.

Strand 5: Getting the enablers right- to creare the conditions of success –including workforce; IM&T; estates; workforce, engagement and health and adult and children social care commissioning integration.

What will be different for the system and patients?

- Patients will have more of their care provided in the community by integrated teams with the GP practice as the foundation of care.
- Patients will only go to acute hospitals when they are acutely ill or for a planned procedure that cannot be done in a community setting.
- Patients will have the skills and confidence to take responsibility for their own health and wellbeing.
- More people will be encouraged to lead healthy lifestyles to prevent the onset of long term conditions.
- Screening and early detection programmes will enable more people to be diagnosed early to enable improved management of disease and to reduce burden.
- Professionals will have access to a shared record to improve the quality and outcome of patient care.
- General Practitioners will increasingly use their skills to support the most complex patients and routine care will be delivered by other professionals.
- General Practice will be increasingly working in networks to improve resilience and capacity.
- The system will be in financial balance, be achieving its performance targets and operate as “one system”.
- Delivery of RTT, A&E, Ambulance, Cancer, mental health targets. We will also reduce out of area placements.
- Services delivered from fit for purposes premises.

How we will achieve financial sustainability

- The Leicester, Leicestershire and Rutland system will spend £2.121 billion on health and social care in 2016/17.
- If nothing is done the system deficit by 2020/21 will be £399.3m, health £341.6 and social care £57.7m.
- We aim to save across our five priority areas, this will realise savings of £412.9m. To deliver these savings LLR has requested investment of £98.4m from the national Sustainability and Transformation Fund over five years, bringing the system into financial balance by the end of the period.
- To realise our transformation plans the system will require £350m capital, including capital raised from alternative sources such as PF2 and funding some investments from disposal proceeds.

Key Workforce Changes

Primary care up 10% between 2016/17 (2271 WTE) and 2020 (2505 WTE)
Provider workforce down 4% over the same period from 19805 to 18303

Key Bed Changes

Acute Beds 2016/17 beds 1940 2020/21 beds 1697
Community Hospital Beds 2016/17 beds 233 2020/21 beds 195

Purpose and Vision

This plan sets out the actions that we need to take across the health and care system in Leicester, Leicestershire and Rutland (LLR) over the next five years in order to improve health outcomes for patients and ensure our services are safe and high quality, within the financial resources available.

The plan builds on the **vision** of our existing Better Care Together (BCT) programme to:

"Support you through every stage of life: helping children and parents so they have the very best start in life, helping you stay well in mind and body caring for the most vulnerable and frail and when life comes to an end."

The Better Care Together objectives are to:

- Deliver high quality, citizen-centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff and citizens, resulting in a reduction in the time spent avoidably in hospital
- Reduce inequalities in care (both physical and mental) across and within communities in Leicester, Leicestershire and Rutland (LLR) Local Health and Adult and children social Care Economy
- Increase the number of those citizens with mental, physical health and social care needs reporting a positive experience of care across all health and social settings
- Optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system
- All health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate
- Improve the utilisation of workforce and the development of new capacity and capabilities where appropriate, in the people and the technology used.

Through BCT we have already delivered significant improvements in services and quality of care for patients over recent years. For example, we have commissioned a Mental Health crisis house, expanded the Intensive community Support (ICS), reduced mortality rates, delivered our Better Care Funds, reduced in rates of delayed transfers of care, and begun construction of a new Emergency Department (ED).

At a time when finances of much of the NHS have deteriorated we have held our local position and fulfilled our financial plans. In 2015-16 we achieved savings across partner organisations, and University Hospitals Leicester (UHL)'s deficit shrank by £2m more than was originally planned.

There are areas where we are not doing well enough for our patients against some constitutional standards. Growth in emergency admissions has led to an imbalance in capacity and demand. This is all too evident from safety concerns around ED overcrowding and performance, and ambulance waiting times. We are also facing a changing age profile and growing health needs in our population, while the public sector funding climate is uncertain and the scale of the challenge over coming years increases across NHS, local authority and partners such as the police.

The above leads us to three priorities that our Sustainability and Transformation area will have a relentless focus on over the next two years, they are:

- Drive improvements in health and social care;
- Deliver core access and quality standards; and
- Restore and maintain financial balance.

For our STP process we have convened a set of discussion between April and October 2016 about how we upgrade our work in a number of targeted areas. We have developed this by means of existing formal BCT arrangements (Partnership Board, Delivery Group), individual organisation engagement with Boards and executive teams, alongside a series of joint clinical, managerial and patient conversations including HealthWatch and our Public and Patient Involvement Monitoring and Assurance Group (PPI MAG) representatives.

Reconfiguration decisions will include consultation with Designated Safeguarding Professionals to ensure all services commissioned meet the statutory requirement to safeguard and promote the welfare of children and adults.

The local consensus

This conversation has generated a shared view across the system health and social care leadership community (clinical, lay and managerial) on the scale of the challenge and the actions we need to take to address it. This is across two fronts: operational delivery today while planning for the future.

Locally, we have used the STP process as an opportunity to do five things:

Update our existing BCT plans: we have taken account of learning from experience of schemes over the last two years, particularly actual impact of new services, like Intensive Community Support. This has enabled us to refresh our capacity plan to get a more realistic view on what healthcare in the future needs to look like.

Reflect on latest national policy direction and context:

- Adopt a place-based approach to planning, service delivery and use of NHS resource allocation that focuses on population health and how the "LLR pound" is spent.
- Increase commissioner and provider collaboration. We are co-creating solutions and improving services, with clinicians and other health and social care professionals collaborating across traditional boundaries.
- Increase integration between health, adult and children social care and public health.
- Adopt new models of care and our learning from these, particularly the Urgent and Emergency Care (UEC) Vanguard, our planned care Alliance, and GP Federations.
- Respond to recent national policy and guidance including the financial reset, 2017-19 planning guidance which moves planning and contracting into a two year timeframe and the introduction of STP area control totals.

Identify the key issues, and the resulting decisions that we must make: some things are critical to system sustainability over this period. Given the limited resources – not only financial but also workforce availability and managerial and clinical capacity to manage change – we must focus our efforts on doing these things well over a prolonged period. While the overall BCT programme will continue to make progress across the whole of health and social care services, this plan is intentionally targeted and not a "plan for everything".

Address those areas where our existing BCT plans did not offer an adequate solution: particularly in primary care and some community hospital services, around which there was insufficient consensus to make real progress on plans.

Focus on upgrading delivery and implementation arrangements: notwithstanding the improvements that have been delivered under BCT, the pace of change has been too slow and scale of impact too limited. Our focus to date has been on work-streams and pathway redesign but it has become increasingly evident that the way we have organised ourselves and the misalignment of purpose and incentives now limits the rate of progress. We are learning what does and does not

work in terms of implementation, particularly the need for a more collaborative approach and greater focus on culture, relationships and behaviour.

The result is a plan that demonstrates a set of solutions which taken together enable LLR to reach a sustainable position by 2020/12. This STP represents the continuation of our BCT journey, not a replacement for, nor fundamental change of direction to, it. The STP process has enabled us to look at BCT through a specific lens of system sustainability and this has sharpened the focus on delivering a smaller number of big priorities.

It is a plan that sets out what we would need to do to address the triple aim "gaps". **Health and Wellbeing, Care and Quality,** and **Finance and Efficiency.** Inevitably the early years of the plan are more detailed in terms of solutions to address these. The later years are subject to assumptions about what it would be reasonable for the system to deliver based on current position, scale of opportunity and future demand.

This plan is ambitious. Given the scale of the challenge of balancing finances with demand and new treatments this is inevitable if we are to be viable in five years. We must moderate the current trend of increasing acute hospital activity. Given current operational pressures on the system this is a substantial task. We are confident from current opportunity and experience elsewhere, particularly internationally, that this is possible, but it will only be achieved if we do something significantly different to make it happen.

We will need to refresh elements of our BCT-Pre-Consultation Business Case. Once this tasks is done we are confident that, subject to NHS England support, we will be in a position to move to formal public consultation on the big service reconfiguration decisions regarding new pathways and models of care.

Our challenge against the three gaps

We know what we need to address across the system. This section sets out the local context for Leicester, Leicestershire and Rutland (LLR) using public health data, the STP Data Pack, and analysis of gaps against the three key STP areas of **improving health and wellbeing, care and quality** and **finance and sustainability**. This also reflects what we know from patients, carers and public feedback about their perception of local priorities, which are:

- **For GP services:** access and availability, seeing the same doctor, GP location and compassion
- **For Hospital services:** cleanliness, waiting times, accessibility, facilities, safe discharge
- **For the Community:** activities for the elderly, home services, availability of residential and care homes, care packages for patients discharged from hospital and care for people with learning disabilities.

Gap 1: Health and Wellbeing Gap

Across Leicester, Leicestershire and Rutland STP area we have a total population of 1,061,800 with a forecast increase over the next five years of 3.6% for children and young people, 1.7% for adults and 11.1% for older people. The age structure of the area is on par with the national average but there is a variation with Leicester having a higher population of young people and East Leicestershire and Rutland has more people age over 50. Analysing our health data identified the following areas that we need to address.

- **Reducing the variation in life expectancy:** in Leicester the average life expectancy is 77.3 years for males and 81.9 years for females and in Rutland it is 81 years for men and 84.7 for women. More variation can be found across the STP footprint, for example in Leicester city the gap between the best and worst life expectancy is 8 years. The difference in life expectancy is complex and is impacted on by deprivation; lifestyle and the wider determinant of health.
- **Reducing the variation in health outcomes:** there is considerable difference in health outcomes across the STP footprint. For example 43.8% of diabetes patients in Leicester city have all three of the NICE recommended treatments targets compared to 41.9% of patients in East Leicestershire and Rutland. People feeling supported with a long term condition to manage their condition is 66.4% in West Leicestershire and Leicester city at 58.5%.
- **Reduce premature mortality:** premature mortality across the STP footprint is caused by cardiovascular disease, respiratory, diseases, cancer and liver disease, the level of premature mortality varies across LLR. More than 50% of the burden of strokes; 65% of CHD; 70% of COPD and 80% of lung cancer are due to behavioural risk and we will tackle this through early detection programmes and preventative public health strategies and programmes. Infant mortality has improved in Leicester with the city now being comparable to that of England. However the still birth rate at 6.5 days per 1,000 total births in 2012/14 is higher than the national average of 4.7. A strategy is in place which focuses on targeted work on predisposing factors including prematurity and small for date babies.
- **Improve the early detection of cancers and cancer performance:** one year survival rates from all cancers varies across the STP footprint. In Leicester city the rate is 65.9% compared to East Leicestershire and Rutland which is 70.2%. Cancer is also one of the major causes of premature mortality across the STP footprint. Detecting cancers early improves survival rates for example 5 year survival rates for colon cancer is 1 in 10 if detected at stage 4 but if detected at stage 1 survival after 5 years increases to 9 in 10, this is similar for rectal, ovarian and lung cancers. We also need to improve our performance on 63 day cancer rates.
- **Improving mental health outcomes:** across the STP footprint there is a difference in mental health need, East Leicestershire and Rutland and West Leicestershire have high levels of

Dementia, where Leicester City has high levels of psychosis and all have high levels of depression.

- **Move from chronic disease management to prevention:** much of the above health outcomes are caused by lifestyle and are preventable and late detection leads to costly chronic disease management. The table below shows the modifiable risk factors associated with preventable diseases causing the highest health care need and demand in LLR. Focusing on this through primary and secondary prevention will help shift the demand curve and improve outcomes. The main modifiable risk factors with preventable diseases causing the highest care need and demand are demonstrated in the table below.

		Preventable diseases						
		CVD	T2DM	Respiratory	Cancer	Frailty	Dementia	Falls
Modifiable risk factors	Smoking	●	●	●	●	●	●	
	Alcohol	●	●		●	●	●	●
	Overweight	●	●		●	●	●	
	Physical activity	●	●		●	●	●	●
	Social isolation and loneliness					●	●	
	Vaccination			●	●	●		
	Support for carers					●	●	
	Blood pressure control	●	●				●	●
	AF detection & management	●				●	●	●
	T2DM detection & management	●	◐			●	●	●

Gap 2: Care and Quality Gap

The main quality and care gaps that need addressing across Leicester, Leicestershire and Rutland are:

- **Improving performance of the Urgent Care system in LLR**: Our current performance against the A&E four hour target is 79.48% at September 2016 our 999 performance for Red 1 is 67.7% and Red 2 is 56.5%. Our ambulance handover delays are 12.8% for handovers greater than thirty minutes and 6.2% for handovers greater than one hour. The Sustainability and Transformation Funding trajectory set for A&E performance is 92.1% of patients seen under 4 hours by March 2017. This will be achieved through a whole system redesign of the urgent care system through the Vanguard programme and through our Recovery Action Plan. In addition through our solutions set out in this plan we will reduce the numbers attending ED and improve crisis mental health services.
- **Tackling poor patient experience:** there are a number of areas where we know patients have a bad experience of care. LLR is below the average for patient experience of GP services. Across LLR 10% of GP practices inspected were rated as “Requires Improvement”

by the CQC and 3% are rated as “Inadequate”. Both our main providers have been rated as “Requires Improvement”. For the social care sector across LLR the number of care homes rated as “Requires Improvement” is 40% and 1% are rated as inadequate. Domiciliary care is rated well.

- **Supporting Carers:** There are a significant number of carers in the local area. It is estimated there are in excess of 100,000 people in Leicester, Leicestershire and Rutland providing some form of unpaid care. Carers play a critical role in supporting service users and this has a positive impact on reducing the need for formal public service intervention and support. Carers report lower quality of life and satisfaction levels than the national average and appear to spend more hours caring than in other areas of the country. This is a growing area of need that could be further supported through increases community resilience and capacity. Our work on integrated teams will include supporting carers.
- **Supporting people to manage their Mental Health:** we know that the model of mental health services has been secondary care-focused with challenges across a number of areas. These include capacity in the crisis pathway, IAPT recovery and access performance levels which vary across the three CCGs, high level of depression in all CCGs and Leicester City is in the top quartile for Psychosis. Out-of-county placements and specialist placements remain high across LLR.
- **Improving independence and autonomy:** our local system has traditionally been based on services and pathways, rather than individuals, our Personal Health Budgets uptake is low, and, across LLR, we are in the worst quartile for “people with a long term condition feeling supported to manage their conditions”. Promote empowerment and autonomy for adults, including those who lack capacity for a particular decision as embodied in the Mental Capacity Act 2005 (MCA), implementing an approach which appropriately balances this with safeguarding.
- **Improving the sustainability of primary care:** primary care is under increasing pressure from patient demand, recruitment and retention issues and a decrease in the proportion of NHS expenditure spent in primary care over recent years. The result is pressure from avoidable appointments, insufficient staffing and increasing workloads for practice staff.
- **Services in the right place:** LLR has three acute hospital sites and nine community hospital sites this results in workforce being spread too thinly and limited resilience at individual sites. The plans set out in this STP mean more services will be delivered at home or in community settings. Both of these things mean we have to consider the configuration of service across our sites, the number of sites, and reducing duplication, and provide a model that is more sustainable from a workforce perspective and sees patients in the most appropriate setting.
- **Safeguarding:** The complexity of issues relating to substance abuse, mental health and domestic violence has been a continuing theme in child and adult Serious Case Reviews and Domestic Homicide Reviews undertaken by the LLR Safeguarding Children and Adult Boards. Clear coordinated care pathways for families with particular vulnerabilities are needed to ensure parents and children receive timely and accessible help. Local services need clear signposting and clear criteria for referral and acceptance and rejection of cases.
- **Health Care Associated Infection:** a strategic ambition has been developed to improve the quality of patient care by reduction in health care associated infections over the duration of the STP, through appropriate application of evidence and guidance in Leicester, Leicestershire and Rutland. We aim to reduce the burden of sepsis from urinary tract infection and from pneumonia infections.
- **Anti-microbial resistance:** the strategic ambition for this is closely interlinked with the plan for healthcare associated infection. In line with the national CQUIN and Quality Premium, we aim to reduce the use of antibiotics and in particular the use of broad-spectrum antibiotics. This will be achieved through focussing on urinary infections and chest infections,

epidemiologically identified as the most significant. As the plan develops we will add other key infections.

- **Interfaces of care**: we know that often things go wrong for patients at the interface of care, across organisational boundaries. Our recent work on end of life care identified gaps in joint working across primary and secondary care with a lack of consistent structured approaches to joint working which are being addressed through our Learning Lessons to Improve care programme. Other solutions set out in this STP will also support better joint working including plans for integrated teams; integrated urgent and emergency care; and health and social care joint commissioning.

Gap 3: Finance and Efficiency

The analysis of the Finance and Efficiency Gap identifies the following need addressing:

- **Delivering financial balance across the system:** The current system financial gap is £6.7m taking into account Sustainability and Transformation Funding of £25m. We know that if we do nothing by 2020/21 the financial gap across LLR will be £399.3m. The focus for this STP is to ensure that we can bring the system back into balance by 2020/21.
- **Getting our Planned Care pathways right:** our analysis, including the NHS Right Care information, shows that we could make significant improvements in the way we manage elective care across LLR and support continued delivery of waiting time standards. Variation in referral is a key issue. As a system we still have a traditional approach to follow-up appointments and much of our elective work is done in acute settings when it does not need to be.
- **Provider efficiency and productivity:** providers have plans to drive efficiency and productivity, this is a continuous process. Within these plans there is particular emphasis on the Carter Review recommendations, reducing variation, reducing agency spend, and procurement. Longer term efficiencies will come out of the work detailed in our Digital Road Map, the Urgent and Emergency Care Vanguard and integrated place-based teams.
- **Making best use of our estates:** much of the estate across LLR is owned by University Hospital Leicester and Leicestershire Partnership Trust, there are a small number of properties which are owned or managed by NHS Property Services. The service reconfiguration work detailed in this plan has resulted in estate strategies for both provider organisations which will consolidate the estate onto fewer sites. The next phase of our estate work is to improve utilisation rates and to explore what opportunities there are to work with local authorities and wider public sector on estate efficiencies.
- **Efficiencies in prescribing:** across the three CCGs considerable work has been done to improve the effectiveness and efficiency of prescribing. This includes switches, reducing wastage and implementing guidance. While this focus needs to continue there are opportunities to work together with providers to improve the effectiveness and efficiency of prescribing across all organisations.
- **Improving care through the use of effective IT:** we know that we have multiple systems across LLR. This reduces our ability to provide integrated care and wastes time through duplication of effort. We also want to use technology to improve patient's independence and daily lives.
- **Back office efficiencies:** currently STP partners have in the main their own back office functions we are exploring developing more collaborative solutions and early work indicates that integrating Information Services, Procurement and Finance functions can release £2million across the system by reducing duplication and increased efficiencies. Other areas may include Information Systems, IM&T and Human Resources, complaints and legal governance, business planning, quality assurance, health and safety, safeguarding, risk

management and clinical governance. We aim to achieve back office costs of no more than 7% of income by 2018 and 6% by 2020.

- **Over Diagnosis and Treatment:** we have a Low Priority Treatment Policy and a Procedures of Limited Clinical Value Policy while these are in place we have identified variation in activity levels across the CCGs and against procedures in the policies. As a result more focus will be on rigorous application of the policies and identification new procedures of limited clinical value.
- **Continuing Health Spend:** across the three CCGs work has been undertaken to improve our position in relation to the number of packages and the cost of packages including robust application of guidance and scrutiny of package costs. However as a system we are still outliers in terms of cost and number of packages; in the main we benchmark in the two lowest quartiles. While we have done considerable work over the last two years to reduce this position we know more can be done to bring the system into the lower quartiles.
- **Raising Demand:** we are continuing to see above inflation growth in acute activity and we need to reverse this trend if the system is to achieve financial balance. Primary care is also under significant pressure from patient demand where appointments have increased by 11% over the last few years. To manage this demand we need a different model of primary care and a conversation with the public about what their responsibility is, across the whole spectrum of health and social care, and what can be expected of general practice.

Our solutions

As described in the previous chapter we have identified our gaps against the areas of health and wellbeing; Care and Quality and Finance and Efficiency. This has led us to have a focus on five Strands of work for our STP, they are:

Strand 1 New Models of Care focused on prevention and moderating demand growth: the focus of this strand is using new models of care to bring about system wide transformation, moving our efforts upstream to reduce dependency. This will be achieved through a redesigned urgent and emergency care offer, the development of integrated placed based teams, ensuring primary care is resilient and improving the effectiveness of planned care. The impact of this will be about bending the demand curve for acute hospital admissions and bed days as well as reducing high cost placements in health and adult and children social care and impact on other public sector service.

Strand 2 Service Configuration to ensure clinical and financial sustainability: this strand focus on the reconfiguration of acute and community hospitals to ensure that right services are in the right setting of care which optimises the use of public sector estate and ensures clinical adjacencies that deliver safe high quality care and the lowest estate cost possible.

Strand 3 Redesign Pathways to deliver improved outcomes for patients and deliver core access and quality: over the last two years through our Better Care Together Programme we have started the journey to redesign pathways across a number of clinical workstreams. This work will continue under the Sustainability and Transformation Plan. This also includes our work on prevention which cuts across the Better Care Together workstreams; Long Term Conditions; Cancer; Mental Health; Learning Disabilities and Continuing healthcare and personalisation.

Strand 4 Operational Efficiencies: the focus of this strand is about becoming more efficient at the things we currently do for example theatre utilisation and working collaboratively to reduce costs in areas where we have functional duplication. This includes back office functions across providers and commissioners and medicine optimisation. This incorporates the steps we are taking to implement the Carter Review recommendations.

Strand 5 Getting the enablers right to create the conditions for success: in order to support the delivery of the above strands of work there are a number of key enablers these are workforce; IM&T; estates, engagement and health and social care commissioning integration.

Strand 1: New Models of Care focused on prevention and moderation of demand growth

This programme is about a redesigned urgent and emergency care system to support the delivery of the national constitutional target of 95% of patients seen within 4 hours; the development of integrated teams; ensuring a primary care sector that is resilient and can respond to the new models of care; and improving the effectiveness and efficiency of planned care and. It is also a key component of the "right sizing" of the acute sector by making it safe to reduce inpatient beds capacity through the provision of alternative pathways and out of hospital services.

Home First

The overarching model of care across LLR is the "home first "model. This model was originally highlighted by Dr Ian Sturgess in the 2014 Sturgess Report on the Urgent Care Pathway in LLR. However, the principles of home first are not only applicable to an urgent presentation but

define our approach for integrated care across LLR. This approach requires all teams and individuals whether in secondary, community or primary care to ask “Why is this patient not at home?” or “How best can we keep them at home?”

If an emergency admission to hospital does occur, then the ‘home first’ principle applies. Namely, that if someone is admitted to hospital and after necessary interventions and treatment, the system’s primary aim will be to return that person to the home address from which they came.

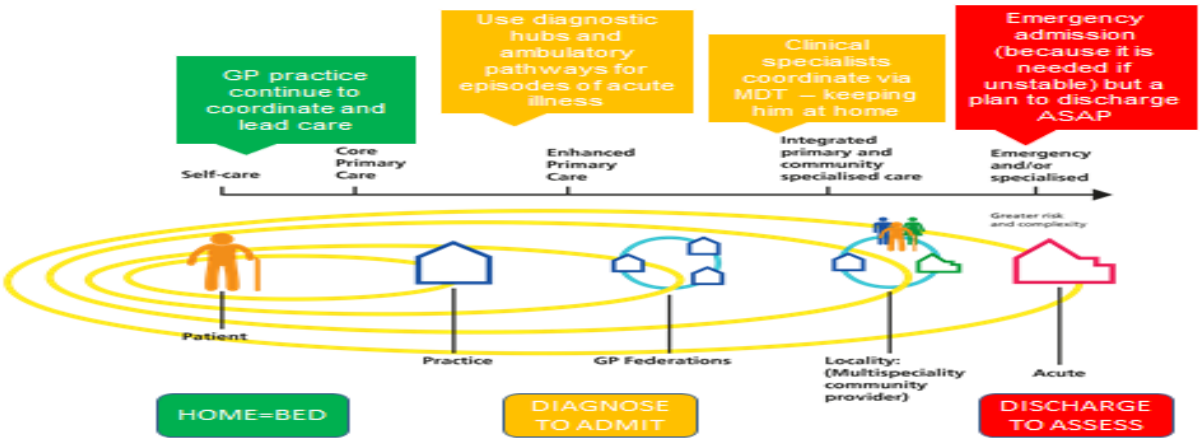
If there is a need for on-going assessments around decisions for further care, these take place within the persons ‘usual environment’ where they are likely to function at their best. This is to avoid ‘crisis’ decision making about the long term care from a ‘hospital bed’. A recognition that remaining in Hospital when there is no longer any ‘acute’ or ‘sub acute’ need to remain in Hospital, in particular, for people with frailty risks the development of de-conditioning, which can worsen outcomes.

Likewise in the community, teams will be required to place patients and their carers at the centre of the design and delivery of care. This requires a move away from organisationally driven provision to integrated placed based provision.

The principles underpinning this model are:

- Patients, carers and family are at the centre of this model.
- The patient will be known by their registered GP and that a medical management plan and care plan is consistently transferred between settings of care.
- Rehabilitation and reablement should be undertaken at home or in a community care setting.
- Inpatient beds should be utilised for acute and sub –acute care.
- The need to optimise and maintain independence for as long as possible.
- Deliver a Trusted assessment concept which is central to the application of this model.
- The Discharge to assess concept underpins the Home First model.

The home first model is based on transforming services for all patients but is particularly urgent priority for the rising number of patients with long term and complex conditions .It requires a fundamental shift towards care that is co-ordinated around the full range of an individual’s needs (rather than care based around single diseases) and care that truly prioritises prevention and support for maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services is available in the right place at the right time.



Concrete actions

- **Develop the model and service capacity for the delivery of a home first approach:** undertake a service capacity review to determine the level of service provision required to implement Home First and develop the necessary pathways linking where appropriate to other workstreams including Integrated Teams and Urgent Care (discharge pathways).
- **Community beds:** with a Home First approach the requirment for rehabilitation beds in community hospitalsis likely to reduce – an assummed level of impact has already been factored into our community hopsital reconfiguration plans, however as we progress the model we keep this under review.

Urgent and Emergency Care

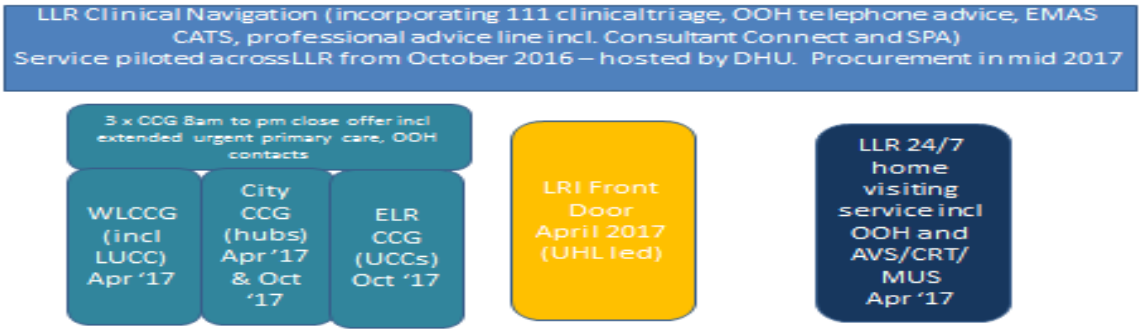
This section describes a model for Urgent and Emergency care across LLR together with the actions we are taking to improve the NHS Constitutional target of the percentage of people who spend four hours or less in A&E.

A New Model of Urgent Care

The CCGs will commission, through their Urgent and Emergency Care Vanguard Programme, a system which provides responsive, accessible person-centred services as close to home as possible. Services will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services that exploit innovation and promote care in the right setting at the right time.

Urgent care services in LLR will be consistently available 24 hours per day, 7 days a week in community and hospital settings. Clinical triage and navigation is a central part of the new integrated urgent care offer, reducing demand on ambulances and acute emergency services. The following diagram identifies the components of our integrated system.

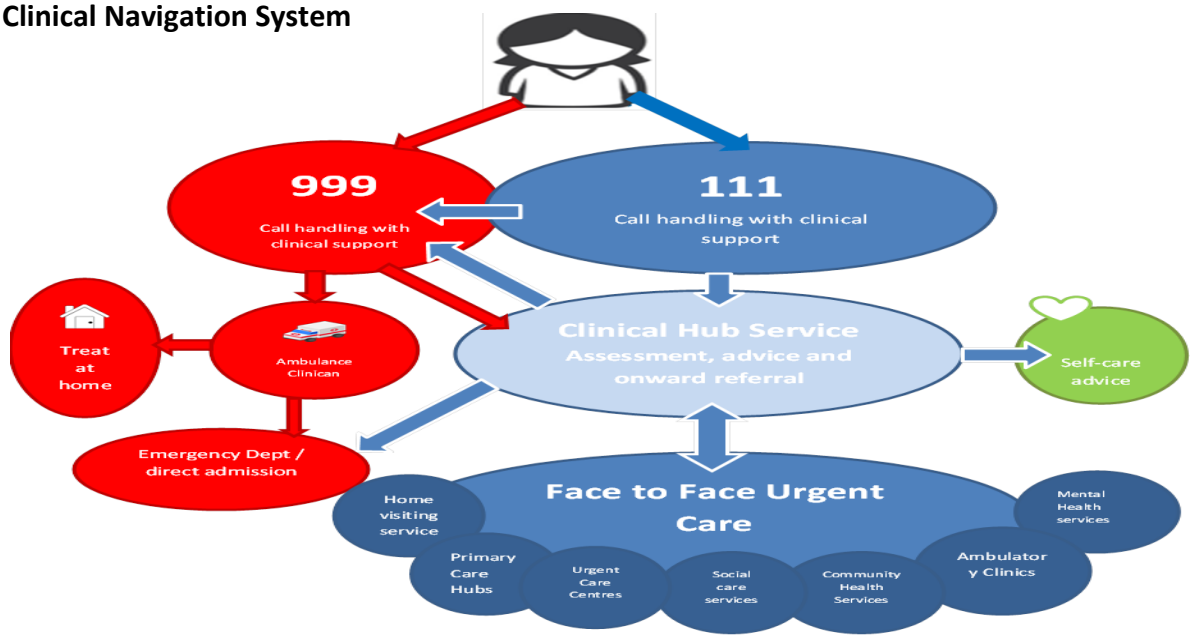
New Urgent Care System in LLR



The main changes which will be delivered by the new service model are:

- The creation of a clinical navigation service, providing telephone advice, assessment and onward referral for people calling NHS 111 and 999. The clinicians working in the service will have access to patients' primary care records and care plans, where relevant, and will be able to directly book patients into primary and community urgent care services. The service will include warm transfer callers to specialist advice for mental health, medication and dental issues. Future plans for the navigation hub include bringing it together with a professional advice line and integration with a single point of access for social care. A diagram setting out this model is provided at the end of this section.
- Extended access to primary care across LLR – so that patients can access primary care services 8am to a minimum of 8pm every day of the week.
- Urgent Care Centres will offer a range of diagnostic tests and medical expertise for people with more complex or urgent needs, and we will strengthen community based ambulatory care pathways which can avoid admission without the need to referral to acute hospital.
- An integrated streaming and urgent care service at the front door of Leicester Royal Infirmary Emergency Department, staffed by senior GPs working within the rebuilt Emergency Department.
- A 24/7 urgent care home visiting service across LLR, including out of hours home visiting and an acute visiting service for people with complex needs or living in care homes.

The Clinical Navigation System



Improving NHS Constitutional Performance

LLR has experienced significant challenges in relation to urgent care system performance, both for A&E waiting times and ambulance response times. We have developed an A&E Recovery Action Plan which responds to national guidance on A&E Improvement and addresses the key interventions that we need to take forward in LLR to improve emergency care system performance. The five intervention areas for LLR are:

- **Developing streaming at the front door of LRI Emergency Department**: this includes increasing the streaming and treating and redirection of patients from the ED front door; maximising the use of ambulatory pathways to avoid ED attendance, review short stay capacity and demand; develop ED internal professional standards and learning from others.

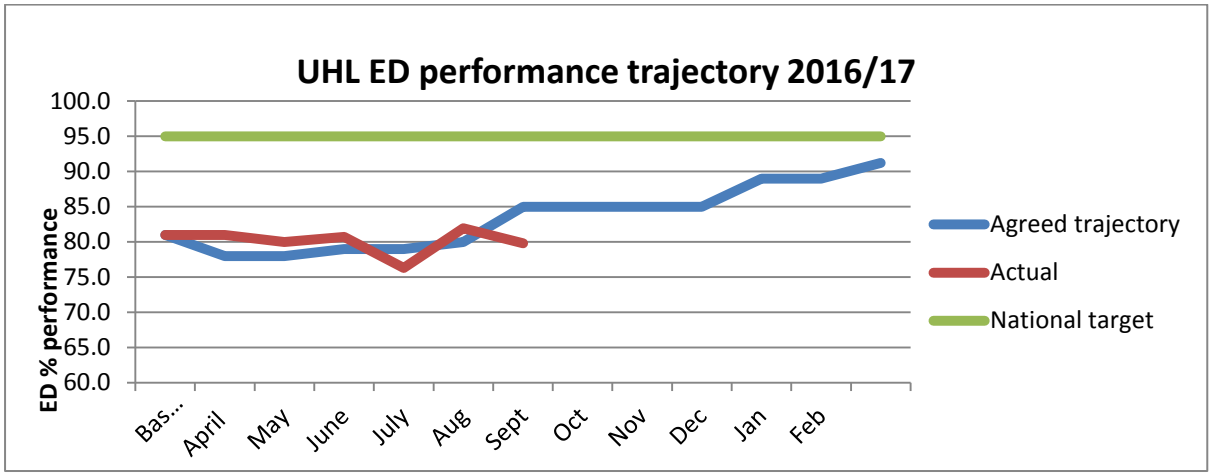
- **Managing demand for urgent care in order to minimise presentations at the Emergency Department:** including introducing clinical navigation, increasing the numbers of people calling NHS 111 who receive clinical triage and advice, ensure GPs have direct access to Consultant support, ensuring alternatives are available in the community such as extended GP hours and targeted visiting services, looking at high user postcodes, ensuring those patients discharged from the Acute Trust with a PARR+ score of +5 are provided with adequate community support and increased utilisation of Intensive Community Service capacity to prevent acute activity.

- **Improving Ambulance response times**: including implementation of A&E Front Door Clinical Navigator and the mobile Directory of Service and sustain the current high levels of hear and treat.

- **Improving flow within hospital**: including the implementation of SAFER patient flow bundle, trail senior acute physicians in ED, reduce time from bed allocation to departure from ED, reduce handover time for medical and nursing teams, reduce delays for diagnostics, reducing overnight breaches, implement direct admissions from ED to specialities and learning from other systems

- **Improving discharge processes**: including reviewing the model of Intensive Community Support (ICS) for opportunities to increase usage and support a home first model, establish pathway of reablement patients and discharge to assess, implement an electronic solution to support a trusted assessment upon transfer of care, improve the pathway to support effective transfer of care for people with dementia and adapt acute SAFER flow bundle to address community hospital service requirements.

Our trajectories for improving A&E performance in 2016/2017 are shown below:



Concrete Actions

- Develop an integrated community urgent care offer including clinical telephony-based clinical navigation services, General Practice extended hours, GP+ services, home based visiting and crisis response services. We will begin to put this in place from October 2016, completing the process in October 2017.
- An integrated clinical navigation hub including triage of ambulance disposition, from October 2016. The hub will extend to include adult and children social care services by 2018, and will act as a single point of access to step up and step down services.
- Enhanced services for ambulatory assessment in community settings, with rapid access to diagnostics to support assessment and admission avoidance.
- Ensure clinical information is shared to support triage, assessment and treatment of urgent care presentations – including Summary Care Record and enabling access to the full electronic primary care record in urgent care services.
- Implement a new pathway at the Leicester Royal Infirmary Front Door enhancing senior clinical presence and effective streaming to ensure patients are seen in the most appropriate setting.
- Improve mental health crisis services, including psychiatric liaison, clinical triage from 111 and crisis cars in the community to prevent admission.
- Continue to improve compliance with the 7-day services priority clinical standards within the acute hospital, within the available financial and manpower resources.
- Develop a real-time demand and activity model to improve management of operational resource and capacity.
- Implement new discharge pathways to provide an integrated, discharge to assess model which is based on the principle of 'home first'.
- Implement SAFER and Red/Green Days in both community and acute inpatient settings.
- Support the development of integrated clinical teams and enable shared approaches to risk.

- Develop an urgent care Alliance, which will bring providers and commissioners into a closer relationship, with a shared set of outcomes. The Urgent Care Alliance will support shared approaches to risk management and clinical governance, workforce planning and capacity planning to meet demand.

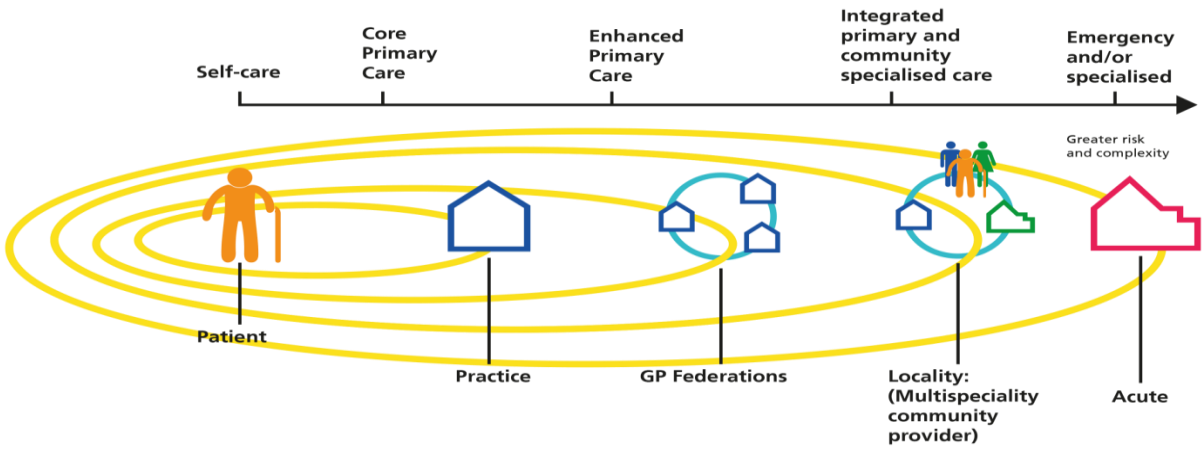
Integrated Teams

Our Better Care Together Programme is in the process of redesigning services to support a model where ill health can be prevented, unnecessary demand on the health and social care system avoided and hospital stays reduced. To date development has been based on individual workstreams improving pathways and patient outcomes through collaboration. While this has been successful in starting to redesign pathways, our workstream leads are telling us that to make a real shift in the demand curve we have to move to integrated placed based teams.

Demand comes from an ageing population; increasing level of need from people with long term conditions; high levels of admissions for ambulatory care sensitive conditions; over reliance on emergency and urgent care; and inconsistent delivery due to the lack of skills and confidence to maintain the target patient cohorts in the community.

So what needs to be different?

Our model of integration wraps around the patient and their GP practice, extending the care and support that can be delivered in community settings through multidisciplinary working, with the aim of reducing the amount of care and support delivered in acute settings, so that only care that should and must be delivered in the acute setting will take place there in the future. It is designed to improve health outcomes and wellbeing, increase our citizens, clinician and staff satisfaction and at the same time moderate the cost of delivering that care. This is demonstrated in the diagram below.



In our model the general practice and primary health care team will remain the basic unit of care, with the individual practice list retained as the foundation of that care. Our integrated locality teams are the geographical unit at which care is commissioned, coordinated and provided. Whilst a proportion of care will remain within a patient's own practice, an increasingly large proportion will be delivered by locality based integrated teams coming together to deliver care for an identified population. The model places the patient or service user at the centre, with the GP as primary route

for accessing care. The GP is the designated accountable care coordinator for the most complex patients in community settings.

Focus of Integrated Teams

As integrated teams develop they will be responsible and accountable for the care of all patients within their defined geographical "place". However, the focus of the initial phase of our programme will be on those patients most at risk. The following priority cohorts of patients have been identified, via the Adjusted Clinical Groups (ACG) risk stratification system:

- Over 18's with five or more chronic conditions
- All adults with a "frailty" marker, regardless of age but related to impaired function
- Adults whose secondary care costs are predicated to cost three or more times the average cost over the next twelve months.

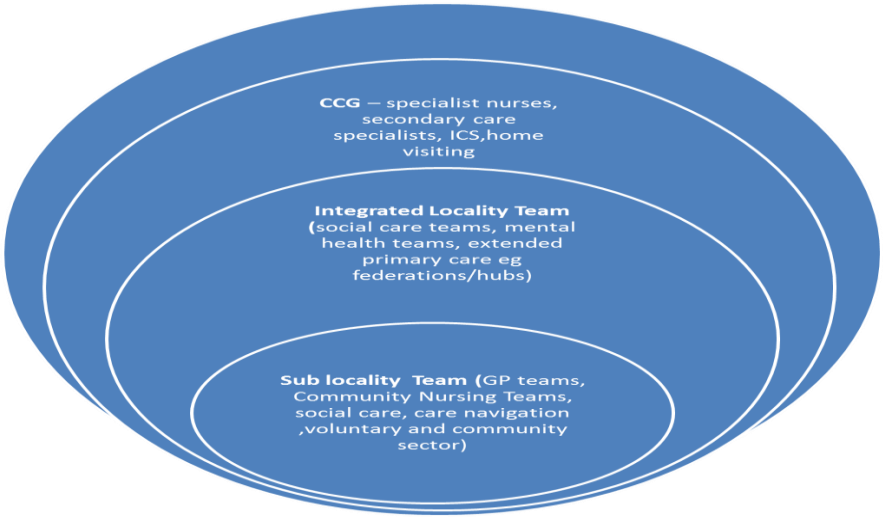
Identifying a targeted patient cohort will enable us to test models and evaluate the impact of integrated teams prior to extending the approach to the wider patient cohort, such as children. During this time patients outside of these cohorts will receive services as normal. However as the model of integrated teams develops we will expand the cohorts.

What services will be included in Integrated Teams?

Through integration general practices, GP Federations, adult and children social care, acute and community care will work with commissioners to introduce a new model of care focussing on four areas:

- Increasing prevention and self-management
- Developing accessible and responsive unscheduled primary and community care
- Developing extended primary and community teams
- Securing specialist support.

The services that will be included within the integrated teams is demonstrated in the following diagram.



The development of integrated locality teams in the initial phase is about bringing existing health and social care teams together to build a new integrated model of provision. Through the effective use of existing resources including the targeting of Better Care Funds, integrated teams will:

- Operate “as one” under a single leadership team.
- Have joint accountability for care coordination and outcomes for their population.
- Provide care in local communities and peoples own homes with less dependency on acute care.
- Create a standardised consistent offer for our citizens and patients through Leicester, Leicestershire and Rutland wide service redesign with interventions delivered at a local level.
- Target resources more effectively based on detailed understanding of population need, demand, service journeys and utilisation and real time data.
- Focus on prevention, the individuals responsibility for their own health and wellbeing, early diagnosis and management of risk factors.
- Through co-redesign create a far more cost efficient and clinically effective person centred model of care.
- Through an allocated placed based budget and integration of health and adult and children social care teams, care will be delivered in the right place, first time.

The critical task initially is to bring the team together and enable them to “get going” on care redesign. All partner organisations are committed to empowering staff to test models and work differently for the benefit of patient care. So in the first phase this is not about changing the employment status of staff or implementing capitated placed based budgets.
However learning from the MCP vanguards demonstrates that to be sustainable and fulfil their potential integrated teams will need to be effectively commissioned so that resources, structures and contracts help rather than hinder staff to do the right thing.

Where will the Integrated Teams be based?

The geographical spread of integrated teams will be based on ten established localities across LLR with a population size of between 63,000 and 121,000. For some services there will sub localities, eighteen in total, which are circa 35,000 in size.

So what will the impact be?

Learning from the national vanguard sites and through local engagements with patients and service users and clinical teams demonstrates that not only is this instinctively the right thing to do but will have an advantage impact on acute activity. Through data analysis we have identified the numbers in each cohort and the levels of need in each cohort to develop an indicative cost and benefit impact:

Cohort Numbers

Leicester City CCG					East Leicestershire & Rutland CCG				West Leicestershire CCG				LLR Cohort Total
Central	North & East	North & West	South	LCCG Total	Blaby & Lutterworth	Melton, Rutland & Harborough	Oadby & Wigston	ELRCCG Total	Hinckley & Bosworth	North & South Charnwood	North West Leicestershire	WLCCG Total	
33,157	16,454	25,842	16,651	**92,104**	23,372	35,795	12,901	**72,068**	24,771	33,541	10,652	**68,964**	**233,136**

Impact on admissions

	Activity					
Category	ED Attends	Unplanned Admissions	absoloute admission proportion	target proportion of admissions per risk group 2021	Level of desired avoided admissions	proportinal allocation of avoided admission per risk group 2021
Very High	17359	18147	32.90%	20.00%	9821	5969
High	16900	15825	28.69%	20.00%	8564	5969
Medium	29804	20183	36.60%	25.00%	10922	7461
Low	1888	870	1.58%	2.05%	471	612
Healthy User	256	125	0.23%	0.20%	68	60
Total	**66207**	**55150**			**29845**	**20071**

The potential cost saving per annum from the risk stratified cohort is £5.9m and a 128 bed reduction. Whilst the impact currently focuses on the acute sector the sense from our social care colleagues is that there will be wider efficiency gain in the reduction in high cost care packages.

Workforce

The development of Integrated Locality teams will require significant change in how the workforce is aligned and led. Currently primary, community and social care staff provide their services under separate structural and contractual arrangements; however the Integrated Locality Teams will operate “as one team” delivering joint outcomes for the populations they serve. Through the Locality Leadership team, comprised of managerial and clinical leaders from primary, community and adult and children social care, they will hold joint accountability for care coordination and outcomes across organisational teams and boundaries.

The locality leadership teams with the support of Whole Systems Partnership will review current staffing and skill mix, identifying the care functions that will be required to support the cohort of patients identified for the initial phase of roll out.

Intelligence from the ACG risk stratification tool will be used as the cornerstone for this work, together with other intelligence from elsewhere that adds value to the assumptions. For each care functions we will work with the Locality leadership teams to describe the skill mix necessary to deliver these care functions effectively by considering the following:

- What existing care functions might we continue and do more of
- Are there skill mix and activity gains to be made
- What new activity will the teams start to do and how much

- What activity will the teams stop doing and how will staff affected be redeployed and retrained.

Initial, high level data modelling has been focussed on two elements of the patients pathway proactive preventative care, and step up care (step-down care for these cohorts is assumed to be picked up within the existing workforce due to the recent expansion of ICS or 'hospital at home' services). Initial assumptions have been made about how many hours of care would be needed to make a difference in each cohort of patients, over and above existing provision, to reduce admissions to hospital. These are indicative at this stage and will be further validated and modelled by the locality leadership teams.

Concreate Actions

- **Governance:** the Integrated Locality Teams Programme Board has been established and has affirmed the initial patient cohort; undertaken initial modelling of workforce impact; developed a state of readiness methodology to performing a baseline assessment for locality leadership teams in each CCG areas to inform pace and scale of roll out; and incorporated learning from the MCP vanguards into the development planning.
- **Prevention and Self-Management**: support people to manage their own health and well-being with a targeted approach to ensure specific cohorts of people access an approved menu of non-medical interventions including social support systems in the community. Identifying when a non-clinical intervention will produce improved experience and outcomes for patient.
- **Accessible and responsive primary can community car**e: ensure there is a GP led team with a mix of skills and disciplines utilising new technology to manage patients who need a same day appointment or service. Freeing up sufficient GP time to support those patients with more complex needs (more detailed provided in the Resilient Primary Care section).
- **Extended primary and community care teams**: joining up care provided by multiple professionals who support the same caseloads of people in a locality. Pooling the local care resources to manage people at moderate and high risk. Proactive use of shared data and care plans so that more targeted, proactive care can be delivered through multi-disciplinary teams.
- **Securing specialist support**: bringing specialists support nearer to patients in their communities and reducing the time taken to access specialist input, by reducing the number of separate steps in care pathways.

Resilient Primary Care

Across LLR there are over 130 GP practices, ranging from single handed practitioners to registered lists of over 38,000 patients. There are a variety of delivery methods, premises and historical funding differences and a wide range of care models using GPs and other health care professionals. Outcomes for patients differ based on age, sex, deprivation, ethnicity and rurality and there are inequalities across the system. This story will be mirrored across the majority of STP footprints across England.

CCG	Population	Number of Practices	Average List size	Contract Split	GP Headcount (Partners in brackets)	Registered Nurses WTE
ELR	325,000	31	10483	GMS 31	204 (148)	83
WL	374,000	48	7792	GMS 48	184 (130)	67
City	376,000	59	6642	APMS 13 PMS 1 GMS 45	180 (120)	68

Within LLR all of the CCGs have taken on responsibility for delegated co-commissioning and have worked hard to ensure additional investment has been channelled into General Practice to improve the outcomes for patients and focus on ensuring care closer to home.

CCG Primary Care Budgets 2016/17			
	West	**East**	**City**
Delegated co-commissioning budgets	44,070,553	39,545,837	48,441,423
Other: Including Community Based Services, Quality schemes and incentives.	6,274,700	6,386,033	4,380,659
TOTAL	**50,345,253**	**45,931,870**	**52,822,082**

NB: These figures do not include any BCF or PMAF investment or other services commissioned for primary care e.g .AVS/CRT

Although there are significant challenges in the system through demographic change and demand, there are many examples of real innovation within individual practices and across groups of practices working together in legal Federations. The leadership from the GP board members of each of the three CCGs in LLR and the desire to improve patient care has created an environment where our practices are prepared to develop new ways of working to improve outcomes and manage the demand of modern General Practice These developments range from practices merging together into multi-site providers offering an innovative approach to patient needs, to pharmacists being employed to manage workload and patients with Long Term conditions and extended hours hubs to meet the needs of patients This innovation has shown that General Practice even through adversity, with the right support, investment and leadership can adapt to manage the challenges for modern primary care medicine.

Delivering the GP Five Year Forward View

Primary medical care is the foundation of a high performing health care system and as such is critical to the successful implementation of this Sustainability and Transformation Plan. Over the next five years our new model for general practice will be realised. The practice and primary healthcare team will remain as the core unit of care, with the individual practice patient lists retained as the foundation of care. However, while a large proportion of care will remain with a patient's own practice, an increasingly significant proportion will be provided by practices coming together to collaborate in networks or federations using their expertise, sharing premises, staff and resources to deliver care for and on behalf of each other. In this way it will be possible to improve access and provide an extended range of service to our patients, as well as creating an environment that attracts Doctors and other health professionals into a career in primary health care

The LLR promise to the patient is consistently high quality care which is responsive and accessible, integrated, sustainable and preventative. Currently we have not fully realised the potential of general practice and too often patients receive care in hospital that could be safely provided in the community, coordinated through their general practice, supported by the wider health and social care teams.

This is not going to be an easy task, there are many challenges facing General Practice, including workforce, funding and demand, but the vision remains that through focussed investment, improved premises and IT solutions and with additional integrated services supporting General Practice to be able to manage their patients appropriately in a closer to home setting there will be improved outcomes for our patients with the ability to access the right health care professional for their needs.

Our vision for primary care

We have a clear vision for the future of primary care in which is:

> General practice is the foundation of a strong, vibrant, joined up health and social care system. The new system is patient centred, joined up and integrated, engaging local people who use services as partners in planning and commissioning, which results in the provision of accessible high quality, safe needs based care.

This will be achieved through expanded and integrated primary and community health care teams, offering a wider range of services, with increased access to rapid diagnostic assessment and, crucially, patients taking increased responsibility for their own health (see the Integrated Teams section).

The model of general practice

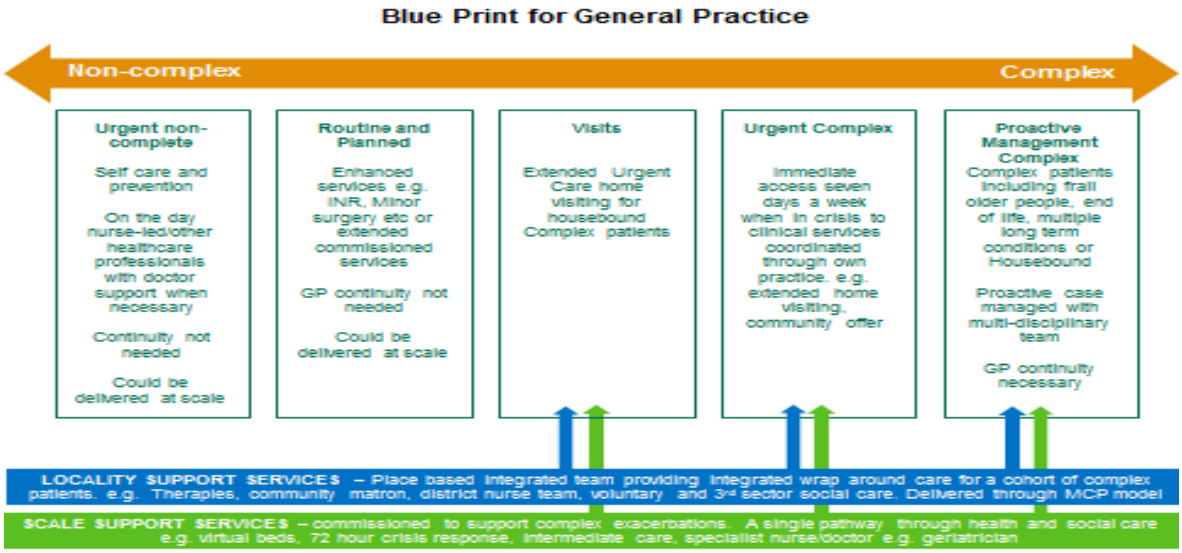
Over the next 5 years our new model of general practice will be realised. The practice and primary healthcare team will remain the basic unit of care, with the individual practice patient list retained as the foundation of care. However, whilst a large proportion of care will remain with a patient's own practice thereby recognising the importance of the therapeutic doctor – patient relationship, an increasingly significant proportion will be provided by practices coming together to collaborate, using their expertise, sharing premises, staff and resources to deliver care for and behalf of each other. In this way, it will be possible to improve access and provide an extended range of services to our patients at scale.

Our model is based on the GP as expert clinical generalist working in the community, with general practice being the locus of control, ensuring the effective co-ordination of care. The GP has a pivotal role in tackling co-morbidity and health inequalities but increasingly they will work with specialist co-located in primary and community settings, supported by community providers and social care to create integrated out of hospital care.

Key to supporting patients is the ability to provide a differential service according to need. Not every patient requires contact with a doctor or an appointment on the same day. A cohort of patients, especially those with multiple co-morbidities who are at risk of admission for their complex

condition require a more pro-active offer that could involve a multi-disciplinary team including social care, community nursing and specialist care. Integrated care combines a range of disciplines across health, social services and voluntary organisations to create person-centred care.

Person-centred care recognises that an individual is best placed to make decision about their own health, lifestyle and the level and location of treatment. Successful integrated person-centred care will tend to keep a person in their own home for as long as possible. This model puts the GP at the centre of health care provision working with a range of services to ensure patients access the right services first time. This new model of general practice is demonstrated in the diagram below.



This model of general practice maintains the general practice team at the centre of care with all practices providing a level of urgent primary care access as well as planned services and should support patients in self-care management as well as accessing other appropriate health services. To meet the needs of patients, now and in the future, the model of delivery will need to adapt. This adaptation is based around patient need and seeing the right health care professional for their condition. The evidence shows that patients with complex needs require a coordinated package of care that will require care planning, regular proactive interventions and support. This continuous care is best provided by a multi-disciplinary team with the GP at the heart of that care. This level of service utilises a GPs skills to best effect and patients will be streamed accordingly. All other patients will have access with another appropriate health professional, when needed, supported by a GP

At the heart of General Practice is the core prevention agenda, whereby the population are empowered to make the right lifestyle choices to maintain their health. When people do require support, they are able to manage their own conditions through appropriate information, tools and when necessary the ability to access the right integrated pathway first time, whether that is health, social care or support from the third sector.

Currently too many people use emergency acute services because primary care is perceived as inaccessible where and when they need it. 60 to 70% of emergency admissions are of people with long term conditions or frailty. These patients are known to the system and particularly to general practice. Active planning ought to prevent emergency admissions, and expedite discharge whenever a hospital stay cannot be avoided. Our ambition is to correct this situation and shift the care system so that bulk of work is done through scheduled care, as opposed to the current situation where it is in urgent care.

Going forward we do not believe the status quo will enable GPs to deliver everything patients need in the 21st century. A new model of health and adult and children social care is required that builds on the needs of patients and the strengths and values of general practice.

When intervention is necessary, every patient should be able to access the care they need from the appropriate clinician whether from their own practice, in the community or on a locality or system footprint, in a timely fashion seven days per week.

This access will not necessarily be from a GP, but a nurse, pharmacist, Advanced Nurse Practitioner, Extended Care Practitioner or other health professional according to need. This offer is intrinsically linked with the already developed plans, being piloted and evaluated now through the Leicester, Leicestershire and Rutland Emergency and Urgent Care Vanguard. By April 2017 this will have generated a new model of home visiting, Out-of-Hours provision, clinical navigation, Urgent Care and enhanced primary care access, which in combination will provide a twenty-four hour service across LLR.

Workforce changes

General Practice will not be sustainable or fit for purpose for the next decade without change and crucially without support to grow its workforce. A competent and skilled workforce is a key enabler in implementing the plan to support a sustainable primary care. We cannot address the current GP shortage in isolation: increasing the capacity and capability of practice nurses, practice managers and other health care professionals is vital if we are to address the increased demand on primary care.

Workforce planning and modelling assumptions in primary care need to incorporate new, emerging and more sustainable models of primary care. We need to develop a primary care workforce which is fit for purpose now and in the future rather than merely increasing numbers.

Developing primary care services that span different professional perspectives and work across the traditional primary and secondary care interface is vital. The findings of our engagement programme to date indicate that we must:

- Target the existing primary care workforce to improve recruitment and retention but equally important to identify new capabilities, competencies, skills and behaviours required to make an enhanced primary care offer.
- Identify new roles and capabilities in new staff groups. There is an urgent need to focus on alternative professional roles that support integration, increase capacity and reduce admissions by freeing up GPs time to manage increasing complexity. Such roles include primary care physicians' assistants.

- Identify roles and competencies currently that sit outside of primary care that will be required to support the demand. Such roles include primary care paramedical staff, community pharmacists, emergency care practitioners, and specialist roles such as geriatricians.
- Actively support undergraduate medical, nursing and pharmacy training and GP training at a federated level to promote our practices as positive places to work to aid recruitment and retention.
- To this end we will work with our federated localities, our neighbouring CCGs, local universities and Health Education East Midlands (HEEM) to u to identify current skills and extended skills that could benefit patients and practices.

For over a year this has driven the primary care workforce agenda through an LLR-wide delivery group consisting of stakeholders including HEE, LMC, LPC and clinicians. Baseline assessments have been completed, three multi-disciplinary training hubs have been established and Education networks are working across the footprint. This has resulted in new delivery models and extended roles including Clinical Pharmacists and Emergency Care Practitioners. This forms the basis for a longer term strategy to deliver the solutions for a sustainable service.

It is clear that new models of working and workforce shortages will require a change in workforce planning. These models including streaming of patients or provision through federations or integrated teams will bring together groups of existing and new health professionals to meet the future needs of patients covering larger geographical areas. This will mitigate some of the risk of additional workload, ageing and more complex patient needs...

The workforce metrics show that there are many GPs and nurses working in primary care who intend to retire within the next five years. The plan for a future proof workforce must account not just for replacing these clinicians, but growing the appropriate numbers of staff with the right skills for new models of primary health care. To support this, the plan accounts for a net increase of 1% per year for doctors, but 3% per year for other health professionals to match the skills and capacity necessary and in recognition of workforce pressures.

GP (WTE)		**GP Support staff (WTE)**	
Current	**2020/21**	**Current**	**2020/21**
593	617	1,678	1,888

What Primary Medical Care will look like five years from now?

If this plan is fully implemented, we envisage General Practice in LLR looking like this:

- General Practice with registered lists will remain at the heart of the model offering a comprehensive service to patients based on differential need according to condition and complexity.
- We will actively encourage practices to work together in networks or merge and provide services on multiple sites offering planned and unplanned services to meet patient's needs. This will reduce bureaucracy and enable economies of scale to enable greater clinical workforce focus.

- CCGs in LLR have already invested significantly into the development of formal legal GP Federations who do and will work as collective providers of services for patients such as enhanced services.
- These federations will be active partners in alliance partnerships or integrated teams supporting place based models of care.
- Place based care provided around geographically defined populations. This will support the adaptation of services for patients, which will act as a catalyst to new models of GP collaboration for core services.
- GPs will increasingly have portfolio careers.

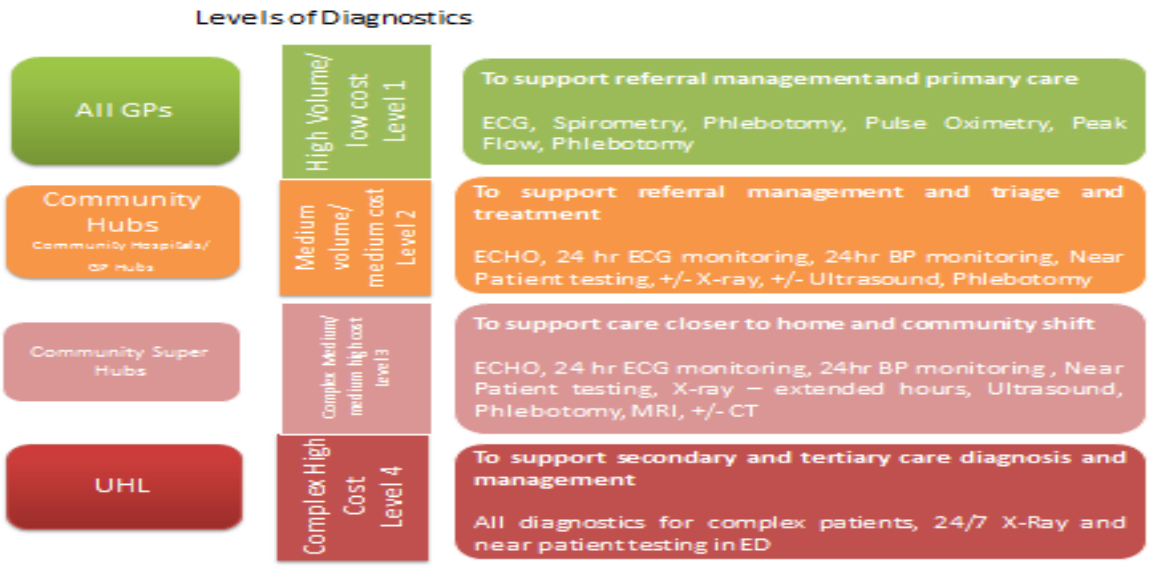
Concrete actions

- Focusing on improvements in primary care, better integration of services through place-based teams. .
- Deliver the Leicester, Leicestershire and Rutland Workforce Plan to improve recruitment and retention of medical staff in primary medical care and develop the required skill mix to deliver the future model of primary care and support integrated placed based teams.
- Use a range of professionals to deliver care particularly to those with less complex health needs.
- Support the development of Federations.
- Work with Federations to enable more collaboration between practices.
- Ensure access to extended primary care services in the evening and weekend outside of core GP opening hours in multiple sites across the geography.
- Develop integrated place-based teams with the general practice at the heart of care.
- Implement the local Digital Roadmap and the requirements set out in the GP IT Operating Model 2016/18.
- Support practices through the Estate and Technology Transformation Fund process based on the LLR Estate Strategy.
- Support practices to take forward the initiatives within the General Practice Five Year Forward View including the 10 High Impact Changes and the General Practice Development Programme.

Planned Care

LLR currently has a traditional model of planned care where the majority of activity takes place in acute settings with face to face follow ups. This model relies on patients travelling to one of the three City based sites and is often hampered by pressure of emergency demand. There are some outpatient services delivered from the community hospitals in the county; however in many cases community hospital capacity is underutilised. Demand is increasing and improving the efficiency of planned care is a key component of our STP financial plan we know there are opportunities to become more efficient and improve patient pathways.

Over the last three years LLR has put in place an Alliance model for elective care that can be delivered in community settings. This model of contracting includes an Alliance Agreement which binds the providers together with commissioners to deliver elective care in community settings including left shift of services from the acute sector. The Alliance model will be used to further move activity from the acute sector to community settings. To support this we will develop a number of diagnostic hubs. The diagram below identifies the different levels of diagnostics to be provided in different settings.



Concrete actions

- Improve theatre utilisation ensure outpatient slots are booked, DNAs (Did Not Attends) reduced, and length of stay shortened. These actions sit within the cost improvement element of our financial plan.
- Redesign thirty-two planned care specialities to shift over 150,000 outpatients and over 20,000 day case procedures from an acute site to community settings, maximising the use of community hospitals and the proposed planned care centre.
- Take out any unnecessary appointments new and follow-up, reducing by an average of 30% across the specialities by using remote options and technology.
- Develop a referral hub to ensure referrals are dealt with by the most appropriate professional whether that is a Consultants, GPs with special interest, specialist nurses or allied professionals.
- Work with public health to identify treatments with no or low clinical evidence of effectiveness to develop evidence bases policies and pathways to be implemented across primary and secondary care.
- Develop an integrated acute and community MSK physiotherapy service.
- Develop a planned ambulatory care hub to manage procedures which require a stay of less than twenty-three hours.
- Use technology to provide alternatives to face-to-face consultations and develop further our electronic referral system with a plan within the next eighteen months to make it the default for most planned care referrals.

Strand 2 Service Configuration to ensure clinical and financial sustainability

Our proposals for service configuration to ensure clinical and financial sustainability are structured on three main areas on which we will go to formal consultation. These are:

- Acute reconfiguration to move all acute clinical services onto two sites, the Leicester Royal Infirmary and the Glenfield.
- Remodel maternity services to consolidate services onto one site at the Royal Infirmary and subject to preferences expressed during consultation provide a midwife lead unit at the General Hospital.
- Reconfiguration of community hospitals to reduce the number of sites with inpatients beds from 8 to 6 sites and redesign services in Lutterworth, Oakham and Hinckley.

Acute Reconfiguration

We know that Leicester is unusual in having three big acute hospitals for the size of the population we serve and this creates problems. Our specialist staff are spread too thinly; we duplicate and triplicate services across sites and it is expensive to run. And over the last two decades there has been significant and sustained underinvestment in the acute estate relative to most acute hospitals.

Many planned elective and outpatient services run alongside our emergency services and as a result when emergency pressures increase it is elective patients that suffer delays and last minute cancellations. Unfortunately the location of the majority of the acute services have not changed following the formation of the Trust in 2000, so in other words it's an accident of history not best clinical practice that gives us our current configuration.

Evidence indicates that patients, and particularly elderly patients, spend too long recovering in large acute hospitals and potentially deteriorating as a result, when they would be better served by rehabilitation services in their own home or in a community hospital. We want to adopt a "Home First" principle where there is an integrated care offer for people living with frailty and complex needs. Our focus will be to ensure that people can remain in their own homes. When this is not possible and they have to be treated in hospital we will ensure that their discharge is appropriately planned to enable them to get back into their home or community environment as soon as appropriate, with minimal risk of readmission.

As a result UHL will need to consolidate acute services onto a smaller footprint and grow its specialised, teaching and research portfolio, only providing in hospital acute care that cannot be provided in the community.

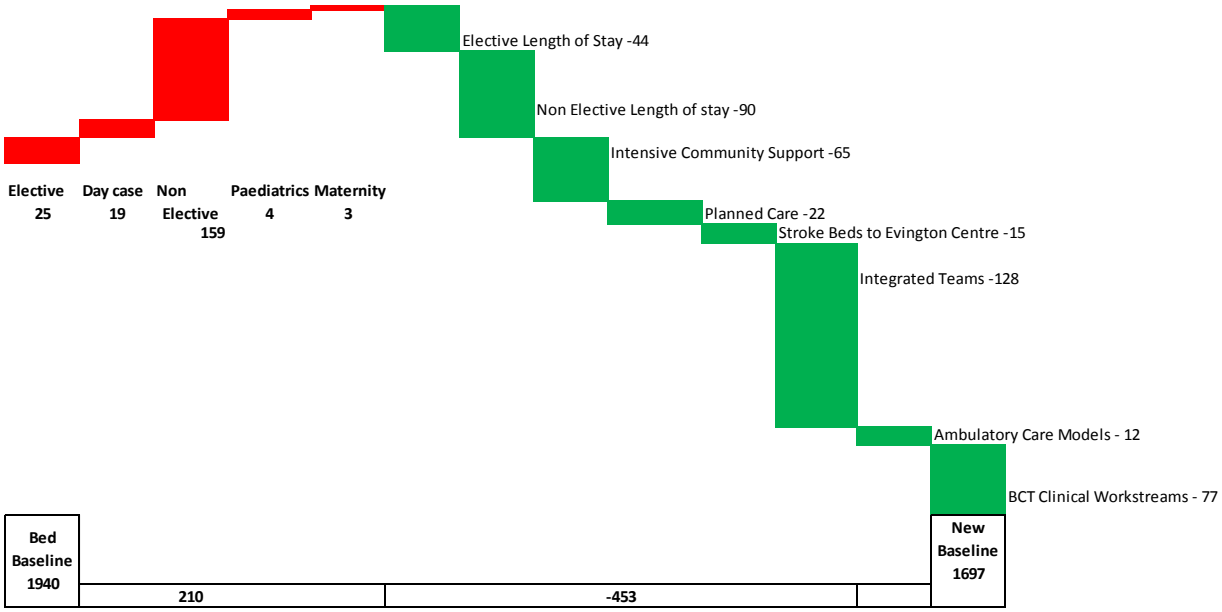
Through our Better Care Together and Better Care Fund programme we already have taken steps on this journey including the development of home based beds and integrated health and social care teams supporting patients in their home and we will take this further through our proposals around integrated placed based teams. The STP process has also led us to question whether we could be more ambitious in terms of how we deliver care in community settings particularly in relation to ambulatory services.

Although shifting the balance of care in the system is one of the important drivers behind our acute reconfiguration plans, they are also driven by three other factors. Firstly, it is not clinically sustainable to maintain three acute sites in a city the size of Leicester. Our medical resources in particular are spread too thinly, making our services operationally unstable. Secondly, by focussing our resources on two acute sites, we can improve our outcomes for patients, for example through increased consultant presence and thus earlier, more regular senior clinical decision-making. Thirdly,

our financial recovery is directly linked to site consolidation. We have calculated this "reconfiguration dividend" at £25.6 million per annum recurrent savings, which is the "structural" element of our current deficit.

In order to consider the impact of the above and the impact of efficiencies planned work has been undertaken to understand the future acute bed capacity requirements. The following bed bridge describes the outcome of this modelling which will take acute beds from the current level of 1940 to 1697 by 2020/21.

The bed bridge below has been updated as further work has been done to assess the impact of the interventions in the bridge. In addition to the changes shown, we are currently considering utilising spare community capacity for sub-acute purposes. This is in order to ensure that we utilise existing estate and minimise investment in new acute estate, whilst ensuring that UHL has access to sufficient beds to operate effectively and can consolidate onto two acute sites. Final decisions will be taken in conjunction with the community beds strategy described in the next section



This has led us to conclude that the fundamental drivers behind the plan to consolidate acute services on to two remains the same. However, we are aware of the constraints on capital availability nationally and we have therefore worked to reduce our capital requirement including the use of alternative sources of finance such as PF2 or continuing utilisation of existing estate.

What does this mean for the General Hospital: Subject to the formal public consultation, the plan remains for acute services to be moved to the Royal Infirmary and Glenfield Hospital. The Leicester Diabetes Centre (as well as potentially some connected services) will remain at the General and will continue to expand to become the pre-eminent diabetes research institute in the UK.

The General will also continue to be home to other health and social care services. The Evington Centre will remain providing community beds for Leicester, incorporating a stroke rehabilitation ward. Joint health and social care teams delivering services in people's homes will continue to have a base at the site. Leicester City CCG are also considering using the General site as a centre for a primary care hub providing extended hours and GP+ services, ambulatory services and diagnostics.

What does this mean for the Royal Infirmary: The Royal Infirmary will continue to be our primary site for emergency care. The Royal will see maternity and gynaecology services consolidation and the completion of the new Emergency Floor. A key component of our overall reconfiguration is the creation of two super ICUs, one at the Royal and Glenfield. The East Midlands Congenital Heart Centre at the Glenfield will move to the Royal as part of the investment to create a properly integrated children's hospital. If congenital heart surgery is ultimately decommissioned then these facilities will be re-purposed for other uses.

What does this mean for the Glenfield: The Glenfield will grow as services move from both the General and the Royal. The first of these moves will be the vascular service so that we can create a complete cardiovascular centre. Renal services, including transplant, will also move to the Glenfield. We also intend to locate our planned ambulatory care hub at the Glenfield.

The following diagram shows the route map to achieving this transformation.

Maternity Services

Following a local review, doctors, midwives, nurses and patient representatives have developed proposals for the future of women's services for Leicestershire, Leicester and Rutland. The proposals for change will ensure greater equality of access to services across the City and counties, reduce waste and offer value for money.

A report in 2012 identified maternity services as unsustainable in the longer term and a review of the services has been taking place since then. UHL currently provide six birth options for women in Leicestershire, Leicester and Rutland. These are home births, community based midwifery care, midwifery led birthing centre at Melton Mowbray, and both midwifery, and doctor led birthing

centres at the Royal Infirmary and Leicester General Hospital. This is a greater number of options than is suggested by NICE guidance; and a recent East Midlands Clinical Senate confirmed that services needed to change to ensure that they are sustainable and equitable for all women across Leicestershire, Leicester and Rutland in the future.

It is proposed that hospital based women's services, including gynaecology and maternity, will be delivered by UHL from one site, the Royal Infirmary. Some outpatient and day case procedures will continue to be delivered from the community hospitals with an increase in services in some cases.

The review identified that some services, such as the standalone midwifery led birthing centre, (no doctor presence), at St Mary's in Melton Mowbray are underutilised. This service is only used by a small proportion of women across the City and counties, and as such it is proposed to close this centre. In order to offer choice, we are considering whether or not to provide a standalone midwifery led unit at the Leicester General. Our proposals are based on the reconfiguration of maternity services to ensure that they are of the highest clinical quality, financially sustainable, equitable (accessible to all) and not introducing unnecessary risk for pregnant women and their babies.

The proposal is that all women in Leicestershire, Leicester and Rutland would be provided with the following equitable maternity options:

1. All obstetric (doctor) led inpatient maternity services will be provided via a shared care (between midwifes and doctors) obstetrics unit at one site, the Royal Infirmary; this means the service would be next to the neonatal and intensive care units in case of emergencies.

2. A midwifery led unit co-located with the obstetric unit at the Royal Infirmary

3. Home birth - Midwife only lead home birth for low risk women, which is as safe as birth in a midwife led unit.

Additionally, subject to women's preferences expressed through the public consultation, a standalone midwifery led unit could be provided at the Leicester General Hospital site.

How will the reconfiguration of acute and maternity impact on quality for patients?

Having three big acute hospitals creates problems, by spreading our specialist staff too thinly across the three sites, resulting in duplication and even triplication of services. Through our Reconfiguration Programme, we will focus our emergency and specialist care at the LRI and the GH, whilst ensuring that appropriate clinical services are provided in the county's community hospitals, to offer care as close to home as possible. The patient is at the heart of reconfiguration, and through consolidation, we will improve patient experience and quality by:

- Reducing unnecessary patient journeys.
- Improving clinical adjacency so that support and diagnostic services are close to where they are needed, promoting closer team working and providing a better patient experience.
- Reducing delays to care by streamlining care pathways.
- Reduce cancellations by protecting our elective beds by separating out emergency and planned care. This will be done by creating a planned ambulatory care hub at the GH as well as re-distributing some of our services into the counties' community hospitals.
- Improving the quality of the patient environment.

Specifically, we will be creating a consolidated women's hospital and an integrated children's hospital on the LRI site, and a planned outpatient and day case centre at the Glenfield. A key

component of our overall reconfiguration is the creation of two 'super Intensive Care Units', one each at the LRI and the GH.

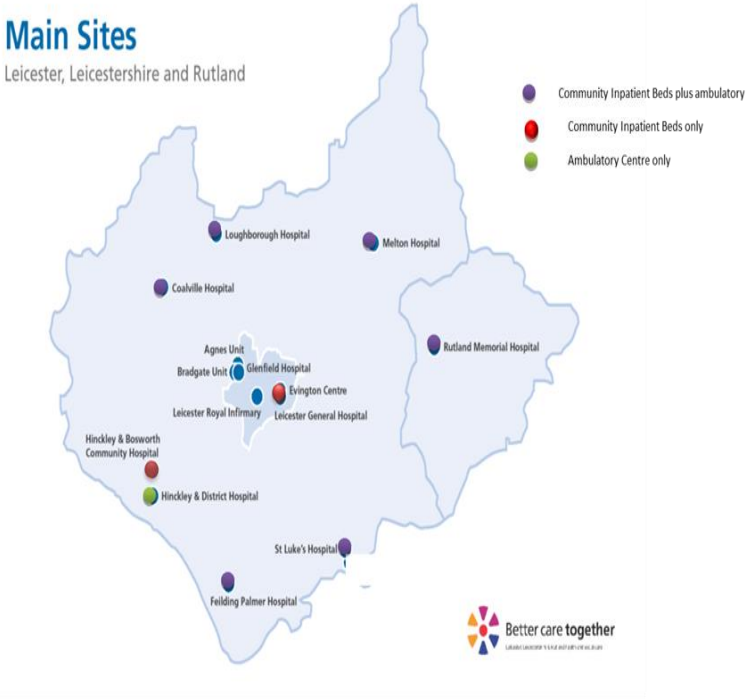
Community Hospitals

Current provision

Across LLR there are nine community hospitals providing a mixture of inpatient beds, community nursing and therapy services and elective care outpatient appointments, diagnostic investigations and treatments. These facilities are very variable in terms of the quality of the estate condition, but many are under-utilised, often have small isolated wards which cause sustainability issues, and are often not fit for 21st century health care delivery.

The Leicester, Leicestershire and Rutland health and social care system has been reviewing and improving the provision of community services over the last few years and has also initiated activity to increase the level of day case procedures and outpatient appointments in community and primary care settings, improving access for patients. The LLR strategy is to provide care for patients closer to home where feasible in facilities fit to deliver sustainable twenty first century health care.

The map and table below show the current provision of inpatient community hospital rehabilitation beds (192) and stroke rehabilitation beds (41) currently provided by LPT:



Place	Current LPT Inpatient Provision
Coalville	Rehab/Sub-Acute (24 beds) Stroke (24 beds)
Loughborough	Rehab/Sub-Acute (24 beds)
Hinckley	Rehab/Sub-Acute (23 beds) Rehab/Sub-Acute (16 beds)
Leicester City	Rehab/Sub-Acute (24 beds) Rehab/Sub-Acute (23 beds) Stroke beds provided by UHL at LGH (15 beds)
Melton	Rehab/Sub-Acute (17 beds)
Oakham	Rehab/Sub-Acute (16 beds)
Market Harborough	Rehab/Sub-Acute (15 beds) Stroke (17 beds)
Lutterworth	Rehab/Sub-Acute (10 beds)
Totals	Rehab/Sub-Acute (192 beds) Stroke (41 beds)

Note: the Stroke total figure above does not include the LGH stroke beds

Changing requirements in response to new models of care

Over recent years the health and care system across LLR has already enacted two significant community hospital reconfigurations following public consultation; the movement of services from Market Harborough and District hospital to the new build St. Lukes hospital in Market Harborough and the closure of Ashby hospital and re-provision of some outpatient services elsewhere in the town. Additionally a new service known as Intensive Community Support (ICS) service was initiated three years ago to provide rehabilitation care to patients out of hospital and avoid unnecessary

hospital stays; the number of ICS 'virtual beds' was increased from 126 to 256 in the latter part of 2015/16.

The next phase of community service reconfiguration considers how best to respond to the new models of care and pathway redesign set out elsewhere in this STP. In particular the following new model of care, clinical sustainability and efficiency issues will impact on the scale and location of community hospitals required:

- Home First model – will support patients to return home to their normal place of residence, reducing inpatient length of stay and the associated deconditioning impact on rehabilitation and reablement
- Integrated Teams – will help to reduce the need for inpatient community hospital beds by avoiding unplanned admissions and supporting reductions in length of stay
- Planned care settings – will see more elective outpatient, diagnostic and day case treatment activity delivered from non-acute hospital sites in primary and community care
- Workforce - ensure that community hospital inpatient facilities have a resilient and sustainable staffing model
- Estates – ensuring that facilities are well utilised and services are delivered in facilities fit for the 21st century healthcare.

Over the past decade, it has become possible to provide a greater range of rehabilitation services for patients in the community hospital setting and for patients in their own homes. As a consequence, there are now 256 intensive community support beds operating across LLR and the number of beds in community hospitals has been gradually reducing over the period to 192 at present.

For both stroke and neurology services a lack of specialist community rehabilitation is resulting in increased admissions, dependency on hospital and community based services and longer lengths of stay in both acute and community beds. We plan to address this by providing a new comprehensive, community based stroke specialist services for stroke survivors who need further rehabilitation after their initial period of rehabilitation in hospital. This new community service will provide patient centred, seamless care for both stroke and neurology patients that require rehabilitation in the community, largely in the patient's usual place of residence. The number of stroke and neurology beds will reduce, but continue to be provided on the three existing sites in Coalville, Evington Centre and Market Harborough.

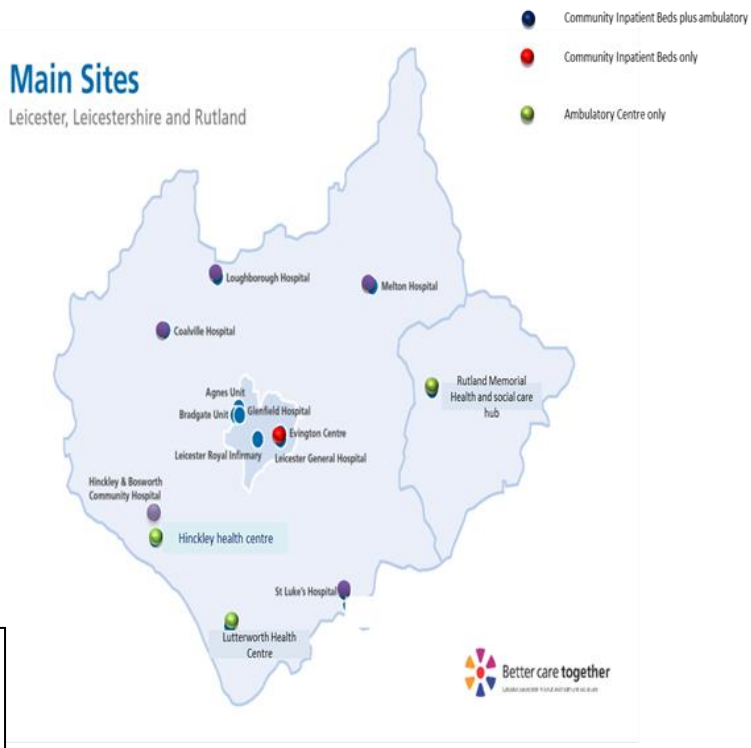
Some community hospitals have small single wards which are too small to be sustainable in the future. Staffing numbers are proportionate to ward size and small single wards have staffing levels that are vulnerable to issues such as short notice sickness, which if not resolved can increase risk and compromise patient safety. Where feasible it is proposed to move towards operating 'paired wards' on a single community hospital site in order to enable flexible and resilient staffing models. Where this is not feasible or desirable in terms of geographic equity of service distribution we are proposing increasing the size of some of the smaller wards to a more optimum scale. In addition, some wards have layouts which do not accord with NICE guidance which identifies ward size and layout as one of the factors in the provision of safe care.

Proposed next phase of changes

In response to the above changes in local models of care, as well as the utilisation and condition of the community hospital estate the following changes are being proposed. Many of these will be subject to formal public consultation in 2017 before any final decisions are made. Several will also require significant NHS capital investment which will need to be secured before any decisions which are ultimately taken could be implemented.

Place	Proposed Inpatient Provision
Coalville	Rehab/Sub-Acute (21 beds) Stroke (15 beds)
Loughborough	Rehab/Sub-Acute (24 beds)
Hinckley	Sub-Acute (21 beds)
Leicester City	Rehab/Sub-Acute (21 beds) Rehab/Sub-Acute (21 beds) Stroke (15 beds)
Melton	Sub-Acute (21 beds)
Oakham	No Beds
Market Harborough	Rehab/Sub-Acute (21 beds) Stroke (15 beds)
Lutterworth	No Beds
Totals	Rehab/Sub-Acute (150 beds) Stroke (45 beds)

Note: the impact of the Home First new care model may see further reductions in the need for inpatient bed based services, particularly in West Leicestershire.



West Leicestershire sites

What does this mean for Hinckley and District Hospital: The condition of this facility is not fit for purpose for providing modern healthcare, has inadequate scope to accommodate the expansion of certain local services and does not lend itself to feasible NHS re-use. As a result the proposal, subject to formal consultation, is to relocate the X-ray and Ultrasound departments into Hinckley Health Centre, which is directly adjacent to and on the same site as Hinckley & District Hospital. To accommodate this, the health centre will be refurbished to increase the number of clinical rooms so that this location can accommodate an extended outpatient provision and new modern X-ray/ultrasound facilities.

What does this mean for Hinckley and Bosworth Community Hospital: This is one of the best condition facilities in LLR with scope for investment to expand the range of local services available. Inpatient community beds will continue to be provided here, but in response to the new Home First and integrated team models of care it is proposed that the number of inpatient beds is reduced from the current two, to a single 21 bed ward. This will create capacity to enable investment in providing a new endoscopy and day case surgery suite within the footprint of the existing building. This will both re-provide existing diagnostic and treatment services provided at Hinckley and District hospital as well as creating additional capacity to enable services to be extended and expanded to meet the needs of a growing and ageing population in Hinckley and the surrounding areas.

What does this mean for Coalville Hospital: This site provides a wide range of general and some specialised services and the NHS is committed to continuing to deliver services from this location. The site will continue to be a key location for providing outpatient services for a range of specialities including Ophthalmology; ENT; Dermatology; Gynaecology; and general surgery. In response to the reduced requirement for inpatient beds as a result of the new models of care set out in the STP it is proposed that the number of inpatient rehab/sub-acute beds will reduce by three and the number of stroke beds by nine. Longer term, once the full impact of the Home First model in particular is more fully evident and understood there may be a requirement for a further reduction in the

rehab/sub-acute provision serving the northern part of West Leicestershire, either at Coalville or nearby Loughborough.

What does this mean for Loughborough Hospital: This site provides a range of urgent care, elective and inpatient services and the NHS is committed to continuing to deliver services from this location. The Planned Care services improvements set out in this STP will see an extended and expanded range of outpatient, diagnostic and day care procedures carried undertaken here. Loughborough will also continue to be the location of the Urgent Care Centre taking advantage of the x-ray and other on-site facilities. A single inpatient ward will continue to operate from here. Longer term, once the full impact of the Home First model in particular is more fully evident and understood there may be a requirement for a further reduction in the rehab/sub-acute provision serving the northern part of West Leicestershire, either at Coalville or Loughborough.

East Leicestershire & Rutland sites

What does this mean for Melton Mowbray Hospital: The proposal is subject to formal consultation, on the Rutland Memorial Hospital proposals, and subject to capital allocation for expansion to increase the inpatient beds from 17 to 21. The hospital will continue to be a base for planned care with greater use of the theatre for day case procedures. An expansion of outpatient specialities linked with outpatient diagnostics will provide access to more one-stop and joined up services at the hospital, as well as nurse lead evening and weekend extended primary care access.

What does this mean for Rutland Memorial Hospital: The proposal is subject to formal consultation and will see the Hospital becoming a hub for health and adult and children social care services. This will include increased planned care outpatient, therapy services, diagnostics and well-being services which will integrate with a GP led evening and weekend urgent care service for the people of Rutland. A feasibility study, designed to ensure the provision of health and social care services for the expanding population of Rutland and exploring options for further health and social care integration, underpins the vision for the hospital. The inpatient beds will close and provision will be available for local patients within a patients' own home using the Home First model, the ICS service or where necessary in other local community hospitals.

What will this mean for St. Luke's Hospital Market Harborough: Initially inpatient beds will remain the same however once the Home First model has been embedded we may see further changes in the configuration of inpatient beds. For ambulatory services, the hospital site will see the opening of the new building in 2017 and the transfer of existing services currently provided at the District Hospital, which will close. This will provide extended planned care and day-case services as well as Endoscopy, therapy services, outpatient diagnostics and well-being services which will integrate with a GP led evening, weekend and home visiting urgent care service for the people of Harborough District.

What does this mean for Feilding Palmer Hospital: The population of Lutterworth is rapidly growing and there is a need for, increased capacity in primary care along with extended outpatient facilities including diagnostic one-stop services. To deliver services to meet local needs, significant investment into community based outpatient and diagnostic capacity is needed. Subject to capital allocation and public consultation, premises will be developed to provide these services on the site, but not necessarily within the existing hospital building. The inpatient beds will close and provision will be available for local patients within a patients' own home using Home First model the ICS service or where necessary in other local community hospitals. Business case options appraisal and public consultation are required to establish the right solution for services in Lutterworth and the viability of the Feilding Palmer hospital site.

Leicester City sites

What does this mean for Leicester Evington Centre: Inpatient beds will reduce by five beds to move towards the 21 bed ward model and the stroke beds currently provided within the Leicester General Hospital will move to the Evington Centre on the General site (owned by LPT). However once the Home First model has been embedded we may see further reductions in inpatient beds.

What will we be formally consulting on?

The following service configuration proposals form the main part of our formal public consultations topics.

Element of services reconfiguration	Would proposed changes if enacted following public consultation close a hospital
The proposal is to move from three acute sites to two (Leicester Royal Infirmary and Glenfield) to ensure that going forward services are clinically sustainable and provided from excellent facilities	Partly. Most acute clinical services will be moved from the General site but part of the site will house the Leicester Diabetes Centre and be home to other community based health and social care services
The proposal is to consolidate maternity services onto the Royal Infirmary site with the option to retain a midwife led birthing unit at the General Hospital	Yes. The midwife led birthing until at St. Marys Hospital Melton Mowbrary will close
The proposed removal of inpatient services from Rutland Memorial Hospital in Oakham.	No. planned care outpatient, therapy services, outpatient diagnostics and well-being services which will integrate with an evening, weekend and home visiting urgent care service for the people of Rutland.
The proposed removal of inpatient services from Feillding Palmer hospital in Lutterworth	Subject to public consultation on service redesign and capital to develop primary care premises to increase capacity for General Practice, incorporate outpatient, services diagnostics and integrated community teams. The hospital building may not be viable and may close
The proposed removal of outpatient services from Feilding Palmer hospital in Lutterworth	Subject to public consultation on service redesign and capital to develop primary care premises to increase capacity for General Practice, incorporate outpatient, services diagnostics and integrated community teams. The hospital building may not be viable and may close
Proposed changes to the provision of services for Hinckley and Bosworth	Yes. Hinckley and District hospital would close

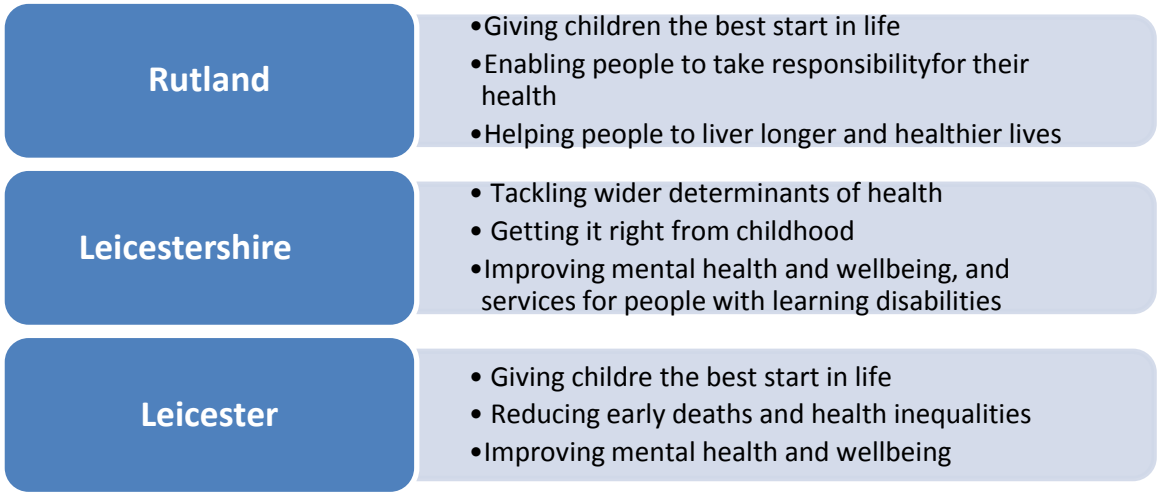
Strand 3 Redesign Pathways to deliver improved outcomes for patients and deliver core access and quality standards

This section describes the intervention we will take to ensure that we deliver improved outcomes, access and quality standards for our patients. Much of this work has already started through our Better Care Together Programme which has been working to improve a range of pathways.

Prevention

Prevention is a key part of Better Care Together. Many factors which drive longer-term demand for social care and secondary care are preventable or could be managed more effectively. Prevention of illness may help people stay working, live independently, or continue caring for loved ones. This will help the health and social care economy to a sustainable position and support the wider economy of LLR. However this is fundamentally about helping people improve their quality of life.

To support the STP prevention work a joint piece of work has been undertaken across the public health teams within LLR to identify the key issues that need to be addressed within the delivery of the various workstreams. These are detailed below:



The prevention agenda is also focused on effective prevention interventions in the short to medium term which impact on lifestyle and behavioural change in risk groups and on reducing the risk of illness and death in people with established disease or risk factors.

Concrete actions

- **Wider determinants of health:** Create an environment that supports community health and builds health into the local area, making healthy behaviour the norm, working with planning, housing, air quality and transport to maximise health benefit and which in the long term will have an impact on mortality.
- **Make better use of risk profiling**: To target communities and places with the poorest health, developing our capability to use real-time data systems to better understand health need and to monitor and evaluate the impact of changes to services on service usage and associated costs.
- **Detecting early:** Programmes to support General Practice in identifying and recording actual prevalence and supporting patients through better management of Long Term Conditions. Early detection programmes and preventative public health strategies and programmes

working closely with patient-led groups, self-help groups and community and voluntary organisations.

- **Primary prevention reducing incidence of disease before it occurs:** Tackling unhealthy behaviours through effective communication with the public, building on approaches such as PHE's Sugar Swap campaign, Dry January and "one You", alongside programmes to reduce alcohol consumption, obesity and support the availability of smoking cessations in acute and well as community settings, and the availability of advice and support through lifestyle hubs. Develop asset-based approaches to working with local communities, maximising their capabilities and resources to enhance health and well-being, improving their networks and resilience and developing social prescribing. Ensure that Making Every Contract Count is maximised.
- **Secondary prevention reducing the impact of disease:** Extend what we know works including better chronic disease self-management, care management to support people with long-term conditions such as AF and hypertension, improved day to day management of patients with complex needs through the development of integrated placed based teams, early disease identification through programmes such as NHS Health Checks co-ordinated with lifestyle services, and the Diabetes Prevention and Structured Education Programme maximising numbers of patients on the schemes.
- **Workforce health:** Develop workforce capability by implementing new approaches to workplace health, maximising the crucial role that staff at all levels play in promoting health and well-being.

How will these interventions close the gaps identified

Gaps	**Wider determinants of health**	**Make better use of risk profiling**	**Detecting early**	**Primary prevention**	**Secondary prevention**	**Workforce health**
Reducing the variation in life expectancy						
Reducing the variation in health outcomes						
Reduce premature mortality						
Improve early detection of cancers						
Chronic disease management to prevention						

What our Prevention programme means for local people

The focus on prevention will lead to a wide range of positive health outcomes for local people:

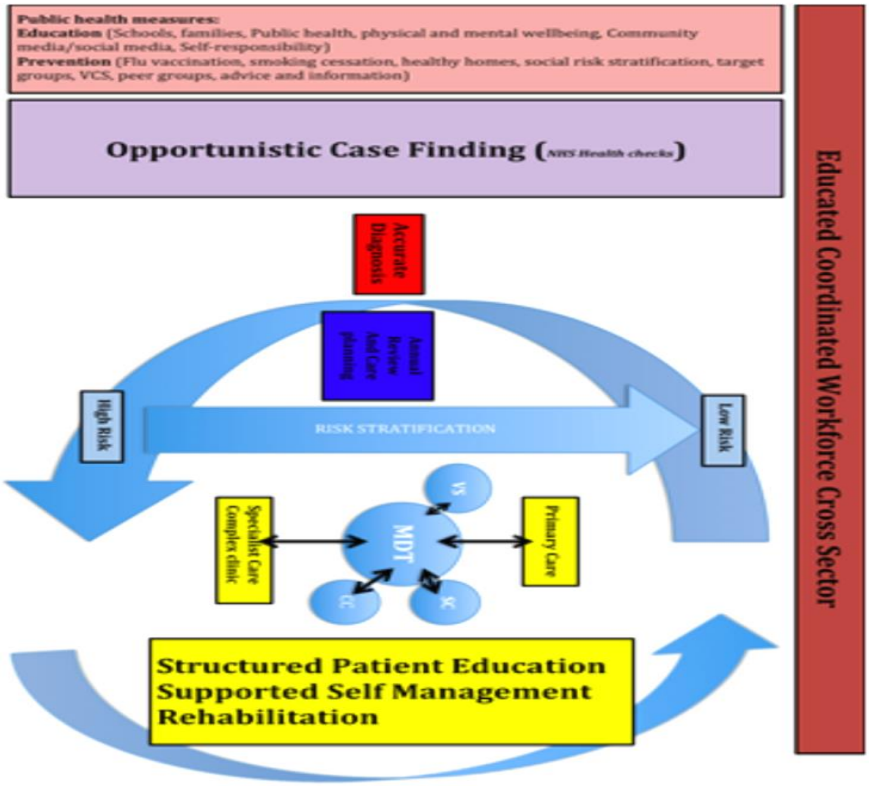
- Improved lifestyle though the reduction in smoking; alcohol; obesity and increases in physical activity will led to less heart disease, lung problems, diabetes and cancer.
- People will have more confidence to manage their own health.
- Less people will develop complex conditions.
- Reducing the likelihood of people with complex conditions going to hospital because of their condition.
- Creating an equal standard of care for all, with less variation in the quality experienced by advantaged and disadvantaged groups.

Long Term Conditions

Current model of care for most long-term conditions are reactive, episodic and fragmented. The result is a hospital and consultant centric service. This does not provide holistic, high quality, cost effective care, nor is it economically sustainable. People with long-term conditions contribute significantly to the pressures on emergency care. Prevalence rates are currently below those expected for example for CKD the actual prevalence rate for Leicester City is 2.77 compared to 5; Atrial Fibrillation in West Leicestershire actual is 1.73 compared to expected of 2.51; and COPD in East Leicestershire and Rutland actual is 1.9 compared to expected of 3.1.

Our vision for long term conditions is person centred, integrated care utilising as its foundation the methodology of the Chronic Care Model;

- Proactive case finding
- Stratification of severity and complexity
- Circular pathways encompassing annual review
- Shared care planning
- End-to- end whole disease pathways
- Cross Cutting and prevention activity
- Learning from patients and carers



Concrete actions

- **Prevent:** in partnership with Local Authorities and Public Health we will scale up a proactive approach to Health Promotion and primary secondary and tertiary ill-health prevention. This will include the implementation of the National Diabetes Prevention Programme.
- **Avoid:** enhance our community-based treatment model and focus on patients with a history of frequent hospital use where same day specialist input and specialised diagnostics are required. We plan to see more patients on an ambulatory basis, involving and supporting

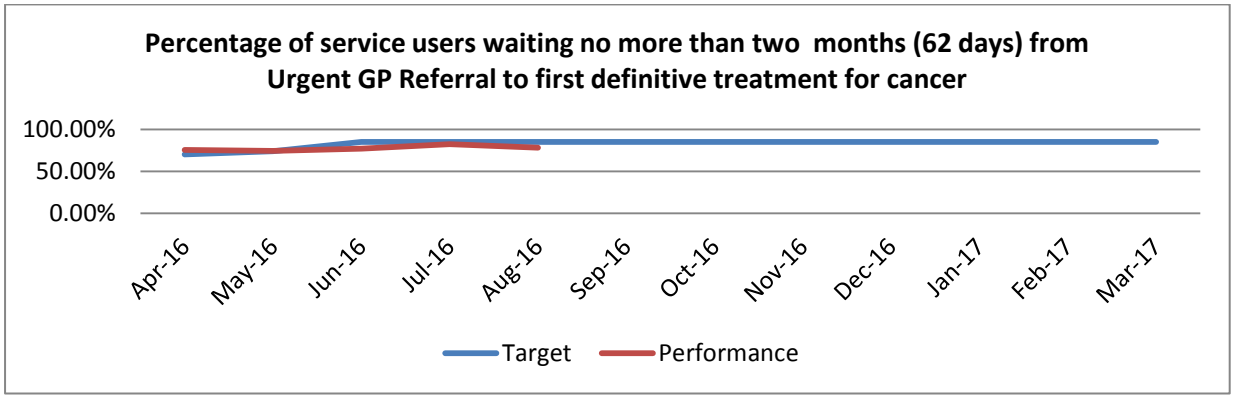
them through education, peer support, health coaching and development of care plans. This will include development of an integrated cardiorespiratory community service, timely specialist interventions through integrated teams from acute and community services. The expansion of the Rapid Access Heart Failure Clinic, Rapid Access Atrial Fibrillation, breathlessness clinic and part of the crisis response management, a low risk ambulatory service at CDU.

- **Reduce:** when exacerbation of long term condition does occur resulting in acute admission, it is our intention to keep the period spent in hospital for as short a time as possible through home crisis support and reablement. This will include the integration of cardiology and respiratory services and the development of an integrated LLR community rehabilitation service for stroke and neurology.

Cancer

Our work on Cancer also forms part of the Better Care Together Long Term Conditions work-stream. Cancer outcomes vary across Leicester, Leicestershire and Rutland. Of the three CCGs Leicester City has the worst outcomes and East Leicestershire and Rutland have the best. All three CCGs have poorer performance in some areas of cancer outcomes compared to the England or Strategic Clinical Network rates. Our one-year survival rates range from 70% in East Leicestershire and Rutland to 66% in Leicester City with a requirement to achieve 75% by 2020. Diagnosing cancer early not only saves lives but limits treatment costs. When ovarian cancer is detected at Stage 1 the five year survival rate is nine in ten with treatment costs of £5,300. However if detected at Stage 4 the five year is one in ten with treatment costs of £15,100. By 2030 LLR will have 50,200 people who are survivors of cancer.

Meeting the NHS Constitutional Cancer standards has been challenging and we have a Recovery Action Plan that will deliver compliance with all standards by March 2017. This action plan will be signed off by our Cancer Board shortly. This will support both the improvements required from acute providers alongside the understanding from the commissioners around where the biggest impact can be made by each tumour site.



We are developing solutions that will not only meet the NHS Constitutional Standards but will also prevent and detect more cancers early and support patients through treatment and into survivorship. We are implementing the Achieving World Class Cancer Outcomes Strategy 2015/20.

Concrete actions

- **Deliver the Constitutional Standard Recovery Action Plan:** to ensure compliance by March 2017.

- **Prevention:** develop and continue to run programmes to prevent and early detect cancers and reduce the risk factors such as smoking.
- **Improve the early detection of cancers:** we will do this through a programme of prevention and early detection, raising the profile of symptoms, improving pathways and access to diagnostics.
- **Develop a survivorship and health recovery offer:** to support patients following diagnosis and treatment including the provision of treatment summaries, health and wellbeing events and cancer care reviews.
- **Review and redesign pathways:** to meet the 2020 requirement that all patients should have access to high quality services working with our local Cancer Alliance.
- **Ensure sufficient capacity** to meet the 2020 standard of 95% of people with a suspected cancer should receive a definitive diagnosis or otherwise within four weeks of referral.

Mental Health

Mental illness is the single largest cause of disability in the UK with one in four people suffering from a mental health problem each year. Our objective is to reflect the Five Year Forward View putting mental health on par with physical health and close the health inequalities gap between people with mental health problems and the population as a whole. We will create an all age response to address the needs of younger, 'working age' and older people.

We will also work to achieve specific planning guidance to maintain mental health access standards, eliminate out of area placements and reduce the incidence of suicide.

Concrete actions

- **Widen choice and effectiveness in crisis response and reduce demand for beds:** Remodel Community Mental Health Teams, review Psychiatric Intensive Care provision, and strengthen; IAPT, Liaison Psychiatry, Perinatal and Eating Disorder services and develop NICE compliant services for First Episodes in Psychosis and Personality Disorder.
- **Increase clinical efficiency and partnership processes**: to create alternatives to acute admission and enable flow through acute hospital beds, including care management, access and support to mainstream and potentially bespoke accommodation.
- **Reduce suicide and increase resilience and promote recovery and independence:** to enable people to manage their health more effectively we will develop awareness and support skills in the population and develop recovery networks, social prescribing and workplace health.
- **Meet rehabilitation needs locally**: we will develop a local integrated offer enabling fewer placements out of area and by conducting rigorous reviews so that people have appropriate care packages closer to home at reduced cost, potentially using this redirected investments to build local infrastructure.

Learning Disabilities

In line with national guidance on Transforming Care, we have a comprehensive plan to transform care for people with learning disabilities, including implementing enhanced community provision, with a corresponding reduction in inpatient capacity, and undertaking our care and treatment reviews. By 2018/19, our aim is to produce and deliver responsible, high quality, safe learning disability services and support that maximise independence, offer choice, are person-centred, good value, and meet the needs and aspirations of individuals and their family carers.

Concrete actions

- **Provide proactive, preventive care**, with better identification of people at risk, and early intervention. We will empower people by expanding personal health budgets and through independent advocacy and a greater choice in housing.
- **Provide specialist multi-disciplinary support** in the community including intensive support when necessary to avoid admission to mental health inpatient settings through the provision of a refocused and enhanced Learning Disability Outreach Team which will reduce the need for inpatient beds.
- **Improve health and wellbeing** of people with Learning Disability and their family carer(s) through reviewing short break provision and ensuring engagement with preventative health initiatives.

Children, maternity and neonates

Our focus is on improving outcomes in maternity, children's emotional health and wellbeing, young people and family services. This involves a range of organisations working together efficiently to improve productivity across universal, targeted and specialist services to improve outcomes for children and young people.

Concrete actions

- **Continue to improve the quality of maternity and neonatal services:** improved access and outcomes for women and their babies based on the principles within Better Births including the formation of a Maternity Network and the development to of integrated pathways between primary and secondary care to provide continuity of care. In addition, and subject to consultation, all obstetric-led inpatient maternity services will be delivered from one site, and options on the provision of midwifery led units will also be consulted on. See Service Reconfiguration Section. Work will be undertaken to further consolidate and develop the neonatal service to meet the responsibilities of being the lead centre for the Central Newborn Network.
- **Delivery of Future in Mind:** our transformational plan to improve the mental health and wellbeing of children and young people focuses on improving resilience; enhancing early support; improving access to the specialist CAMHS service; enhancing the community eating disorder service; developing a children's crisis and home treatment service and developing the workforce.
- **Care in the right place at the right time:** the population of children and young people with general and complex health needs that require clinical intervention is increasing. Work is underway to review The Children Hospital Model to meet the increasing demand, remodelling work will consider where services will be based; increasing the admission age to 18 and 365 days for those who have a complex condition and Special Educational Need; review pathways to consider the best environment for delivery; and deliver the Children's Emergency Care Pathway and the Single Front Door to ensure robust streaming and assessment and delivery of clear pathways for ambulatory care.
- **SEND:** review therapy service for young people aged 16-18 years old to ensure young people transitioning to adult services have access to the appropriate provision; and ensure that personal health budgets are offered to children and young people with Continuing Healthcare Needs.

Continuing Health Care and Personalisation

Leicester, Leicestershire and Rutland has benchmarked in the lower quartiles for Continuing Health Care (CHC), with both numbers and costs of packages being high. Over the last year we have done a considerable amount of work to improve this position but more needs to be done. We also acknowledge that there needs to be a shift in the model to much more personalisation and away from CHC to Personal Health Budgets and Integrated Personal Commissioning. Not only will this give patients better control and choice over their care but it will also support the delivery of a number of the BCT work-streams where tailored care is part of the solution.

Concrete actions

- **Continuing Health Care:** revise, consult and implement new settings of care policy; improve discharge processes so that assessments are completed out of hospital and review high cost placements.
- **Personal Health Budgets:** deliver a minimum of one Personal Health budget per 1,000 of the population. This equates to one thousand across LLR. We are planning to move to an offer that is based on a PHB being the default rather than an option.

Specialised Commissioning

Midlands and East Regional Specialised Commissioning serves a total population of 17m and has a yearly budget of £3.7b, there are 72 trusts and 61 CCGs in the area. As with all sectors of health care specialised commissioning has a range of challenges including growth in demand and cost, growing population with chronic disease, ageing population, and new technologies. There is a predicated funding gap nationally of £0.9b by 2019/20. The split in commissioning responsibilities between NHS England and CCGs can mean fragmentation of the patient pathway and misalignment of incentives, particularly a lack of focus towards prevention. Improving this will require collaboration at a local level and more joined up innovative commissioning across pathways focused on value.

Concrete actions

- Work with the local Specialised Commissioning Team to identify priorities for collaborative commissioning including the expectation within the Commissioning Intentions for 2017/18 and 2018/19 for Prescribed Specialised Service to have collaborative commissioning arrangements covering at least one of the priority service areas (Cancer, Mental Health and Learning Disabilities).
- Explore how collaborative commissioning can improve outcomes and value across the whole pathway for the services described above.
- Work with the local team to identify services that could potentially benefit from being commissioned on a STP footprint.
- Learn from other areas about what works.

Strand 4 Operational Efficiencies

Ensuring we make best use of our resources is key to delivering financial sustainability across the system by 2020/21. Many of our plans set out how we can redesign services and reconfigure our acute and community hospitals to make best use of resources. In this part of our STP we describe how we will improve and back office functions to drive the efficiency agenda further forward.

The Carter Review into the productivity of English non-specialist acute hospitals found that there is significant unwarranted variation across all main resource areas. UHL has plans to implement the recommendations and LPT, although not an acute trust is using the findings as a foundation for its productivity plans.

Provider CIP

Providers have developed plans that are based on benchmarking, analytics and opportunities from national best practice such as Getting It Right First Time, Carter Review and Digital First schemes.

Concrete actions

Beds: For UHL the beds cross-cutting work stream targets the effective and efficient use of the Trusts bed stock. This workstream builds on a number of existing best practice improvement projects on efficient flow and discharge process including the SAFER bundle, integrated and streamlined discharge processes and improved sign-posting. Readmission improvement projects developed throughout 2016/17 will continue into 2017/18 delivering further reductions in the demand on inpatient bed capacity. The programme is also likely to work with community beds to reduce the overall composite LOS across LLR. A particular focus will be on reducing unnecessary variation within the way different wards and their teams practice.

In addition to schemes that are active in 2016/17 additional projects targeting Ambulatory Emergency Medical patients and Same Day Surgical discharge rates will also contribute to reduced demand on inpatient acute wards.

Quantification of the level of improvement has been produced using analytical information from recent (up to Q1 16/17) length of stay datasets. This data has been benchmarked against relevant peers and where the Trust has longer length of stay the opportunity to improve to the upper quartile has been used.

For LPT redesign of clinical services will also result in reduced length of stays.

Theatres: The theatres workstream incorporates efficiencies across all theatres within UHL. Some of the active projects from 2016/17 will continue to deliver increased benefits, such as the improvements in scheduling, utilising best practice tools from NHSi (IMAS) and improved control and escalation systems to reduce wasted time in theatres. A particular focus will be on reducing unnecessary variation within the way different Theatres and their teams practice.

In addition to these projects there will be additional improvements from developments in Day Case Surgery and actions stemming from the Getting It Right First Time Review. These look to improve multiple facets of theatre productivity both utilisation, but also important elements of non-pay expenditure.

Quantification of the level of improvement has been produced based on increase in utilisation of theatres. Estimated 50% achievement of this target level of productivity is projected for 2017/18 with the remainder in 2018/19.

Outpatients: The Outpatients workstream incorporates a UHL wide scheme to improve booking processes that commenced in 2016/17. This will continue into 2017/18 alongside additional schemes on the reduction in conventional face to face follow-up appointments. All elements of the outpatient work stream will overlap with technological developments and reference back to the achievements described in the Digital First strategy as well as UHL's own IM&T strategy. As within the other work streams there will be a significant focus on reducing variation by ensuring the standardisation of clinic templates across the specialities.

Quantification of these large schemes of work have been derived from benchmarking and analytics that moves booking efficiency to 95% and achieving the peer median on all outpatient specialties for New: Follow-up ratio. The full opportunity for this is split across the two years.

Non-pay and Procurement Target: Centrally and CMG led procurement projects will include the development of a category management strategy, as well as more transactional improvements in non-pay cost reduction. This will also incorporate national programmes focussing on reducing price per unit for common consumables, most notably working closely on the Carter procurement standards.

Estates: For UHL **i**mprovements in estate management and upkeep, together with rationalisation and procurement schemes will be delivered across 2017/18 and 2018/19. These schemes will interrelate with the Beds, Theatre and Outpatient workstreams as each area delivers benefits. The Trust has a well-developed site reconfiguration programme which is where most of the financial strategy exists and delivers Carter benchmarks for clinical and non-clinical estates use. A further major area within Estates is the delivery of energy efficient estate.

LPT will continue to implement their 5 year estate strategy which will see rationalisation of the estate using technology to increase productivity and reducing the reliance on physical premises and community hospital reconfiguration.

Corporate and Back Office: Going further than what is suggested within the Carter review, the corporate and back office schemes will deliver improvements in cost where duplication and waste occur, rationalising the total resource required across the two years. This programme will re-examine and redefine the role of corporate and back office functions, leveraging better use of technology to support a whole new model. Some of this model is likely to lead to significant collaboration within partners across LLR and potentially beyond.

CMG led: Smaller grouped improvement schemes delivered in the CMGs will be delivered as part of day to day management. These schemes although smaller in size are greater in number and vary in nature, therefore are captured as one overall work stream.

Workforce: For UHL workforce improvements contained in other cross cutting streams such as Beds, Theatres, Outpatients, are described as part of those programmes. However, in line with the Carter programme, more centralised control systems review, role redesign and rota management projects will also deliver benefits across the Trust. Identification of these areas to improve has come from NHSi agency workforce review tools, as well as utilising HRD network and other national exemplar practice. Benefits will largely manifest themselves in the form of more effective, efficient and greater value for money clinical staff and reduce the total capacity of staffing required.

For LPT focus will the on greater use of bank staff to reduce spend on agency staff.

Across LLR we will be considering the development of a local NHS Bank, across both providers, to collectively reduce spend on agency staff.

Medicine Optimisation

Over the last three years the CCGs have implemented a range of evidence based prescribing measures. This has included medicine switches, reducing wastage and implementing guidance. Work in these areas will continue over the life of the STP. However we recognise that more could be done to improve medicine optimisation working collaboratively with our provider partners for example nationally 6.5% of emergency admissions and re-admissions are caused by avoidable adverse reactions to medicines; there is over £150m a year of avoidable medicines wastage and only 16% of patients taken their medicines as prescribed.

Concrete actions

- Consider the move to an LLR wide prescribing team and greater collaboration working across organisations.
- Better manage the high cost drug budget to support the growth in drugs with NICE Technical appraisals.
- Ensure that the medicine impact of both "left shift" and increased prevention are understood and accounted for.
- Maximise the use of the pharmacy workforce to support clinical services and staff and also increase the use of non-medical prescribers.
- Work together to tackle waste across the system.
- Use real time data analysis tools to improve quality of outcomes for patients and cost efficiency.
- Support patients to take an active role in medicines taking to increase compliance
- Promotion of the self-care agenda to empower patients to manage themselves more effectively.
- Maximise the use of prescribing analysis support tools to reduce polypharmacy which leads to preventable hospital admissions.
- Consider whether cost effective alternatives to medicines could be provided, for example coping strategies for some patients suffering pain.

Back Office Efficiencies

Partners have committed to review back office functions to consider whether they can be carried out more effectively by doing so collectively for example through a shared business service. The aim is by 2018 so that no more than 7% of income will be spent on back office functions with this reducing to 6% by 2020. A Senior Responsible Officer has been appointed to take this work forward and the back office efficiencies programme is part of the formal STP governance structure. The agreed scope and project support will be completed by the end of November 2016 with a target date of end of January 2017 for the completed Outline Business Case and for phased implementation from June 2017 onwards.

Concrete actions

- The first stage of this work involving Information Services, Procurement and Finance functions will release £2million across the system.
- Further financial analysis is being undertaken across additional areas of possible collaboration including Information Services, IM&T and Human Resources.
- Over the longer term a review is planned to assess the potential for integration across organisations to reduce duplication in planning, contracting and strategy.

- Further areas for exploitation have identified. These are complaints and legal governance, business planning, quality assurance, health and safety, safeguarding, risk management and clinical governance.
- Consider the development of an LLR Shared Business Service Unit to incorporate the above services and more if it makes financial sense.
- Improvement in productivity by aligning processes and templates used across the system will be explored for potential to create synergies between co-located and collaborating teams, through increased standardisation, to be realised as standardisation across organisations increases.

Section 9 of our Local Digital Roadmap sets out actions in each year to deliver the above.

Strand 5 Enablers

This section describes the key enablers that will support the delivery of our STP.

Estate

Many of the changes described in this plan have estates implications including providing more planned care in the community; developing placed based teams to deliver services to keep patients at home as long as possible, making maternity services more sustainable and moving services around to ensure that the right services are next to one another for reasons of safety, quality and efficiency.

The impact of our plans on community hospitals is described earlier. However in addition Leicestershire Partnership Trust has an Estates Strategy than aims to consolidate and rationalise all of their estate over the next five years. We also recognise that more can be done to better utilise the public sector estate across LLR and we will work with our partners to ensure we get more efficiency.

Concrete actions

- Implement, following formal consultation, the reconfiguration plans we have for both acute and community estate
- Improve utilisation of the estate using the Carter principles to ensure we are getting best value
- Identify opportunities for co-location, rationalisation and consolidation with the wider public sector local authorities, ambulance and fire services.

Information Management and Technology

To date the LLR community has focused on improving IM&T in four areas – sharing care records, population data analysis, system wide efficiencies which improve integrated working; and supporting BCT workstreams. Our digital road map sets out our vision for the future both for IM&T that supports the delivery of care and using technology to support patients.

Concrete actions

- Shared access to paperless patient records at all clinical interfaces across LLR to improve patient outcomes and support integrated working, alongside removing the use of paper.
- Implementation of a comprehensive Electronic Patient Record within UHL to improve quality and efficiency and facilitate sharing of records across boundaries.
- Encourage patient empowerment to drive up the use of technology to support greater self-care, improvements in health and wellbeing and access to services, alongside developing alternatives to face to face consultations.
- Support independence of patients through the use of technologies such as telehealth and assistive technology.
- Use real-time and historic data to support predictive modelling and improvements in clinical service delivery at the point off care and to support population health analysis and management for effective commissioning.

In 2016/17 to support the delivery of DRM we have made and been successful in making applications to the Estates and Technology Transformation Fund for clinical system migration and

sharing of care plans across the health sector in LLR. Our priorities for 2017/18 are detailed in Appendix 3 of our Digital Road Map but include GP system to GP system interoperability, MIG V2, Mobile DOS and SCR in social care.

Health and social care joint commissioning and integration

Over the last few years there has been increasing joint working between local authorities and CCG's including joint work on our Better Care Fund programmes. Increasingly this work is progressing into joint commissioning with both the city and county areas jointly commissioning domiciliary care and exploring joint commissioning work in relation to residential care. We see that there is much more opportunity in the future to develop our joint commissioning and integration and these are some of the areas we are going to explore:

- Joint commissioning of residential care placements
- Learning Disabilities, including the implementation of the Transformation Plan
- Mental Health, including mental health recovery and resilience hubs and the implementation of the CAMHS Transformation Plan
- Voluntary sector contracts
- Integrated health and care personal budgets including integrated personal commissioning
- Integrated commissioning for prevention
- Development of placed based integrated teams supported by integrated points of access
- Integration through digital for example the electronic summary care record, interoperability programmes and using shared data.

This agenda is not about moving to a combined authority or single LLR health and social care organisation. Some of the above will be done at a local level between the respective CCGs and local authorities but where it makes sense to do things at an LLR level we will do.

Workforce

Delivery of our STP will require strong system leadership, changes in culture and significant changes to workforce capacity and capability. Analysis of the current workforce challenges, impacts of the solution strands on the LLR workforce, and an approach and action plan based on current funding from HEE is included in the Workforce Strategy appended to this document.

In summary, the STP will have the following impacts on workforce:

- Shift of activity
    - Increasing the capacity within primary and community/social care before capacity can be released in acute settings.
    - The projected increase in primary care workforce is around 10% by 2020/21 with a reduction in secondary provider workforce of around 5% over the same period. The overall workforce numbers remain stable against a 2015-16 baseline.
- Change of location – more care provided in patient's home/locality
    - More autonomy for staff
    - Training needs to take into account exposure to different care settings
- Roles and skills mix
    - Potential of new roles and career paths
    - Mitigation of recruitment challenges
- Re-skilling, including for new technology
- Working across organisational boundaries

The above impacts raise a number of challenges for the system to respond to. A summary of workforce challenges and associated actions, which form the basis of the workforce strategy is included below:

Challenge	Approach
Ensuring the future workforce supply, aligned to new models of care	• Integration of BCT workforce enabling group and establishment of LWAB • Developing a system-wide approach to attraction and retention,

Ensuring the system can make the capacity shifts required	• Workforce planning – developing a view of the capacity and capability changes required
	  ○ Establishing a clear baseline
	  ○ Strategic workforce modelling and capacity planning
	  ○ Functional mapping and workforce profiling
	• Developing the ability to move people around the system
	• Developing the Primary Care workforce

Ensuring staff have the right skills and capabilities to perform in the new system	• Developing the curriculum to support both short and long-term skills development and future workforce supply

Ensuring effective management of change and development of the 'system' culture	• Developing a mechanism to provide ongoing support to clinical work streams during implementation
	• Developing Culture
	  ○ Setting vision and direction
	  ○ Staff engagement and change management
	  ○ System leadership capacity
	  ○ System Development and the LLR way

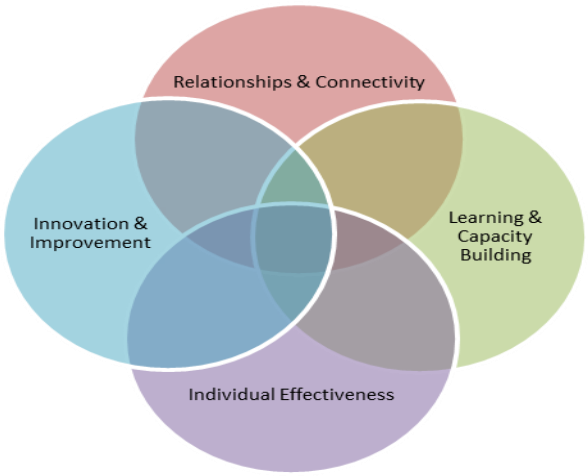
The workforce enabling work stream has established a programme of work to support workforce transformation. This is detailed in the LLR workforce strategy and plan, with the working structure summarized below.

200 clinical and care leaders came together in April 2016 to further consider the potential of new models of care and the support required to deliver them. The outputs of that session started to describe the culture that LLR can begin to work towards.

The 'hard' and 'soft' elements of culture are interdependent and work together to form 'how we do things around here' – this is the totality of the potential 'LLR way'

Some of these elements are already in progress and informed our STP and new governance arrangements. The Clinical Leadership Group has worked with the LLR Organisational Development group to consider an approach to facilitating progress.

In September 2016, clinicians and care leads again met to consider 'Integrated Care across LLR'
In particular they considered aspects of leadership in a system context and validated the below framework for systems leadership development. This framework will underpin a programme of development to be delivered system-wide.



An overall approach to development and culture change was approved by system leaders in November. The approach builds on the outputs from engagement with staff, creating an overall framework for development of the 'LLR Way.'

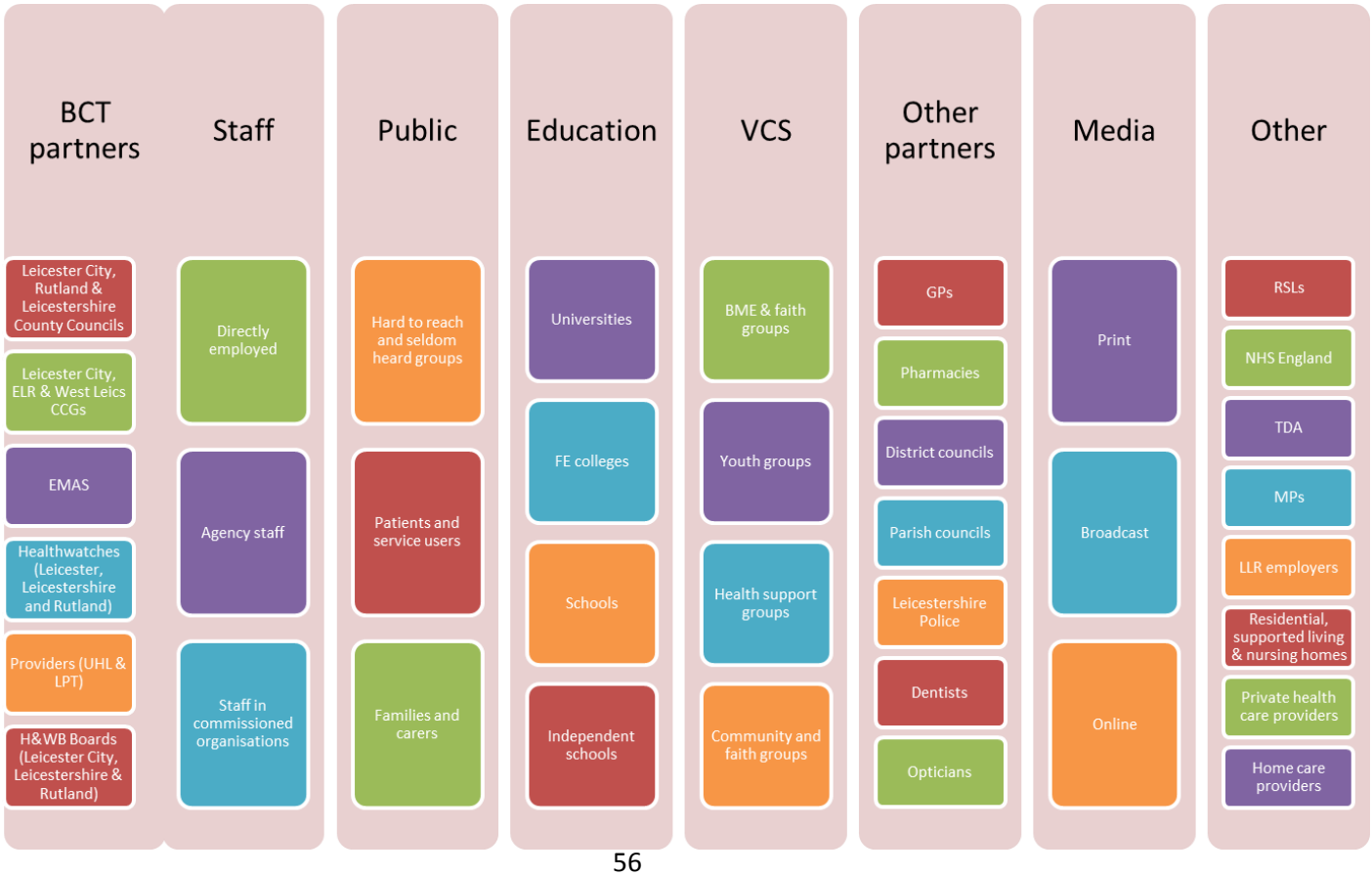
Engagement

Engagement has been integral to the STP process and the associated Better Care Together programme. A wide variety of stakeholders have been involved ranging from statutory bodies, elected officials, local authorities, the voluntary and community sector, right through to patient and public groups and clinicians within the health economy.

Engagement has ensured that our plans have been honed and developed to meet the needs of our community and stakeholders but have also acted as a sounding board to shape key plans.

During spring 2015, a large-scale public campaign was launched across Leicester, Leicestershire and Rutland which explained the current position of health and social care services in the area, and to ensure that the priorities of the local communities and other stakeholders, matched the direction of travel of the Better Care Together programme. The document took the format of both a written document and an online version, to maximise the number of people able to contribute their views. During the campaign over 1000 responses were received, and a population reach of over 375,000 was achieved through various engagement techniques. The data was comprehensively analysed by Arden & GEM CSU, and its outputs were fed into workstreams and the programme's governance structure to ensure the outcomes were contributed into the wider planning of the programme.

In total, a substantial amount of wider engagement has taken place in a number of formats at both work-stream and at a wider Better Care Together programme level, all of which has been recorded, comprehensively analysed and then fed into the programme, with monitoring in place to ensure the engagement themes are fully reflected in the programme plans. To summarise the engagement undertaken as part of BCT, a stakeholder engagement map has been produced, a summary of which is below.



The overall plan for engagement and communications across the health and social care system is overseen by a dedicated Communications and Engagement group, made of the communications and engagement leads for all of the partner organisations. This ensured a joined up and sustained approach to engagement which could draw upon lessons learned from previous large-scale engagement campaigns. To summarise, our engagement included:

- Summary system-wide plans already shared with partner organisation Boards.
- Commissioning of voluntary organisations to engage with each of the protected characteristics.
- Patient and Public Involvement (PPI) representatives via their monthly meeting and the wider patient and public involvement network, and the Leicester Mercury newspaper Patients Panel.
- Voluntary, Community and Faith sector networking events and virtual forum.
- Staff engagement events, briefings, protected learning time, and a dedicated staff webpage.
- Briefings for local councillors and MPs.
- Public facing website and associated social media for people to feedback on and interact with.
- Regular updates and briefing at the health and wellbeing boards and HOSC's

This engagement conducted over a sustained 18 month period as part of Better Care Together has since been further built upon as part of the STP planning process. Our engagement on the STP has made use of existing links and relationships across LLR. Specific engagement on specific elements of the STP has continued such as with individual community hospitals, as has overall engagement on the STP.

The STP engagement process has been devised by communications leads across the Leicester, Leicestershire and Rutland (LLR) STP partners and then monitored and discussed by the programmes Patient and Public Involvement group and Partnership Board.

As many of the plans in LLR's STP build on plans within the previous Better Care Together programme, there has been an opportunity for sustained conversations and engagement with key stakeholders as well as the public on key elements of plans such as the future of the 3 acute hospitals in Leicester, reconfiguration of maternity services and elements of the hospital reconfiguration plans. Key stakeholders engaged in plans include NHS boards, CCG governing bodies, Local Authority Health and Wellbeing Boards, councillors, MPs, staff, and the voluntary and community sector.

Appendix 2 is the communications plan and timeline being used to build upon previous engagement in order to maintain momentum on engagement of the STP with the public and key stakeholders.

Once feedback has been received from NHS England on the LLR STP, the document will go to the LLR System Leadership Team in November (a private meeting) and then to extraordinary public board meetings of STP partners at the end of November 2016. At this point the plan will be in the public domain, and will be accompanied by a public facing summary. In order to maintain momentum on engagement and implementation, a provisional consultation date has been planned for early 2017. Further details of the exact timeline are available in Appendix 2. This timeline will however flex accordingly dependent on the exact dates when feedback is received from NHS England.

Feedback loops and evaluation procedures have also been put in place to ensure that the system is able to capture the feedback from stakeholders on the engagement and incorporate that into

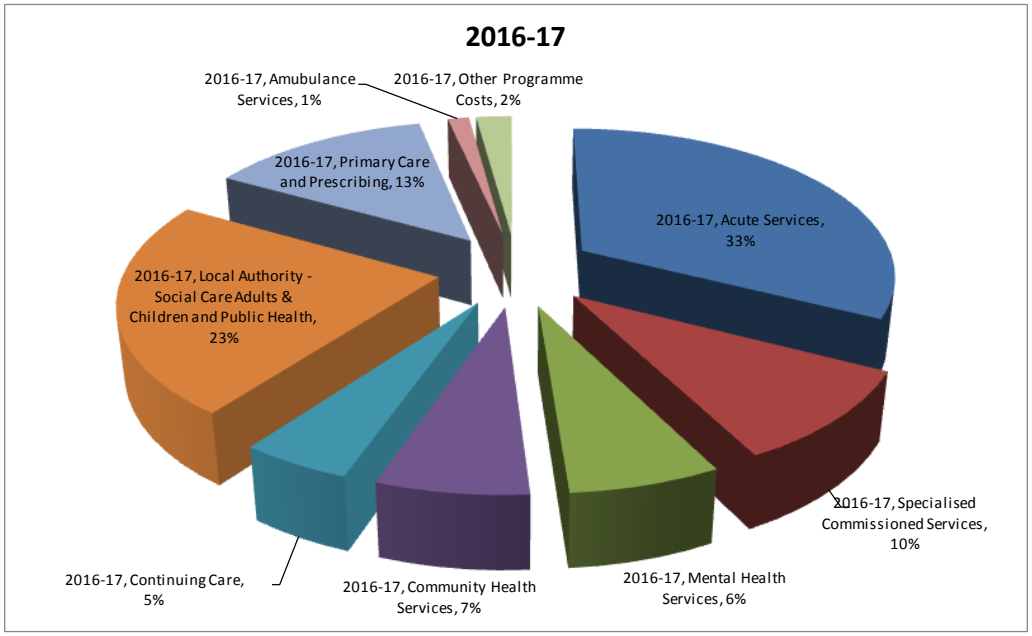
planning, as well as recording all engagement taking place in order to evidence stakeholder involvement and input.

There is a good degree of consensus among the general public (drawing on the results of the large-scale engagement campaign in 2015) that health and adult and children social care services need to evolve to meet the needs of a changing population. Given also that the plans have been discussed and formulated as part of Better Care Together over a number of months or years, there is also a good consensus amongst the partner organisations within the STP. However, Local Authorities are often frustrated at the perceived lack of pace to implement the proposed changes.

Finance

How we spend our money

In 2016-17 LLR will spend £2,420m on health and social care. This is split as follows;



Five year financial gap

All of the health and social care organisations in LLR face financial challenge, as demand and demographic growth for services out-strip the increased resources available year on year.

While there is an expectation in the health sector that the funding available will rise by c. 2% each year, equating to an additional £200m over the time of the plan, predictions for the growth in both cost and demand range from 0.5% in some areas rising to 4.73% in more specialist areas of medicine, year on year.

The social care sector also faces similar challenges with demand in growth matched to a flat or reducing level of funding available to support social care services.

Without developing new ways of working the impact of increased demand creates a financial gap for health and social care over the five year timeframe of this plan of £399.3m

Of this healthcare accounts for £341.6m of the gap, whilst social care gap equals to £57.7m over the same timeframe.

The LLR system has been aware of this continuing demand/resource gap for some years and has developed a number of plans to mitigate this through the local transformation programme, Better Care Together. This plan builds on the earlier Better Care Together plan, which covered the period up to 2018-19. This refresh takes into account the latest information issued regarding the availability of sustainability and transformation funds, and capital availability.

Overall the impact of the growth on the system is primarily in acute and specialised services, this is where the solutions are targeted, and investing in community based services. The table below shows the organisational impacts.

	Do Nothing' Growth	Savings Schemes	Net Planned Growth
UHL	25%	23%	1.92%
LPT	15%	17%	-2.06%
EMAS	19%	11%	8.06%
CCGS	20%	10%	10.32%
Specialised	31%	15%	15.98%
Local Authorities	14%	11%	3.35%

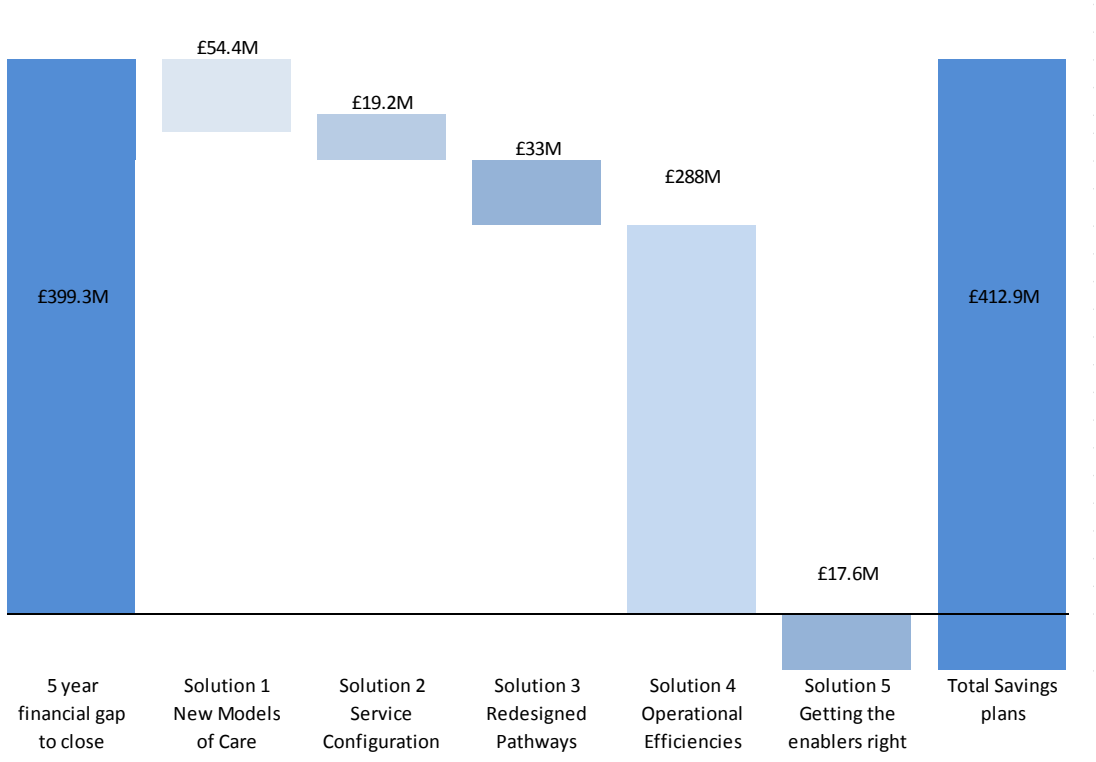
Closing the Gap

Solutions to close the gap are mapped into New Models of Care, Service Configuration, Redesigned Pathways, Operational Efficiencies and Getting the Enablers Right. Savings plans for LLR Local Authorities and for specialised services are included within these solutions.

Schemes for the first two years of the plan are already well developed in both the cost reduction and demand management areas. Those for latter years are agreed in principle; the delivery plans for these will be developed further in the coming months.

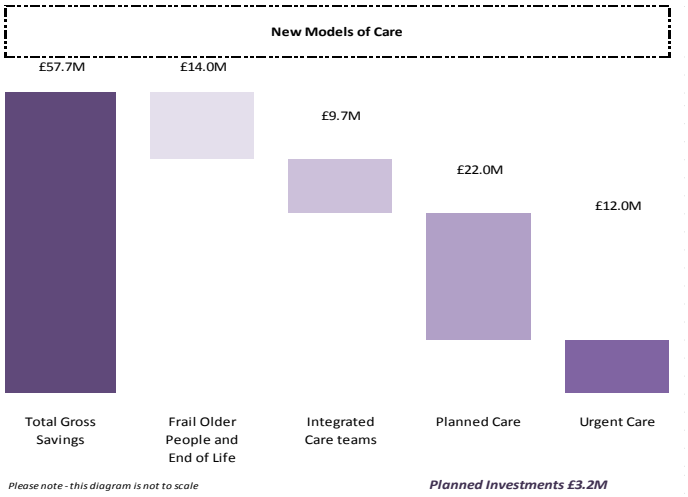
CIP schemes are in place to deliver c. £175m of the required savings. The single largest scheme in LLR is the move from three to two acute sites for UHL. This deals with both quality and workforce issues created by duplicating services over two or more sites. Once the reconfiguration is complete the directly attributable cost saving from this will be around £25.6m each year.

Financial Gap and Savings Plans 2017-2021



In addition to the above solutions the system has assumed net investment of STF funding in 2020-21 of £66M, in order to deliver transformed services. This gives a net gap of £333M saving and net saving of £343M. Currently we have requested additional STF funding in other years as set out in the table under opportunities, challenges and risks and in the finance template submitted.

Strand 1 - New Models of Care Net Savings £54M



Savings in this area are drawn from the following areas;

Integrated place based teams – joining multi-organisation teams from health and social care, eliminating duplicate processes, and expanding the workforce to ensure wrap around care avoids emergency admissions.

Planned Care – targeting best practise new/follow-up ratios and redesigning pathways to ensure appropriate triage of patients, targeting 10% decommissioning.

Urgent Care – Vanguard programme designed to reduce demand in A & E and emergency admissions.

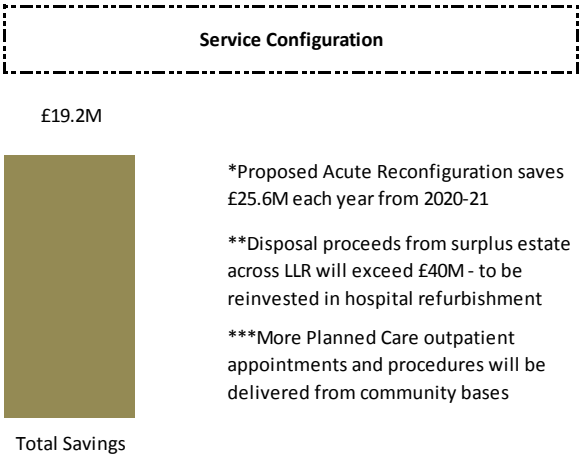
Strand 2 - Service Configuration Net Savings £18.9M

Net savings of £19.2m comprise of the savings made during the configuration, less the additional costs added into the 'as is' running costs.

The acute reconfiguration is expected to deliver gross savings of £25.6M by 2020-21

Community inpatients and planned care provision will account for further gross savings of £8.6M.

This is offset by capital charges in the period 2017-18 to 2021 of £15.1m

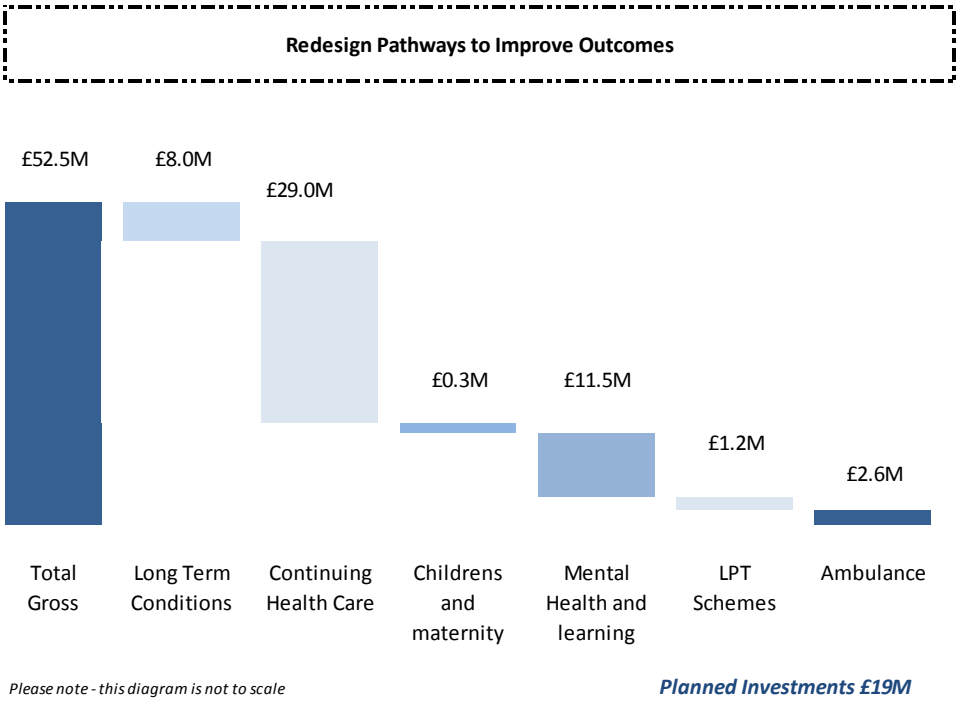


The changes will result in;

- More outpatient appointments and diagnostics will be delivered through a network of community bases, freeing up floor space in acute hospitals
- UHL will provide acute services from two sites
- A single point of access will be created to navigate patients to the right part of the system
- Right size community wards
- Supported by Home First principles and investment in integrated care teams

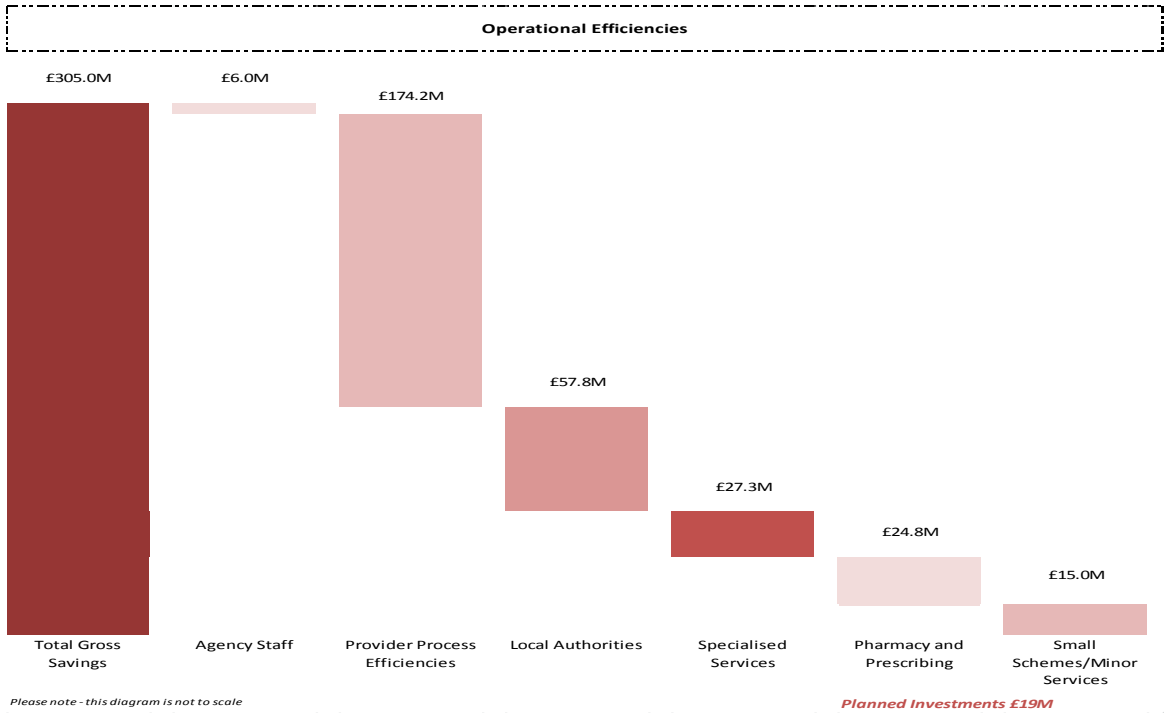
Alongside this staff will be trained to deal with the changing needs of the patients (more multiple long term conditions in an aging population) and able to work flexibly between inpatient and outpatient or patients' homes as the setting for care.

Strand 3 - Redesigned Pathways Net Savings £33M



BCT work streams concentrate on improved health outcomes, particularly for people with long term conditions, Learning Disabilities, and Mental Health Services generating savings for reducing escalation of acute episodes of ill health, saving £38.6M for the period to 2020-21.

Strand 4 - Operational Efficiencies Net Savings £288M



This category covers the efficient use of all the LLR health and social care resources, reducing length of stay, improving theatre productivity, prescribing, etc. This strand also includes;

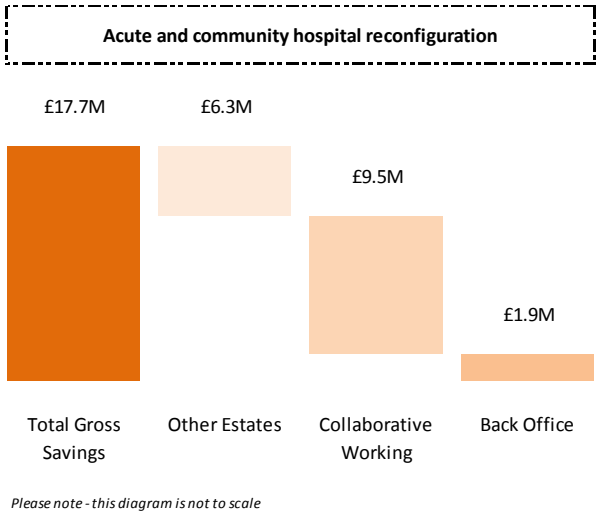
Local authority efficiencies

The Local Authorities have a range of programmes to reduce costs, reviewing commissioning of services, equipment services, applications of technology, and an ambition to regionalise some services across the range of public health and social care services saving £57.8M.

Specialised commissioning savings

Improvement programmes are forecast to deliver a recurrent saving of £27.3M.

Strand 5 – Getting the Enablers right £17.6M



There are a number of key enablers to support the delivery of all of the solutions including joint working, merging both back office functions and some clinical services, aligning workforce, introducing new IM & T solutions and integrating health and social care commissioning. Some investment will be required especially on IM& T solutions and organisational development programmes which will enable the release of £37.7M in savings.

Opportunities, challenges and risks

Sustainability and transformation funding has been made available to the providers for 2017-18 and 2018-19 totalling £23m to support the NHS provider organisations in delivering surplus control totals. For the STPs as a whole a further £1.1 billion has been set aside to support transformation programmes including the delivery of national priorities included in the Five Year Forward View, 7 Day working implementation and Mental Health. The LLR system also has a number of local transformation programmes which will require supporting funding across the 5 year programme to achieve delivery. The table below sets out the recurrent and non-recurrent investment required to deliver all of these priorities:

	17/18		18/19		19/20		20/21	
Investment requirements for transformation	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
	Non Rec	**Rec**	**Non Rec**	**Rec**	**Non Rec**	**Rec**	**Non Rec**	**Rec**
National Priorities								
Seven day services	-	3,500	-	3,500	-	3,500	-	3,500
GP Forward view & extended GP access	-	4,000	-	4,000	-	5,000	-	5,500
Increase Capacity CAMHs and Implementing Access & Waiting Times	-	750	-	750	-	750	-	750
Implementing Recommendations of MH Taskforce	-	500	-	500	-	500	-	500
Cancer Taskforce strategy	500	1,000	500	1,000	-	2,500	-	4,000
National Maternity Review	300	700	300	700	-	1,000	-	1,000
Investment in prevention - Childhood, Obesity, Diabetes Diagnosis and Care	-	1,750	-	2,750	-	3,500	-	4,000
Local Digital Roadmaps and Point of Care Electronic Health Record	2,000	-	350	300	-	400	-	400
Local Priorities								
Planned Care Referral Mangement Hub	200	1,500		1,500		1,500		1,500
Reablement including Social Care support		2,000		2,000		1,500		1,500
Establishment of a joint bank function	500							
Back office efficiency - scoping the options	200							
Community hospital reconfiguration support	250		250					
UEC - Out of Hospital support for reducing demand on Acute services		1,000		1,000		1,000		1,000
System Leadership and Management for Reconfiguration	1,000			1,000		1,000		1,000
Integrated Community Teams (MSCPs)	3,000		4,000		3,000			
Other Investments								41,350
Total	**7,950**	**16,700**	**5,400**	**19,000**	**3,000**	**22,150**	**-**	**66,000**
Total Non Recurrent and Recurrent		**24,650**		**24,400**		**25,150**		**66,000**

Currently the LLR system has an indicative allocation of £66m for transformation funding (some of which will be allocated to the priorities detailed in the table above) to be made available from 2020-21 but without earlier release of these funds there is a risk that some of the solutions will not deliver at the pace needed to achieve transformation and deliver the required savings.

There is a high level of risk of delivery on some of the ambitious plans set out in the solutions, including the implementation of new models of care in a system that continues to see increased demand. Additional demographic and activity growth has been accommodated in the 'do nothing' model in an attempt to mitigate this risk.

Top three financial risks for LLR:

- Funding to develop the capital estate within LLR
- Delivery of a high level of CIP and QIPP programmes to achieve the control total requirements both organisationally and as a system.
- Access to reasonable levels of STF funding in each year of the plan to maximise the chances of success.

LLR Capital Plan

Acute Hospitals Reconfiguration

It is proposed that in the future the acute hospital services in Leicester are delivered from two sites, the Leicester Royal Infirmary and Glenfield Hospital. The table below details the projects required to achieve the reconfiguration plan, with their costs, from 2017-18.

Total Estate Reconfiguration Capital Cost	279,581
Funded by Disposal Proceeds	(28,350)
Net Capital Requirement	**251,231**
ROI	10.20%
Payback Period	11.43 years

Individual project cost and profile

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Disposals £000	Total £000
LGH					(28,350)	**(28,350)**
Emergency Floor - BAU in STP		0	0	0		0
Reprovision of clinical services	6,600	10,000	10,000	5,000		31,600
Vascular Services	0	0	0	0		0
ICU Service Reconfiguration	12,906	0	0	0		12,906
Planned Ambulatory Care Hub	1,728	2,880	19,001	34,000		57,609
ITU LRI	503	7,000	8,300	0		15,803
Women's services	1,966	3,277	22,288	38,000		65,531
Childrens' Hospital	2,577	11,000	4,000	0		17,577
Theatres LRI	1,058	3,500	6,400	0		10,958
Entrance LRI	0	0	2,000	10,000		12,000
Wards/Beds LRI	500	5,800	7,000	7,500		20,800
Wards/Beds GH	552	5,746	5,500	5,500		17,298
Other reconfiguration projects	1,000	3,000	4,500	9,000		17,500
TOTAL ACUTE HOSPITAL RECONFIGURATION CA	**29,389**	**52,203**	**88,989**	**109,000**	(28,350)	**251,231**

The projects are designed to address clinical and financial sustainability inherent within the current configuration and will, in the areas affected, modernise facilities and make better use of the remaining estate footprint. Each project is independent but related in that they will collectively change the overall way in which some services, particularly inpatient services, will be delivered with the aim to reduce the number of bed days and number of emergency admissions experienced by the patients.

It is clear from the table above there are 2 projects which are responsible for nearly half of the total cost; a Planned Ambulatory Care Hub (PACH), providing outpatient and day case procedures in one purpose built facility and consolidation of the majority of Women's services on to the LRI site.

Key Risks

Increased demand and the lack of availability of capital are the key risks to the acute reconfiguration.

Sources of Funding

Significant capital investment is needed to deliver this change and whilst UHL has planned some investment from internally generated capital, it is not possible to fund all of the required investment in this way and as a result some external funding is required.

All funding solutions available to the Trust have been explored with two preferred main options emerging. Primarily the Trust can seek funding in the form of interim capital support loans from the Department of Health but due to changes in the national availability of capital, the Trust has explored and identified PF2 as a potential suitable alternative for the financing of suitable projects, namely the PACH and Women's Services. The Trust is currently in the process of exploring this in more detail.

Dependencies

A number of the STP programmes are designed to lessen the demand on acute services to complement the reconfiguration. The delivery of these work streams will free up sufficient physical capacity to allow the reconfiguration of services and use of the acute estate.

Community Hospital Inpatient Services and Planned Care Reconfiguration

Currently the community service reconfiguration proposes delivering services from six sites, rather than the current eight sites, however there is further emerging thinking around the future model, the detail of which will be considered over the next few weeks and may result in changes to the proposed model included within this submission. The proposed changes will be subject to public consultation and it is therefore envisaged that the first changes will take place in 2018-19, commencing with the extension of facilities in Market Harborough.

A summary of the schemes are shown below:

Total Estate Reconfiguration Capital Cost	19,950
Disposal Proceeds	(14,000)
Net Capital Requirement	**5,950**
ROI* (Based on investment cost before disposal proceeds)	15.60%
Payback Period (based on investment before disposal proceeds)	6.39 years

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Disposals £000	Total £000
Lutterworth (LPT)					(3,000)	(3,000)
Melton (NHSPS)			3,850		(7,000)	(3,150)
Market Harborough (NHSPS)		8,600			(4,000)	4,600
Evington Centre (LPT)				7,500		7,500
TOTAL COMMUNITY HOSPITAL RECONFIGURATION CAPITA		**8,600**	**3,850**	**7,500**	(14,000)	**5,950**

2018-19

Market Harborough (£8.6 million) – a proposed refurbishment and extension to create a 21 bed rehab/sub-acute ward to replace the existing Victorian ward and to accommodate the rehabilitation/sub-acute services transferring from Lutterworth Community Hospital, as part of the proposed safety/sustainability reconfiguration of the community hospital wards.

2019-20

Melton Mowbray (£3.8 million) – a proposed extension to allow for a 21 bed rehab/sub-acute ward on the site to accommodate the rehabilitation/sub-acute services transferring from Oakham

Community Hospital, as part of the proposed safety/sustainability reconfiguration of the community hospital wards.

2020-21

Leicester Evington Centre (£7.5 million) – Conversion and/or extension of a mothballed mental health services for older people ward into a 15 bed ward and gym for stroke/neuro rehabilitation to accommodate the services transferring from Leicester General Hospital, as part of the proposed three-to-two acute site reconfiguration.

Key Risks

The key risks to the scheme are the outcome of a public consultation and the availability of capital funding over the planned reconfiguration period.

Sources of Funding

The ownership of the estate described above is varied therefore the discussions with the various landlords will inform the sources of funding for the development. For those sites owned by Leicestershire Partnership Trust financing will be sought from either the Department of Health, or private financing. This may include financing by local authority partners.

Hinckley and District Ambulatory Care and Diagnostics

A review of service provision in Hinckley was undertaken in 2015 to establish the options available to deliver planned care outpatient services in the town. The proposed service would be an extension of the diagnostics available in Hinckley and Bosworth hospital, and an extension of Hinckley Health Centre. The preferred option, requiring statutory public consultation, if supported would see a move to modern planned care facilities in Hinckley, and result in the closure of Hinckley and District hospital.

Total Capital Cost	7,701
Disposal Proceeds	(2,000)
Net Capital Requirement	**5,701**
ROI	4.67%
Payback Period	21.6 years

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Disposals £000	Total £000
Hinckley & Bosworth Ambulatory Care Refurbishment		4,236				4,236
Hinckley Health Centre Equipment		300				300
Hinckley Health Centre Refurbishment		3,165				3,165
Hinckley and District Hospital Disposal					(2,000)	(2,000)
Hinckley and District		**7,701**	**0**	**0**	**(2,000)**	**5,701**

Key Risks

- Public consultation response leading to difficultly in implementing preferred option (including hospital closure and sale)

- Ability to mobilise in a timely way, due to the complexities of aligning infrastructure changes on three sites, requiring interaction with NHS Property Services and their capacity to undertake required work
- Availability of capital funding across three organisations

Sources of Funding

The source of capital for this project is dependent on the ownership of the asset. It is likely that the request to NHSPS, for Hinckley health centre refurbishment will be cost neutral, as there is an opportunity to dispose of part of the site.

Alternative sources of funding are being sought for the refit of the community hospital to allocate space for planned care. It is likely that the equipment requirement will be NHSE funded.

Oakham and Lutterworth Ambulatory Care and Diagnostics

Total Capital Cost	2,350
Disposal Proceeds	(4,758)
Net Capital Requirement	**(2,408)**
ROI* (Based on investment cost before disposal proceeds)	15.60%
Payback Period (based on investment before disposal proceeds)	6.39 years

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Disposals £000	Total £000
Lutterworth			1,000			**1,000**
Lutterworth Imaging & Diagnostics Equipment			350			**350**
Oakham disposal (current net book value)					(4,758)	**(4,758)**
Oakham				1,000		**1,000**
Total Capital Investment			**1,350**	**1,000**	**(4,758)**	**(2,408)**

2019-20

Lutterworth (£1.0 million) – Extension of Lutterworth Medical Centre to include an ambulatory clinic rooms to accommodate the services transferring from Lutterworth Community Hospital as part of the proposed safety/sustainability reconfiguration of the community hospital wards.

2020-21

Oakham (£1.0 million) – Conversion of the old ward space at the hospital into ambulatory clinic rooms and team base so that health and social care services elsewhere in the town can be co-located on the site as part of a place-based initiative to have a single health and social care campus in the town. Discussions are currently taking place with Rutland Local Authority regarding purchase of the Oakham site.

Risks

While the capital to refurbish the sites is relatively low, it is dependent on the relocation of inpatient services, which requires £16.3m.

Savings may erode if tariff for outpatients new and follow-up appointments decrease significantly.

Sources of Funding

Alternative sources of funding, including local authority partners, are being explored for the required capital investment.

Dependencies

Capacity becoming available by the reconfiguration of inpatient services in the east of the Leicestershire and Rutland.

Electronic Patient Records

UHL have completed a business case process for the purchase and implementation of an Electronic Patient Record (EPR) system working in partnership with a managed business partner, IBM. The business case is due to commence in 2016/17 and be delivered over 2 phases which will conclude in 2018/19. The funding for 2016/17 investment is not yet confirmed, as a result, the delivery timescales are likely to be delayed consistent with the delay in approval.

As the table above shows the scheme has a payback period of less than 6 years as a result of the way in enables service efficiency and effectiveness.

University Hospitals of Leicester

	£000
Total Capital Cost	28,356
ROI	31.40%
Payback Period	5.81 years

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Total £000
EPR phasing	**26,751**	**1,605**			**28,356**

Funding Source

UHL have organised a finance lease arrangement with the supplier as a funding mechanism for the approved business case which will alleviate the need for additional cash funding, however this will require Department of Health Capital Resource Limit allocation. It has therefore become subject to significant delay as a result of capital funding shortages.

Key Risks

The EPR business case is independent of other reconfiguration projects but will be complimentary in terms of enabling services to transform the way in which they deliver care. However there is a risk that executing estate reconfiguration at the same time as implementing an EPR solution is 2 major change projects happening at the same time. As a result UHL has developed a detailed implementation plan with partners IBM and included within the business case significant investment in business change and redesign resources.

Other Capital Schemes

OTHER CAPITAL SCHEMES

ROI and Payback period for the following schemes tbc

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	Total £000
CAMHS relocation		8,000			8,000
City Hub	2,000			2,000	4,000
Total Cost of Other Capital Schemes					**12,000**

The operational rationale for this schemes has determined the need to include these projects as part of the capital requirements for LLR but these schemes are still under development and details of ROI and payback periods have not been included.

CAMHS (£8.0 million) – Development of a 15 bed Tier 4 inpatient unit on the Glenfield General Hospital site to accommodate the LLR unit which is temporarily accommodated at Coalville Community Hospital, as part of the LLR initiative to co-locate all-age inpatient mental health services.

City Hub – Development of an ambulatory diagnostic hub to deliver enhanced primary care to reduce demand on the ED department at the LRI.

Summary of Overall Capital Requirement for Leicester, Leicestershire and Rutland

Overall the total capital requirement to deliver the reconfiguration programme across LLR totals £321.7 across the next four years. Unfortunately funding from the Department of Health is limited and the request nationally for support, from NHS organisations, far outweigh the funds available. In order to reduce the 'ask' LLR is considering alternative funding sources which includes looking to local authority partners for support, commercial funding and selling off unsuitable and surplus estate. The tables summarise the programmes and the potential sources of funding:

Acute Configuration

				Included in STP				
		Prior years	16/17	17/18	18/19	19/20	20/21	Total
		£m	£m	£m	£m	£m	£m	£m
Reconfiguration programme		62.9	20.5	29.4	52.2	89.0	109.0	363.0
Approved to date		(50.7)	-	-	-	-	-	(50.7)
Internally funded		(12.2)	(4.5)	(4.7)	(9.2)	(18.6)	(10.8)	(60.0)
External funding requirement		**-**	**16.0**	**24.7**	**43.0**	**70.4**	**98.2**	**252.3**
Site disposal		-	-			-	(28.4)	(28.4)
PF2		-	-			(27.2)	(70.2)	(97.3)
Welcome Centre		-	-			(2.0)	(10.0)	(12.0)
DH funding requirement		**-**	**16.0**	**24.7**	**43.0**	**41.2**	**(10.4)**	**114.5**

Community Configuration

	16/17	17/18	18/19	19/20	20/21	Total
	£m	£m	£m	£m	£m	£m
Lutterworth reprovision	-	-	-	1.4		1.4
Diagnostic/Primary Care Hub	-	2.0	-	-	2.0	4.0
Hinckley (inc day case theatre)	-	-	7.7	-	-	7.7
East ward reconfiguration -Melton	-	-	-	3.9		3.9
East ward reconfiguration -Harborough	-	-	8.6	-	-	8.6
CAMHS	-	-	-	-	8.0	8.0
Relocation LGH stroke to evington	-	-	-	-	7.5	7.5
Rutland	-	-	-	-	1.0	1.0
External Funding Requirement	0.0	2.0	16.3	5.3	18.5	42.1
Disposals			(6.0)		(14.8)	(20.8)
Commercially funded	-	-		(1.0)	-	(1.0)
Local Authority funded	-	(2.0)	(3.4)	-	(1.0)	(6.4)
DH funding requirement	-	-	**6.9**	**4.3**	**2.7**	**13.9**

Summary of Total Requirement

	£m
UHL Reconfiguration	252.3
Less: Alternative funding	(137.7)
Total UHL DH requirement	**114.6**
Community Hospital & CAMHS reconfiguration	42.1
Less: Alternative funding	(28.2)
Total Community DH requirement	**13.9**
Total LLR DH Capital requirement	**128.5**

Governance, Implementation and Risk

This section describes how we will deliver the solutions set out in this STP.

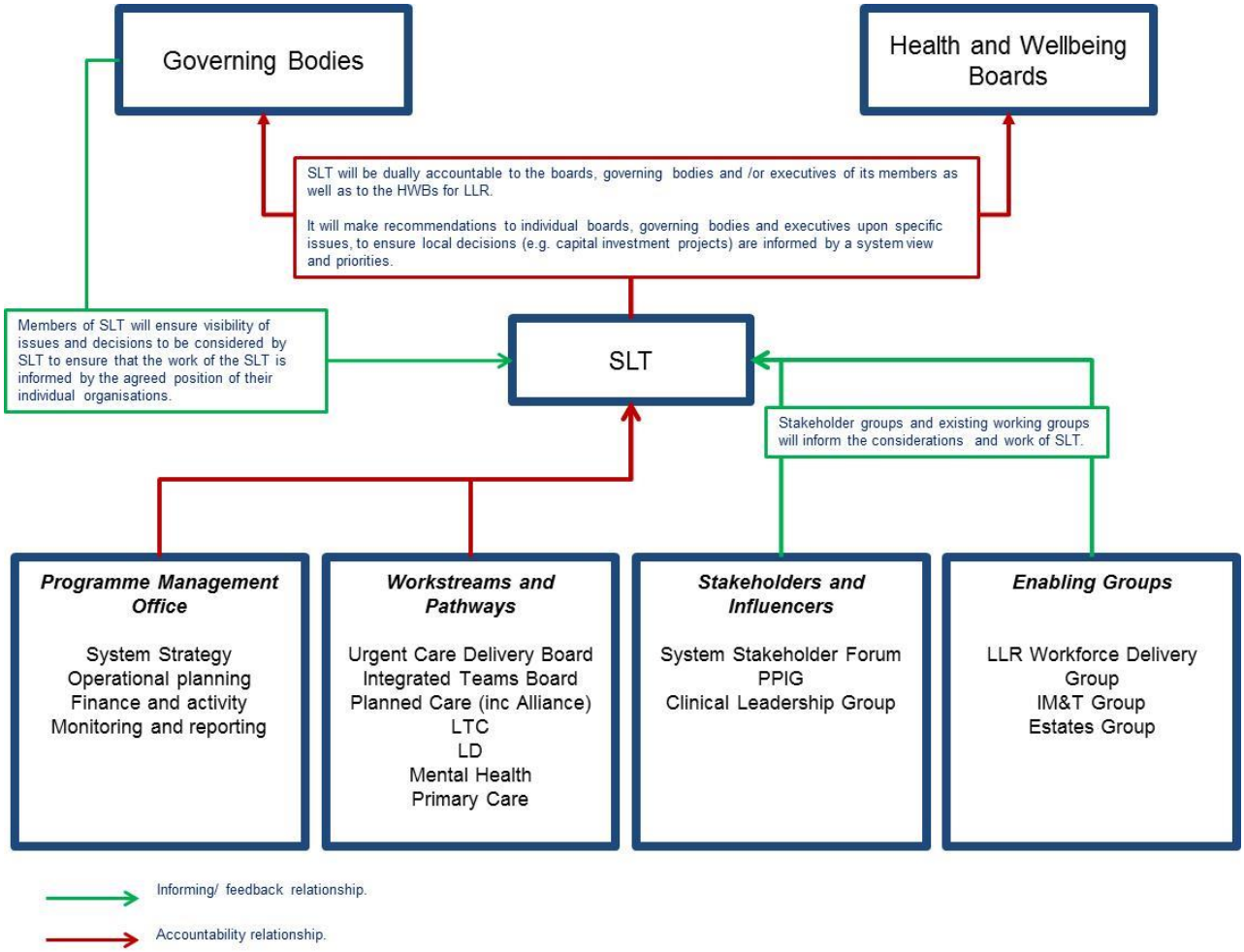
Clear, joint governance with delegated authority

Our STP is deliverable but only if we make a deliberate, concerted and sustained effort now to move to a more collaborative set of delivery and leadership arrangements across the LLR health and care community. We need all parts of the system to move at the same time and direction to achieve the STP goals. We need to send an absolutely clear message to all our staff that we care about and are committed to achieving the same things for local people.

In support of this, we have used the period of developing the STP to review our governance arrangements. This has involved open discussion across partners using a range of forums including: the BCT Partnership Board, individual health and wellbeing boards, partner governing bodies, informal development session and the BCT patient and public involvement group. From these conversations a number of common principles have emerged which have shaped our thinking:

- Need to build on what we have developed through BCT
- Think and act 'best for LLR' first wherever feasible
- But reposition BCT as a 'brand/strapline' not Programme
- And change current arrangements for next phase to accelerate implementation of the STP
- Focus on smaller number of key deliverables
- More formal authority for collective decision taking
- Clearer role for HWB and HOSC
- Must be resourced within existing costs (PMO and organisational)
- Decide and move to new arrangements swiftly.

Based on these, a new set of governance arrangements has been developed which is illustrated in the diagram below.



These new arrangements will involve the following key strengthened elements:

- Replacing the previous separate BCT Partnership Board with a new dual-accountability to the existing statutory governing bodies and health and wellbeing boards
- Creating a new System Leadership Team (SLT) as a joint programme board with membership from the five NHS partner organisations and the three upper tier local authorities.
- We are currently working with legal advisors to refine the \Terms of Reference for this new joint clinical and managerial group which will include clarity regarding its responsibilities and authority ahead of a first meeting on 17 November 2016.
- A new System Stakeholder Forum (SSF): The SSF will be open to all members of Trust and CCG Boards, the Health and Wellbeing Boards for LLR, the Clinical Leadership Group, HealthWatch organisations within LLR, and PPI leads. It will meet three times a year to support the shaping of the strategic direction; identification of priority areas; feedback and sense check on current engagement; identify future issues and test the SLT's thinking on current wicked issues.

A strategic direction towards closer commissioner and provider collaboration

Through the development of our STP we have recognised that there are areas where the NHS organisations locally duplicate functions and processes. Our BCT programme to date has consciously

avoided getting into a discussion about organisational running functions because of the potential distraction factor from the real focus of delivering wholescale change. However, given the scale of financial challenge and the need to support consistent implementation there is a recognition that we need to explore the scope to deliver greater efficiencies in two areas.

From a commissioner perspective, the three LLR CCGs already have well established collaborative arrangements and a number of joint functions. However, there are other areas that we undertake separately which adds duplicative cost into the system overhead. Elsewhere across the Country CCGs are exploring and moving to a range of scenarios across the integration spectrum. Our local thinking is at early stages but will be progressed over the coming months.

From a provider perspective, the main LLR organisations currently operate in a much more autonomous way. There are now examples across the Country of provider networks coming together, including in some cases with new primary care at scale organisations, to form groups that operate in a much more joint way. There is a similar range of possibilities here to the commissioner discussion and local thinking is also at relatively early stages.

Across both the commissioner and provider sectors there is a growing level of interest to explore more openly the potential options across the integration spectrum, the potential implementation and financial benefits, and the feasibility of realising these.

Translating the STP into an aligned two year local contracting arrangement

This STP sets what needs to be done to deliver the required system control total by moderating demand, managing unwarranted clinical variation and reducing cost. This will only be realised if the individual organisations are able to translate this system level plan into a set of two year operational plans and contract agreements. Achieving this, given the scale of the financial challenge and requirement for each organisation to meet its financial duties as required by national planning rules, will be incredibly challenging.

There is a commitment across local NHS clinical commissioners and main NHS providers (UHL and LPT) to seek to change the 'terms of trade' in order to align more effectively the incentives across all parts of the system (rather than continuing the zero sum activity/income mechanisms of historical contract arrangements). Effectively, what we are seeking to do is construct a local two year 'system deal' that hardwires the distribution of the 'LLR pound' to the strategic transformation model and direction set out in this Plan. In headline terms, this would result in substantially lower levels of financial growth over the period into the acute hospital sector than has been the case over recent years in order to enable a greater proportionate shift of resources into primary care and out of hospital services.

Seeking to develop such an approach will require a balance to reflect the relative control over the drivers that impact on demand and activity risk. This will be an iterative process over the coming weeks that will require:

- Working together across organisations to rapidly develop the detailed implementation plans for the schemes that will contribute to moderating demand growth in planned and unplanned care

- Testing and translating this fully into the level of activity detail required to understand the impact on different parts of the system
- Devising systems which allow control and the holding of risk to be aligned
- Reflecting the organisational impact up front in contract envelopes that, taken together, are affordable to the system as well as putting each organisation in a position to meet their individual financial duties
- Seeking to capture these contract values for UHL and LPT in two year block arrangements
- Seeking to create a stronger alignment between the funding of elements of general practice and community health services, and the effectiveness of their respective contributions to moderating demand growth and utilising new service models effectively
- Seeking to create a system level risk pool (through use of existing organisational contingencies and performance related funds) and administering this through the System Leadership Team to help mitigate the consequences of under delivery against demand moderation
- Monitoring (and adjusting where required) organisational control totals throughout the year on a quarterly prospective basis in order to facilitate a system-level focus.

The detail of this system 'deal' is being worked through now ahead of the 23 December 2016 contract agreement deadline. We are under no illusion that this will be an easy task. Or that contract arrangements of themselves will deliver our STP. But what we do believe is that we need to create the conditions where clinicians across the system, can focus on increasing efficiency, moderating demand and reducing unwarranted variation without the penalty of income loss (during the transitional two year period) affecting the viability of their business unit.

There is a clear connection between this desire to change the "terms of trade" and the potential collaborative arrangements described in the previous section. It is recognised that changing organisational responsibilities may unlock some of the current contractual "blockers" to change. The implications do however require further detailed consideration which will take place over the next period.

Significant risks to delivery

As with STPs up and down the country, this is a very ambitious plan. It needs to be in order to seek to balance the various pressures of: continued growth in patient demand; historically low levels of financial growth, and; a requirement to recover and maintain delivery against national access and quality standards.

Not surprisingly therefore a plan of this nature comes with significant risks to delivery:

1. Individual organisational financial positions deteriorate during remainder of 2016/17, impacting on underlying position going into start of 2017/18
2. NHS commissioners and providers fail to agree two year black contracts within which providers can deliver and the system/CCGs can affordability
3. Lack of financial headroom in the system constrains ability to support cost of transformation/transition thereby limiting scale and pace of implementation
4. Activity management plans insufficient to moderate growth in acute activity leaving acute trust exposed to operational pressure between demand and capacity
5. Availability and willingness of clinical and social care workforce to take on new roles in different settings

6. Ability to undertake formal public consultation on major service reconfiguration and successfully take decisions at the end of this
7. Availability of, and ability to secure, access to national capital funding to enable required investment estate modernisation and reconfiguration.