LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 15 DECEMBER 2016

Time: 5:00 pm (please note time of meeting)

Location:
MEETING ROOM G.01, GROUND FLOOR, CITY HALL,
115 CHARLES STREET, LEICESTER, LE1 1FZ

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

G. J. Carey
For Monitoring Officer

NOTE:

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MEMBERS OF THE BOARD

Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Adam Clarke, Assistant City Mayor, Energy and Sustainability

Councillor Piara Singh Clair, Assistant City Mayor, Culture, Leisure and Sport

Councillor Abdul Osman, Assistant City Mayor, Public Health

Councillor Sarah Russell, Assistant City Mayor, Children, Young People and Schools

City Council Officers:

Frances Craven, Strategic Director Children's Services

Steven Forbes, Strategic Director of Adult Social Care

Andy Keeling, Chief Operating Officer

Ruth Tennant, Director Public Health

NHS Representatives:

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

Trish Thompson, Locality Director Central NHS England – Midlands & East (Central England)

Healthwatch / Other Representatives:

Karen Chouhan, Chair, Healthwatch Leicester

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Chief Superintendent, Andy Lee, Head of Local Policing Directorate, Leicestershire Police

Matthew Cane, Group Manager, Leicestershire Fire and Rescue Service

STANDING INVITEES: (Not Board Members)

Kaye Burnett, Chair, Better Care Together Programme
Toby Sanders, Senior Responsible Officer, Better Care Together Programme
Richard Henderson, Acting Chief Executive, East Midlands Ambulance Service NHS Trust

Information for members of the public

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- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

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.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

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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 to be discussed at the meeting.

3. MINUTES OF THE PREVIOUS MEETING **Appendix A (Pages 1 - 12)**

The Minutes of the previous meeting of the Board held on 10 October 2016 are attached and the Board is asked to confirm them as a correct record.

4. SUSTAINABILITY AND TRANSFORMATION PLAN **Appendix B (Pages 13 - 96)**

Toby Sanders, Senior Responsible Officer for the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan to submit the draft Sustainability and Transformation Plan that was released on 21 November 2016 and a report on the proposed governance role of Health and Wellbeing Boards in the process.

5. THE 2016 ADULT AUTISM SELF-ASSESSMENT - EVALUATING PROGRESS IN LOCAL AUTHORITIES ALONG WITH PARTNER AGENCIES **Appendix C (Pages 97 - 110)**

Yasmin Surti (Lead Commissioner Leaning Difficulties and Mental Health) and John Singh (Strategy & Implementation Manager, Leicester City Clinical Commissioning Group) to present the 2016 Autism Self-Assessment Framework which is designed to assess the progress made by the Local Authority and its partners over the last two years.

6. LONELINESS AND ISOLATION EVIDENCE REVIEW

Appendix D (Pages 111 - 124)

To receive a briefing report that provides information about the risks, impacts and interventions for loneliness and social isolation, highlights the position in Leicester and informs discussion about options for further work. The Board is requested to accept this briefing in order to inform multiagency discussion about isolation and loneliness in Leicester.

John Mair-Jenkins, Speciality Registrar, Public Health, will attend the meeting.

7. LOCAL CHILDREN'S SAFEGUARDING ANNUAL REPORT

Appendix E (Pages 125 - 186)

To receive the Leicester Safeguarding Children Board Annual Report 2015-2016. The Board is requested to note the content of the report, disseminate key messages to staff, discuss the report in team meetings and service briefings and provide assurances that the above activity has been undertaken.

Steven Gauntley, Head of Service Children's Safeguarding Unit and Janet Russel, Interim Leicester Safeguarding Children Board Manager will attend the meeting.

8. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

9. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will be held on the following dates:-

Monday 6th February 2017 – 3.00pm
Monday 3rd April 2017 – 2.00pm

Meetings of the Board are scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

10. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: MONDAY, 10 OCTOBER 2016 at 3:00 pm

P R E S E N T :

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
John Adler	–	Chief Executive, University Hospitals of Leicester NHS Trust.
Ivan Browne	–	Deputy Director of Public Health.
Karen Chouhan	–	Chair, Healthwatch Leicester.
Councillor Piara Singh Clair	–	Assistant City Mayor, Culture, Leisure and Sport, Leicester City Council.
Councillor Adam Clarke	–	Assistant City Mayor, Energy and Sustainability, Leicester City Council.
Matthew Cane	–	Group Manager, Leicestershire Fire and Rescue Service
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
Andy Keeling	–	Chief Operating Officer, Leicester City Council.
Sue Lock	–	Managing Director, Leicester Clinical Commissioning Group
Superintendent Mark Newcombe	–	Adviser to the Police and Crime Commissioner, Office of the Police and Crime Commissioner.
Councillor Abdul Osman	–	Assistant City Mayor, Public Health, Leicester City Council.

Councillor Sarah Russell	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council.

Standing Invitees

Toby Sanders	Senior Responsible Officer – Better Care Together Programme

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

26. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Lord Willy Bach, Leicester Leicestershire and Rutland, Police and Crime Commissioner.
Frances Craven, Strategic Director of Children's Services, Leicester City Council.
Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group.
Chief Superintendent Andy Lee, Head of Local Policing Directorate, Leicestershire Police.
Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust.
Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group.
Ruth Tennant, Director of Public Health, Leicester City Council.
Trish Thompson, Locality Director Central NHS England – Midlands & East (Central England)

The Chair stated that there were two changes to the Board's membership as follows:-

a) Matthew Cane – Group Manager Leicestershire Fire and Rescue Service who has replaced Steve Robinson-Day (Collaboration Manager) who has retired.

b) Professor Martin Tobin, Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester has resigned from the Board following his appointment as the Director of the newly formed Leicester Precision Medicine Institute.

The Chair welcomed Mr Cane to his first meeting and expressed congratulations to Professor Tobin on his new appointment and thanked him for his contributions to the Board. The Chair would discuss Professor Tobin's replacement on the Board with both Universities.

27. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting. No such declarations were made.

28. MINUTES OF THE PREVIOUS MEETING

AGREED:

That the Minutes of the previous meeting of the Board held on 18th August 2016 be confirmed as a correct record.

29. SUSTAINABILITY AND TRANSFORMATION PLAN

Toby Sanders, Senior Responsible Officer for the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan gave a presentation to update the Board on the progress with the STP since the last update to the Board at its meeting on 6 June 2016. (Minute 10 refers)

The final Plan was expected to be submitted at the end of October 2016 to NHS England and when it had received approval it would be made available for public consultation.

The key points to note from the presentation were:-

STP Update

a) The Plan addressed local issues and implemented the NHS 5 year forward view to March 2021. It made the case for national/external capital investment and access to non-recurrent transformation funding.

b) It built upon the Better Care Together proposals and showed how sustainability would be achieved. In developing the STP each area has to show how they were going to ensure sustainability in the following areas:-

- Health and Wellbeing
  (Lifestyle and Prevention, Outcome and Inequalities, Mental and Health Parity of Esteem).

- Improving care and quality
  (Emergency Care Pathway, General Practice variation and resilience and clinical workforce supply).

- Ensuring financial sustainability (improving productivity and closing the financial gap)
  (Provider systems and processes [internal efficiency], estates configuration and back office systems).

c) By 2021 current spending across LLR would increase from the current expenditure of £1.6b to £1.8b. However, the increased demand on services and demographic growth, together with the cost of delivering services, was estimated to outstrip available resources by £450m across the NHS and £70m across local authorities.

d) As a result of the STP process and a review of the 'triple aim' gaps (above), there would be focus upon the following five work strands:-

- New models of care focusing upon prevention and moderating demand growth.
  - Urgent and emergency care.
  - Integrated locality teams.
  - Resilient primary medical care.
  - Planned care.

- Service configuration to ensure clinical and financial sustainability.
  - Move acute hospital services to 2 sites (LRI and Glenfield)
  - Consolidate maternity services at the LRI.
  - Smaller overall reduction in acute hospital beds than originally planned.
  - Reduce the number of community hospital sites with impatient wards from 8-6.
  - Move Hinckley day case and diagnostic services from Mount Road to Sunnyside/health Centre.
  - Detailed proposals being developed for community services in Hinckley, Oakham and Lutterworth.
  - Changes subject to external capital investment (c£350m).
  - No decisions taken until after formal public consultation.

- Redesign pathways to deliver improved outcomes for patients and deliver core access and quality.
  - Builds on the work carried out on the BCT work streams and key local access/quality issues involving prevention, long term conditions, cancer, mental health, learning disabilities and continuing healthcare and personalisation.

- Operational efficiencies to reduce variation and waste.
  - Back office efficiencies/reducing corporate overheads.
  - Medicines optimisation – reviews, cost and waste.
  - Best value procurement.
  - Provider system/process efficiencies to reduce delay and duplication.
  - Rostering systems and job planning to reduce use of agency staff.
  - Estate utilisation across the wider public sector.

- Getting the enablers right to create the conditions for success.
  - Patient and public involvement.
  - Clinical leadership.

- Workforce.
- IM&T (Local Digital Roadmaps).
- Estates.
- Integration between health and social care commissioning.
- Organisational development/culture.

e) Once the STP had received assurance from NHS England it would be made public in November. Strengthened governance and delivery arrangements were also planned to be implemented in November. The plan would then be translated into 2 year operational plans and the operational contracts put in place to support the management of services.

f) Public consultation was expected to take place in January 2017.

STP Governance Arrangements

a) New governance arrangements were being designed with a view to simplifying ownership and to increase clinical leaderships and public visibility. It was intended to have dual ownership through both Health and Wellbeing Board and individual NHS Boards.

b) A new System Leadership Team (SLT) was proposed with both clinical and executive membership with individual delegated authority to represent commissioners and providers of services.

c) Greater stakeholder transparency was planned with public meetings and a quarterly forum. Multi agency implementation teams would deliver the priorities with strong patient involvement.

d) Draft proposals would be submitted during October.

STP Patient and Public engagement

a) PPI groups and Healthwatch would be involved in shaping issues and priorities.

b) Most proposals were already in the public domain through BCT and UHL's 5 year plan; and there had already been summary presentations on the STP made in public. The full STP documents would be made available in November 2017.

c) A new System Stakeholder Forum to start in November would provide wider on-going discussion.

d) Communications and engagement would be issued by each partner organisation's communication teams.

The Chair commented that, whilst there were no major surprises in the context of LLR, the various decisions would need very different methods of

consideration, particularly in the political context. He also commented that the issue of BCT branding should be reviewed as it now had negative images from the public resulting from long delays in making plans available for public consultation. He also felt that the Health Needs Neighbourhood Centres would need to be examined in greater detail to assess their impact upon local government services and different areas of the city.

Members in discussing the presentation made the following comments and observations:-

a) There was an apparent paradox as Health and Wellbeing Boards were expected to have system leadership on health issues in their areas but Boards would only receive the STP Plan after it had been given approval by NHS England.

b) The Board should have key role in the process but the complexity of political accountability amongst constituent partners should be recognised and decision making should not be made by the 'STP' as such but by individual constituent partners.

c) The Board was expected to have ownership of the STP and whilst there would be an opportunity to engage with the public and the plans might change as they advance through the process; the Board had not had full and complete details of the STP proposals prior to consultation.

d) Healthwatch should be involved with the System Leadership Team (SLT) and members questioned how patients and the public could be involved in the process.

e) It would be helpful to have a diagram clearly setting out where decisions will be made and whether there will be any public involvement to make the process more transparent compared to the current opaque process.

f) The proposed roles of the Boards in the process would need further clarity around the references to 'ownership' as these would be interpreted differently by different partners in the process.

g) The frustration with the process of the STP delaying the consultation on the BCT was also shared by some health partners and providers.

In response the Senior Responsible Officer stated that:-

a) Patients and the public had an important part to play and this role would be discussed at a meeting later in the week. There was a role for a forum to act as a sounding board on STP issues as they emerged. Patients, carers and families were already closely involved in a number of work stream issues.

b) The current draft STP could be shared with Board members in confidence at this stage if requested.

c) The intention for the SLT was to have all members as full equal members with decision making authority.

AGREED:

1. That the Senior Responsible Officer be thanked for the representation.

2. That the Board recognises its need to play an important role in the governance arrangements for the STP.

3. The Board should have a lead role around the primary care strand of STP.

4. The Terms of Reference for the Board in the Governance arrangements should be submitted to the next meeting of the Board.

30. INFANT MORTALITY STRATEGY

Clare Mills, Lead Commissioner (Healthy Child Programme), Public Health and Nicola Bassindale, Service Manager (Strategy, Quality & Performance), Education & Children's Services presented a report outlining the new strategy to reduce infant mortality in Leicester, Leicestershire and Rutland.

It was noted that the strategy would run from 2016 to 2019 with an associated action log that recorded current and planned actions across a range of risk factors. Progress would be monitored by the LLR Infant Mortality Strategy Group (IMSG) with scrutiny and oversight by the Maternity Services Liaison Committee (MSCL).

The IMSG had identified a number of issues and would meet quarterly to review the progress on the action log and to consider a key issue. The City had higher rates of infant mortality and stillbirths than regional and national rates but was comparable with the comparator group. However, the numbers involved were small and the contributing factors were complex; involving issues such as smoking during pregnancy, maternal obesity, poverty, substance misuse, language barriers and late access to the maternity pathways.

During discussion on the strategy the following comments and observations were made:-

a) The second sentence in Issue 2.3 of the Action Log should read Mothers from Asian or Asian British ethnic groups are reported to have smaller babies.

b) The Young People's Council should be involved in engaging with young mothers.

c) GPs had an important role to play in the process but were not identified within the Action Log. Information should be shared across the whole health system and all involved should be clear about what was expected of them.

d) There were no primary care representatives on the steering group but midwives were involved.

e) There were difficulties in breaking figures down into ethnicity in view of the low numbers involved, as this could potentially identify specific families and well as become statistically unreliable.

The Chair commented that the Board endorsed the general strategy and commented that the quality of information given to parents was inconsistent and there could be a more integrated approach.

AGREED:

That the Board supported the actions and recommendations in the report and the Chair would consider whether the Board would be the appropriate place to receive updates on the progress made with the strategy in the future.

31. FINAL REPORT ON THE DELIVERY OF THE JOINT HEALTH AND WELLBEING STRATEGY (2013-16)

Members received a report that presented final information on progress in delivering the Joint Health and Wellbeing Strategy: 'Closing the Gap'. The responsibility for ensuring effective delivery of this strategy had been devolved to the Leicester City Joint Integrated Commissioning Board (JICB).

The Board was asked to note progress on the delivery of the Joint Health and Wellbeing Strategy and the areas of concern highlighted in the report and the response of the JICB to these (section 3.7).

Measures that had shown particular improvement relative to the baseline in the strategy were:-

Breastfeeding at 6-8 weeks – 62.1% compared to the baseline on 54.9%

Smoking in pregnancy – The decline experienced in 2013/14 has been reversed and the rate of 11.8% in 2014/15 and the early part of 2015/16 shows an improvement on the baseline.

Teenage conception rates - There had been a significant improvement from the baseline.

Diabetes – The Management of blood sugar levels had improved from 62% to 69.7%.

Carers' receiving needs assessments - The 2015/16 data (45.4%) shows an improvement of over 140% from the baseline data.18.8%).

Older people who are still at home 91 days after discharge from hospital into reablement - Performance had improved from 77.2% from the baseline to 91.5% in 2015/6.

Older people admitted on a permanent basis to residential or nursing care The rate of admissions had fallen from 763 per 100,000 to 653 per 100,000 since the baseline was established.

Dementia diagnosis rates - The percentage of patients diagnosed with dementia against the expected prevalence for the population had increased from the 2011/12 baseline of 52% to 88.2% in November 2015.

Measures which had shown deterioration from the baseline in the strategy were:-

Obesity in children in Year Six - The positive improvements through 2009/12 had not been sustained. And the performance in 2014/15 had fallen below the previous 'worst' position in 2009/10. However, the performance remained better than the Council's comparator group average (experiencing a similar decline in 2014/15), but was below the England average. The solutions to this issue were complex and effort continued to address them.

Smoking cessation - 4 week quit rates - The 2014/15 outturn data and year to date information for 2015/16 confirmed previously reported concerns about this measure. This deterioration reflected a national decline in quit rates, largely attributed to limited national marketing, the increased usage of e-cigarettes and the difficulties in reaching / working effectively with entrenched smokers. However, Leicester continued to out-perform its comparator authorities. Leicester had a supportive framework towards the use of e-cigarettes.

Coverage of cervical screening in women - This had been considered as an area of concern by the Board previously. Data published in November 2015 confirmed a year on year decline from the baseline in the strategy. The marked decline in 2014/15 could be attributed in part to a change in recording methodology. The drop in the England average was 4.3% with Leicester experiencing a 4.9% drop. Leicester also continued to under-perform against both the England and our comparator averages. Work continued with Public Health England and National Health England to understand the issues and to consider proposals to address them.

Following comments from Members it was noted:-

a) The improvements in oral health in children under 5 years old was included within the strategy and significant improvements had been made in the last 3 years.

b) The Council was now performing well nationally in relation to reducing

the delays in the transfer of care from hospital to social care.

The Chair welcomed the report and thanked all those that had been involved collectively in the initiatives within the strategy. The Strategy had been about making changes and significant improvements had been achieved through deliberate and targeted decisions and interventions. The scale of progress had generally been pleasing.

AGREED:

The Board noted the progress the delivery of the Joint Health and Wellbeing Strategy and the actions that were planned.

32. ADULTS JOINT STRATEGIC NEEDS ASSESSMENT 2016

The Deputy Director of Public Health presented a report on the progress in updating the Joint Strategic Needs Assessment 2016 (JSNA). The JSNA was predominantly web-based and iterative in nature, with annual reviews of sections planned. It is produced by a multi-agency team overseen by the JSNA Programme Board.

A summary document, Snapshots: Health and Wellbeing in Leicester had been prepared to both accompany the briefings and to promote use of the web pages. The infographics in the Snapshots document would be made available on the web pages for downloading and use in presentations of various types.

The first block of the Adults Section of the JSNA 2016 was in the final stages of delivery and would shortly be on the Council's website. Appendix B to the report listed the topics that would be added later in the year on various Adult lifestyle factors, specific health conditions and specific population groups such as Homeless and Lesbian Gay Bisexual and Transgender. Children and young people's topics were also planned to be added later in the year.

The JSNA was available to social care and health organisations to help inform service provision. The intention was to make the JSNA more of a web based information resource rather than merely a list of tables and statistics. The Snapshots were designed as an accessible way into the JSNA, and the website would also include a series of slides that could be used by anyone for use in presentations and training within their own organisations.

AGREED:

That the progress made to date and the approach taken to make the JSNA more accessible and user friendly be welcomed.

33. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public present at the meeting.

34. DATES OF FUTURE MEETINGS

It was noted that future meetings of the Board would be held on the following dates:-

Thursday 15th December 2016 – 5.00pm
Monday 6th February 2017 – 3.00pm
Monday 3rd April 2017 – 2.00pm

Meetings of the Board were scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

35. ANY OTHER URGENT BUSINESS

There were no items to be considered.

36. CLOSE OF MEETING

The Chair declared the meeting closed at 4.35pm.

LEICESTER CITY HEALTH AND WELLBEING BOARD
15th December 2016

Subject:	Leicester, Leicestershire and Rutland Sustainability and Transformation Plan
Presented to the Health and Wellbeing Board by:	Toby Sanders
Author:	Toby Sanders

EXECUTIVE SUMMARY:

The following papers are submitted to the board for consideration:

The draft *Sustainability and Transformation Plan.* This was released on 21st November 2016. It sets out actions for the LLR STP footprint until 2020/21.

The Role of the Health and Wellbeing Boards outlines the proposed role of each of the health and wellbeing boards in the Leicester, Leicestershire and Rutland STP footprint.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Note the contents of the STP Plan
- Discuss plans to engage and consult with local people as plans develop.
- Discuss the role of the HWB in relation to the STP.
    - Approve – taking on a greater role in relation to the STP as set out in the paper
    - Approve – the five specific functions outlined in paragraph nine.
    - Approve – the specific areas of service reconfiguration and new models of care focus for each HWB set out in the table at paragraph eleven
    - Note – the areas that would remain within the governance of other parts of the system.

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.

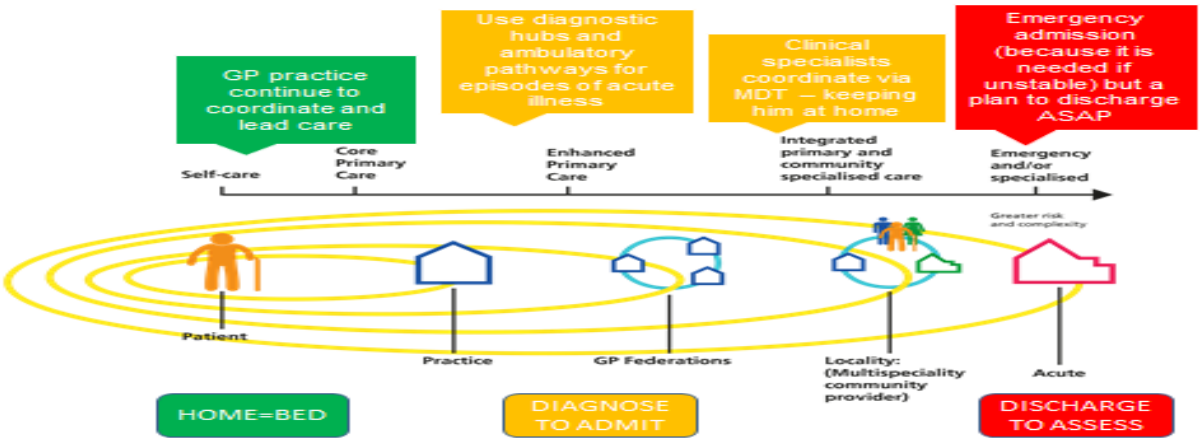
If there is a need for on-going assessments around decisions for further care, these take place within the persons ‘usual environment’ where they are likely to function at their best. This is to avoid ‘crisis’ decision making about the long term care from a ‘hospital bed’. A recognition that remaining 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

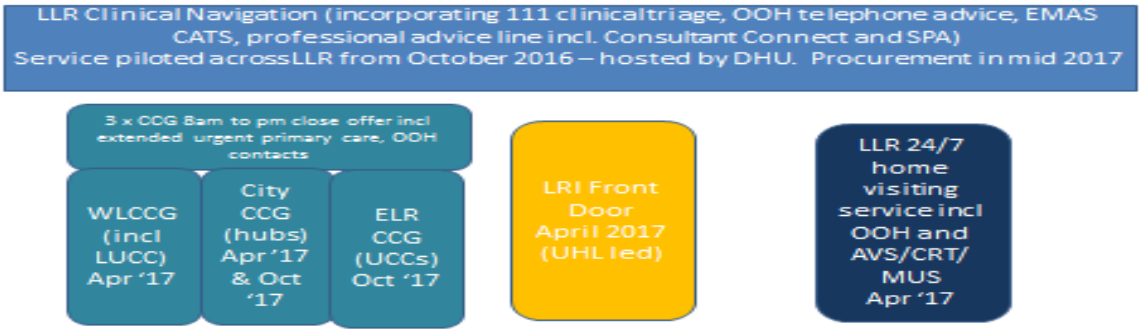
This section describes a model for Urgent and Emergency care across LLR together with the actions we are taking to improve the NHS Constitutional target of the percentage of people who spend four hours or less in A&E.

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.

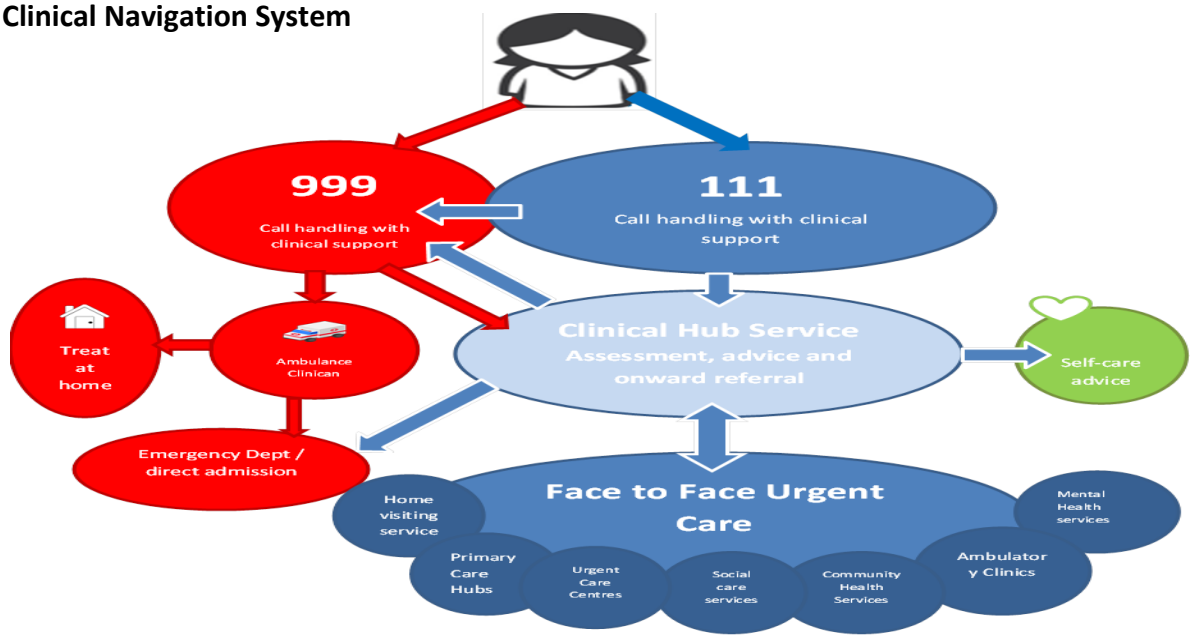
New Urgent Care System in LLR



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.

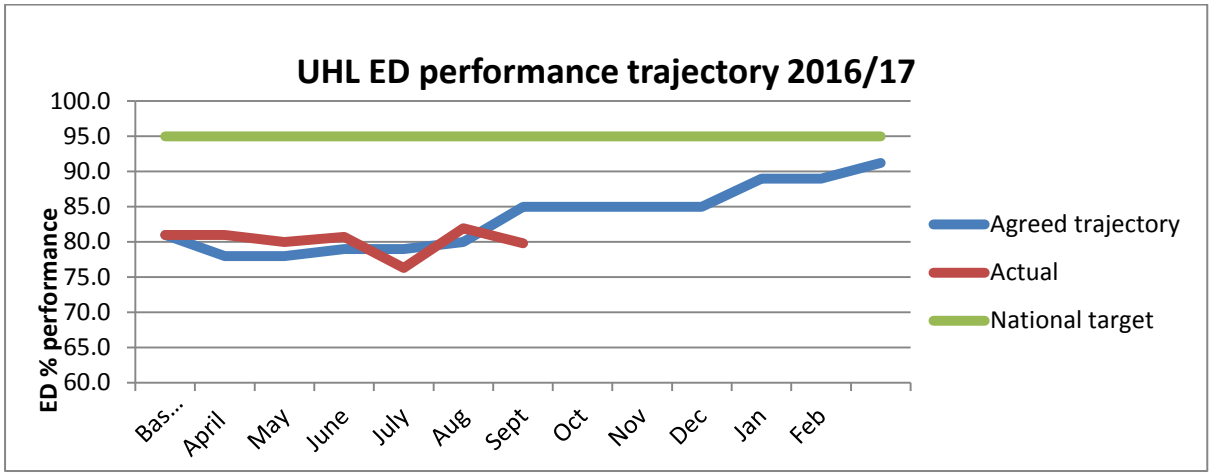
- **Managing demand for urgent care in order to minimise presentations at the Emergency Department:** including introducing clinical navigation, increasing the numbers of people calling NHS 111 who receive clinical triage and advice, ensure GPs have direct access to Consultant support, ensuring alternatives 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.

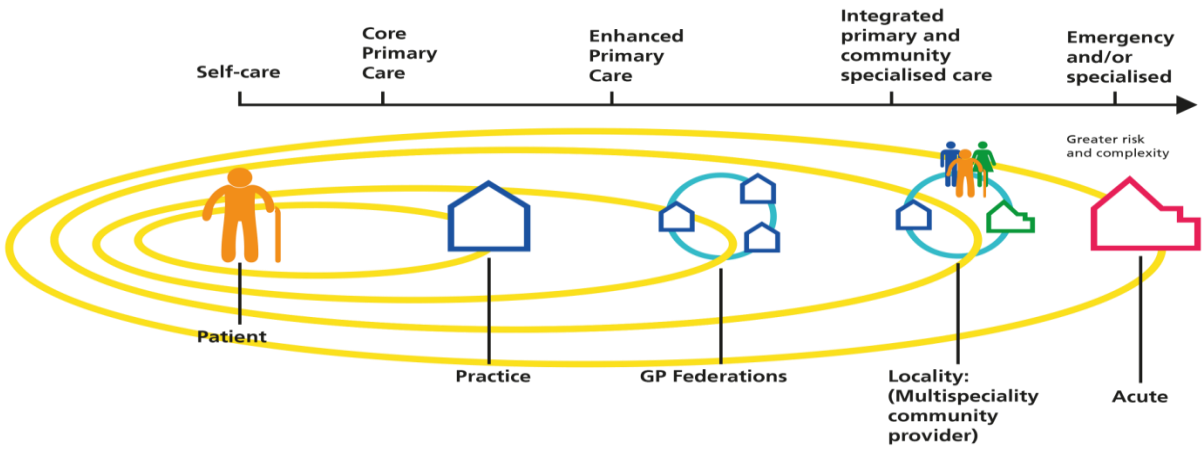
Integrated Teams

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.

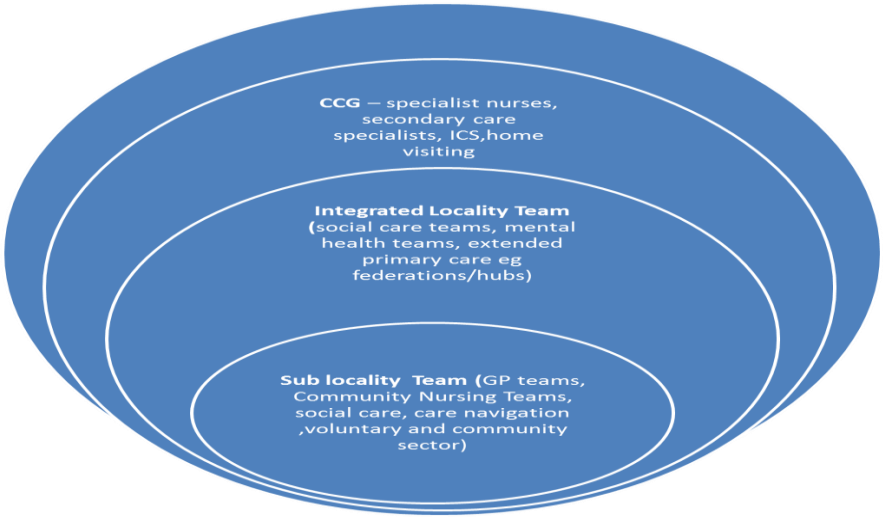
Identifying a targeted patient cohort will enable us to test models and evaluate the impact of integrated teams prior to extending the approach to the wider patient cohort, such as children. During this time patients outside of these cohorts will receive services as normal. However as the model of integrated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

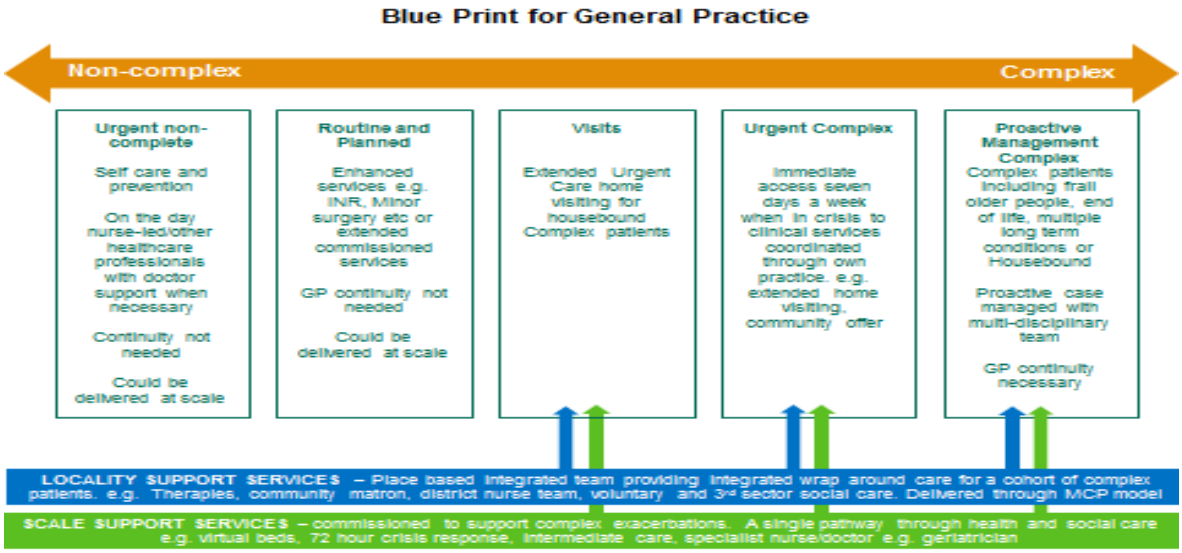
Over the next 5 years our new model of general practice will be realised. The practice and primary healthcare team will remain the basic unit of care, with the individual practice patient list retained as the foundation of care. However, whilst a large proportion of care will remain with a patient's 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.

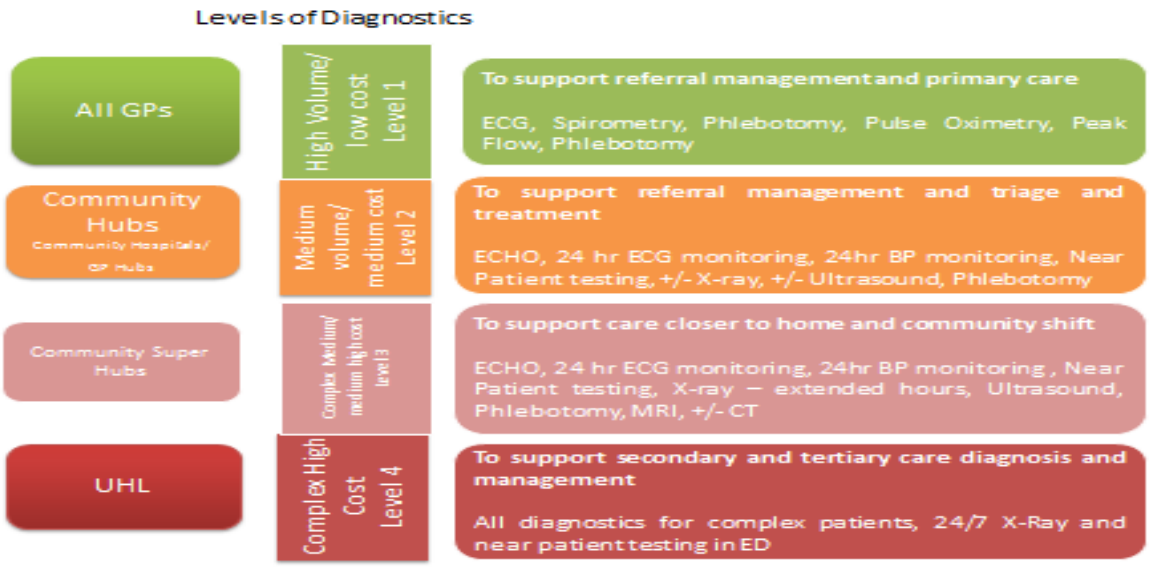
Concrete actions

- 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.

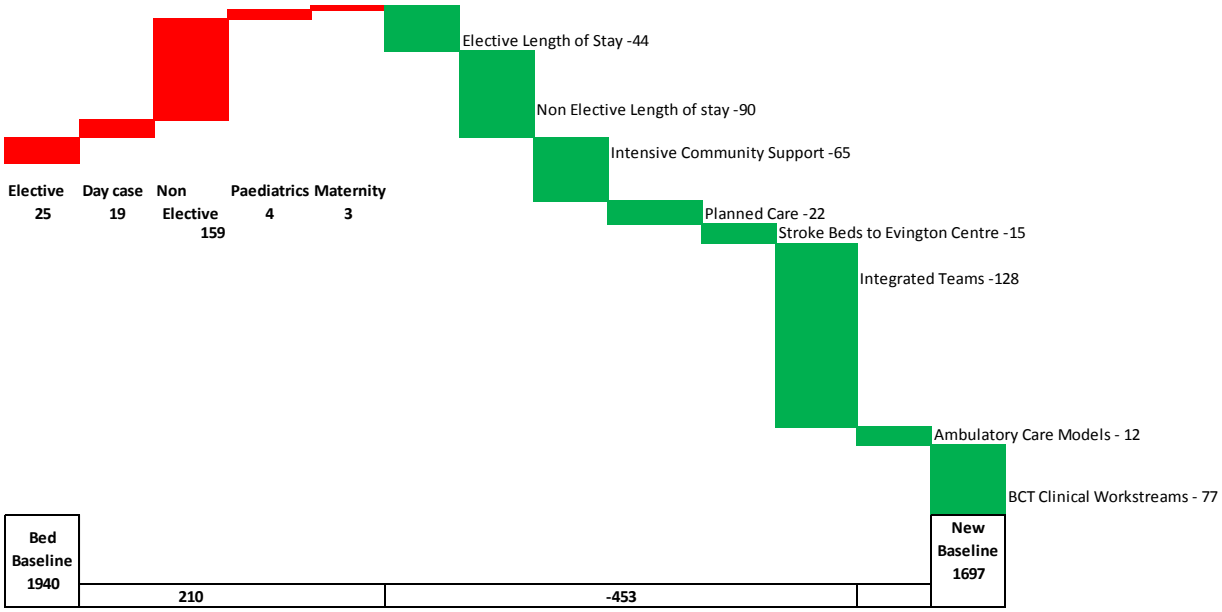
Through our Better Care Together and Better Care Fund programme we already have taken steps on this journey including the development of home based beds and integrated health and social care teams supporting patients in their home and we will take this further through our proposals around integrated 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.

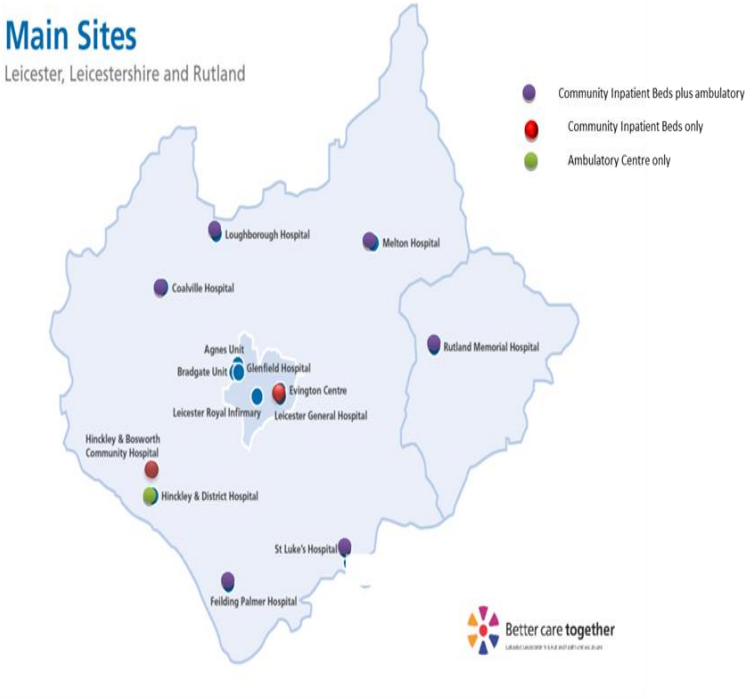
Community Hospitals

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.

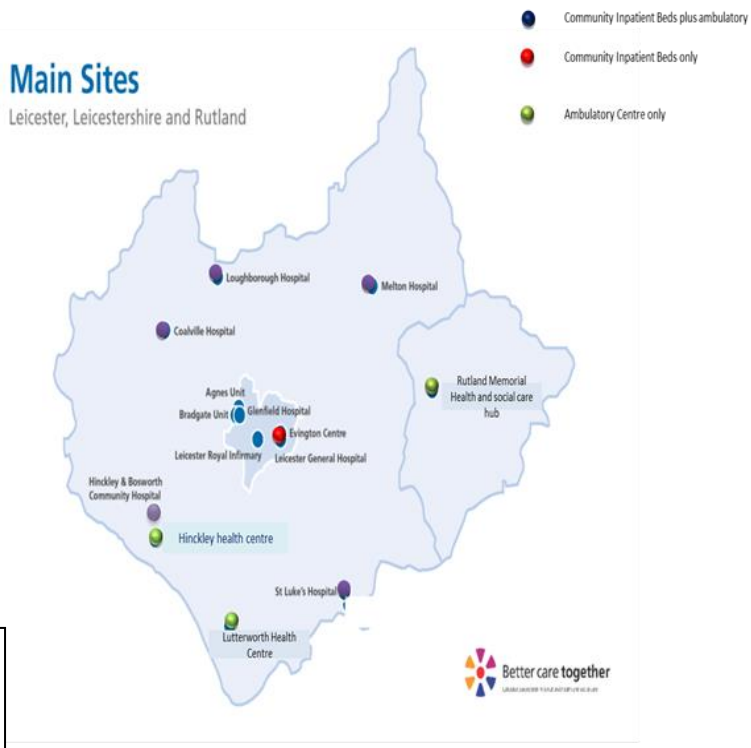
Some community hospitals have small single wards which are too small to be sustainable in the future. Staffing numbers are proportionate to ward size and small single wards have staffing levels that are vulnerable to issues such as short notice sickness, which if not resolved can increase risk and compromise 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

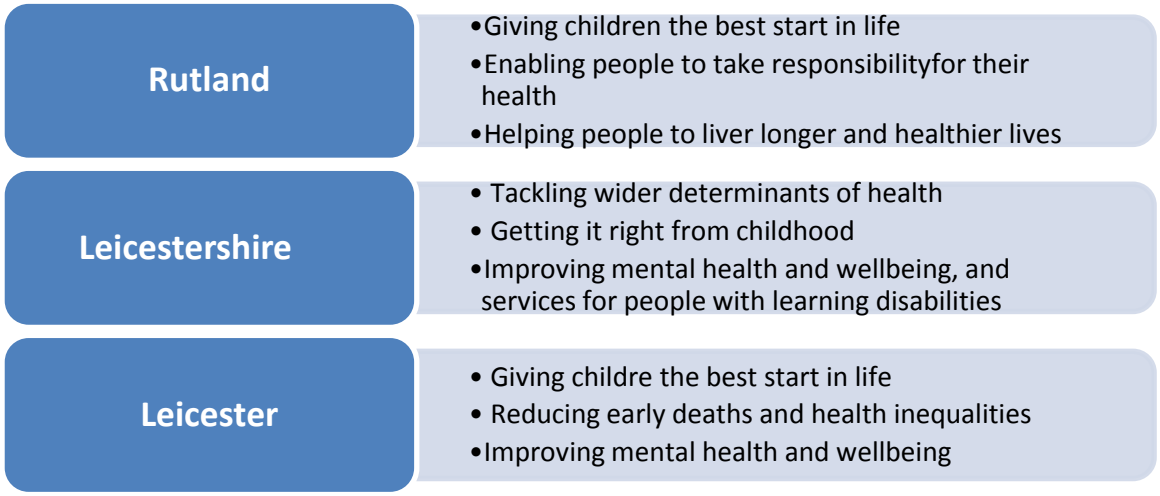
Strand 3 Redesign Pathways to deliver improved outcomes for patients and deliver core access and quality standards

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:

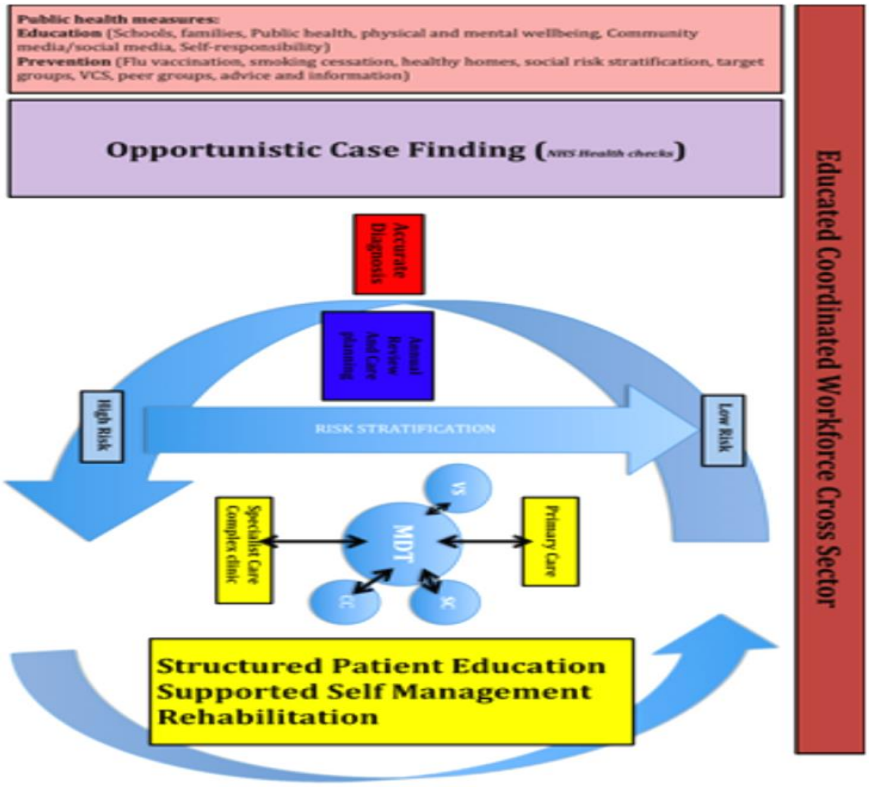
- Improved lifestyle though the reduction in smoking; alcohol; obesity and increases in physical activity will led to less heart disease, lung problems, diabetes and cancer.
- People will have more confidence to manage their own health.
- Less people will develop complex conditions.
- Reducing the likelihood 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

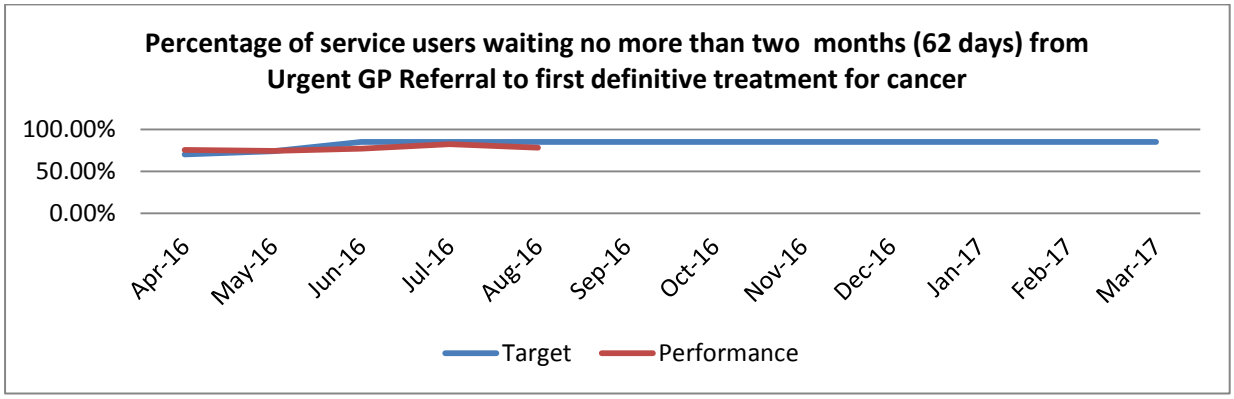
them through education, peer support, health coaching and development of care plans. This will include development of an integrated cardiorespiratory community service, timely specialist interventions through integrated teams from acute and community services. The expansion of the Rapid Access Heart 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

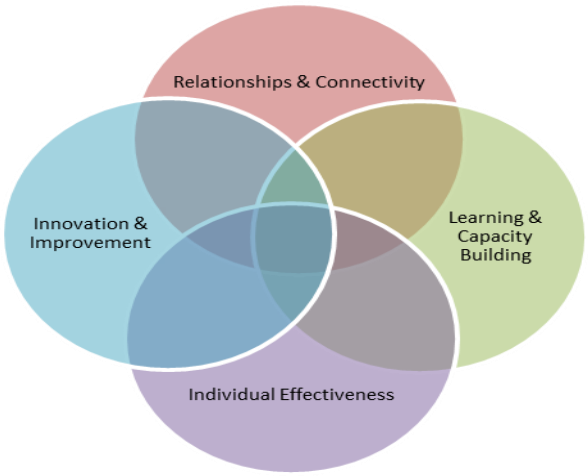
The workforce enabling work stream has established a programme of work to support workforce transformation. This is detailed in the LLR workforce strategy and plan, with the working structure summarized below.

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.'

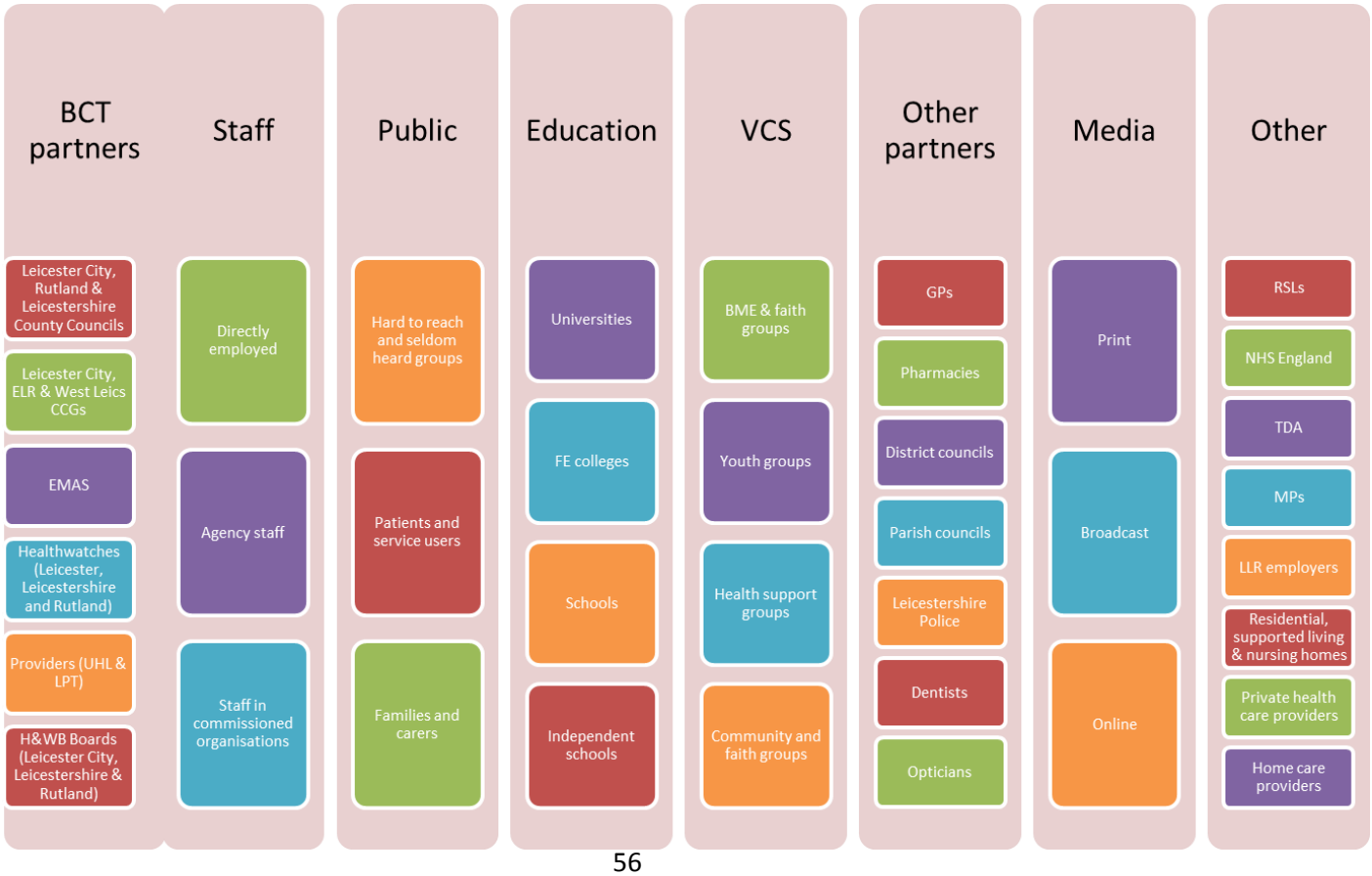
Engagement

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

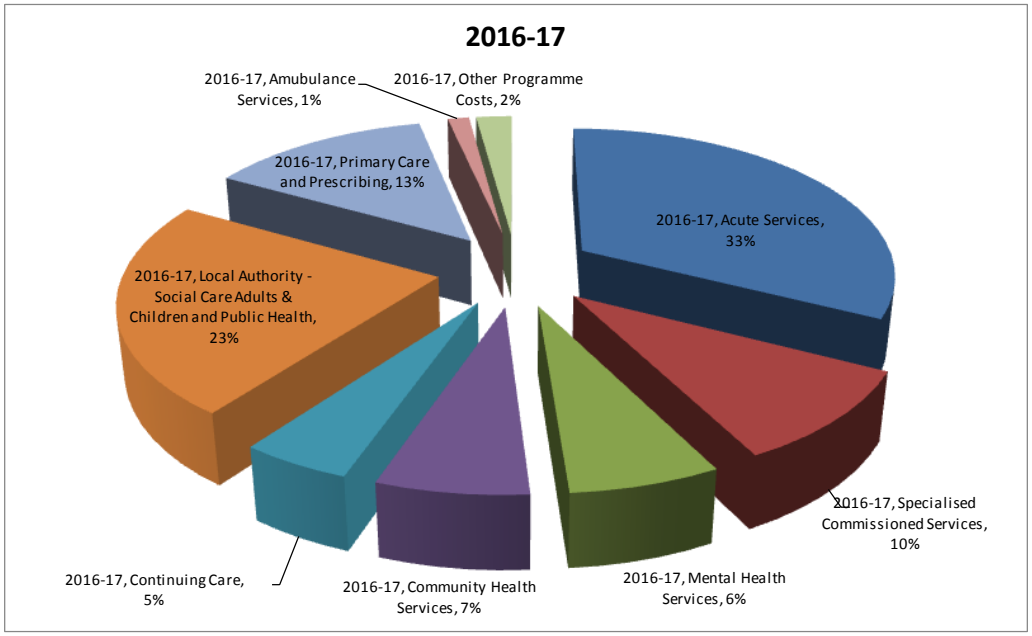
planning, as well as recording all engagement taking place in order to evidence stakeholder involvement and input.

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%

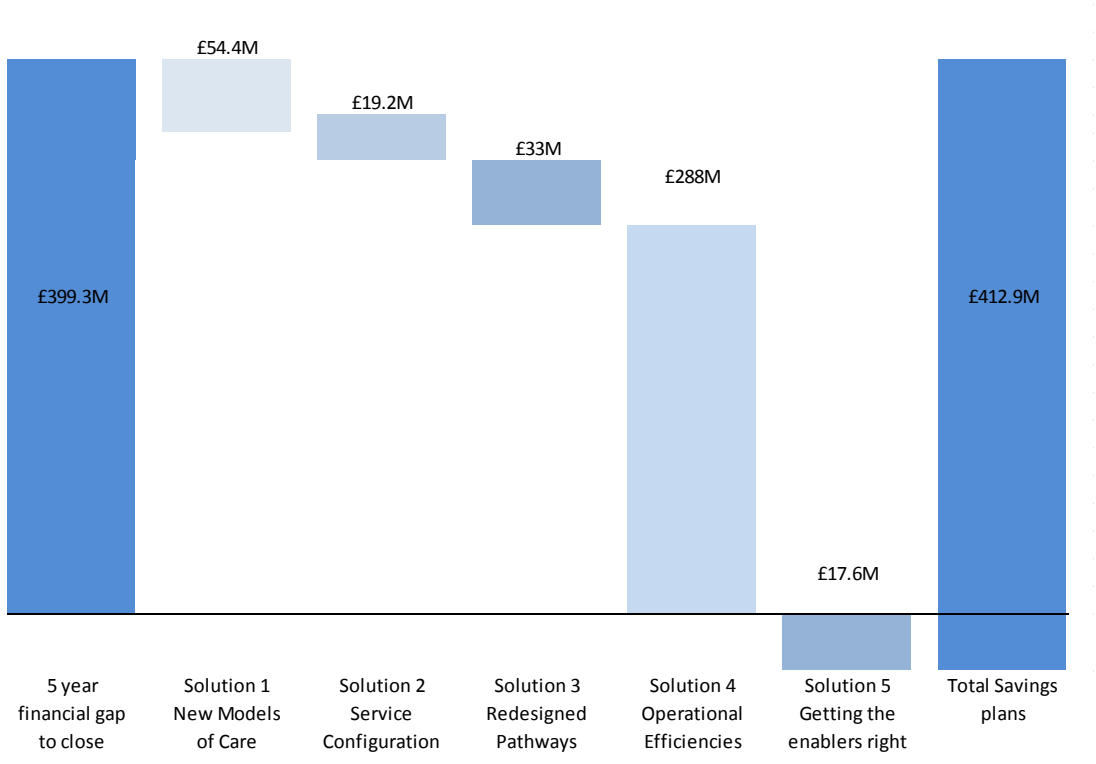
Closing the Gap

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.

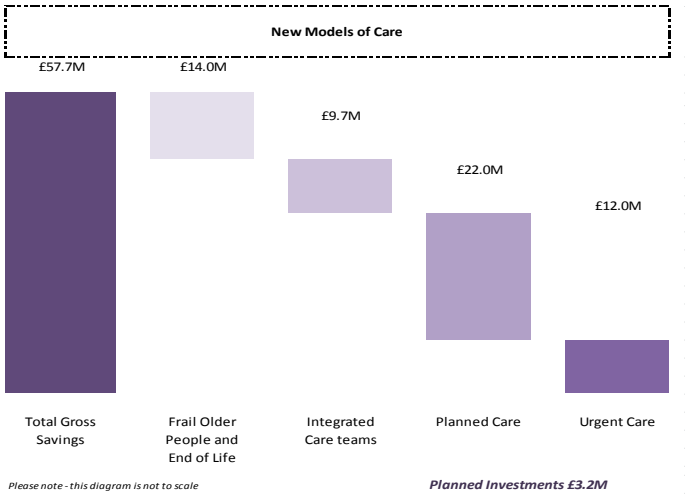
CIP schemes are in place to deliver c. £175m of the required savings. The single largest scheme in LLR is the move from three to two acute sites for UHL. This deals with both quality and workforce issues created by duplicating services over two or more sites. Once the reconfiguration is complete the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

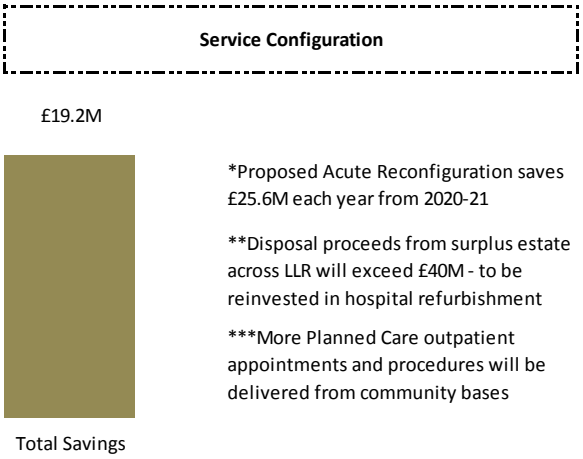
Strand 2 - Service Configuration Net Savings £18.9M

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

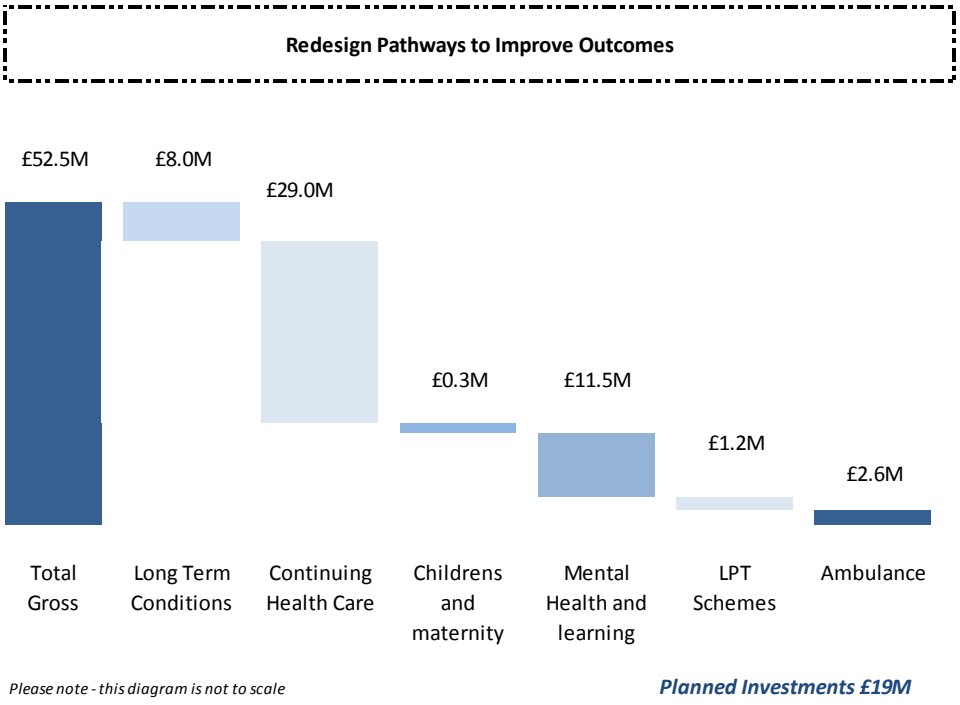


The changes will result in;

- 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

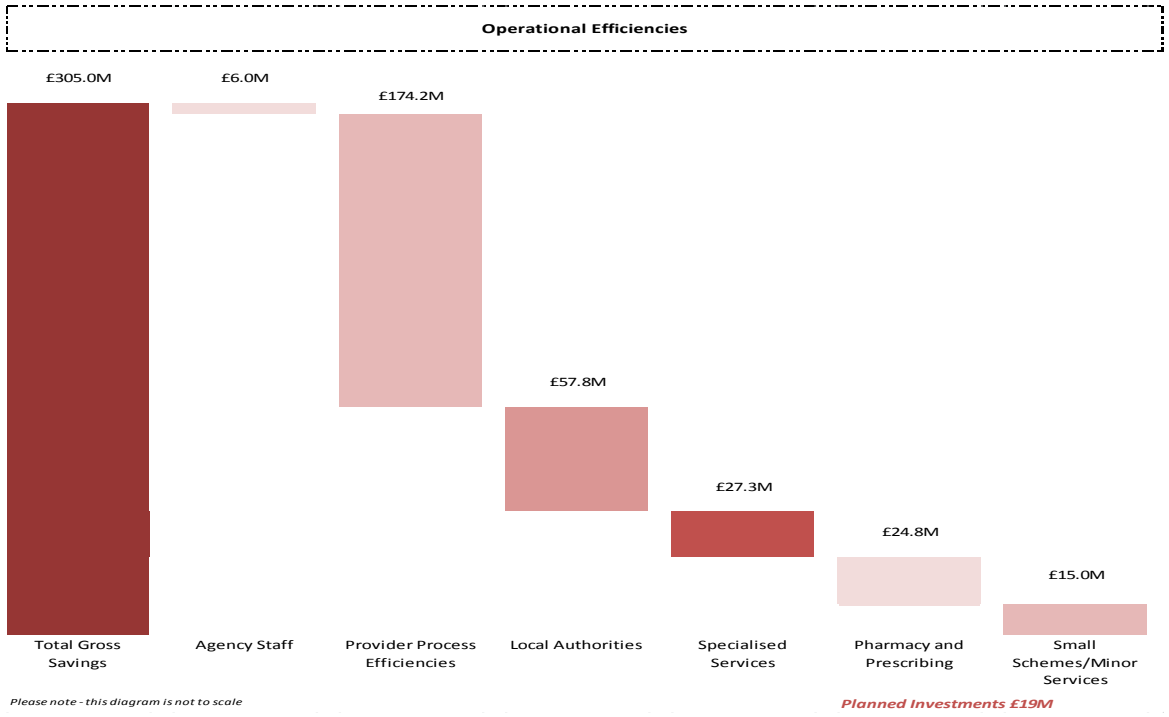
Alongside this staff will be trained to deal with the changing needs of the patients (more multiple long term conditions in an aging population) and able to work flexibly between inpatient and outpatient or patients' homes as the setting for care.

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;

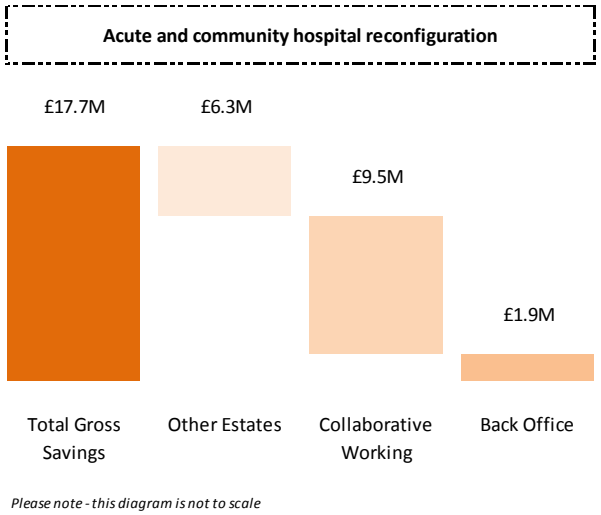
Local authority efficiencies

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.

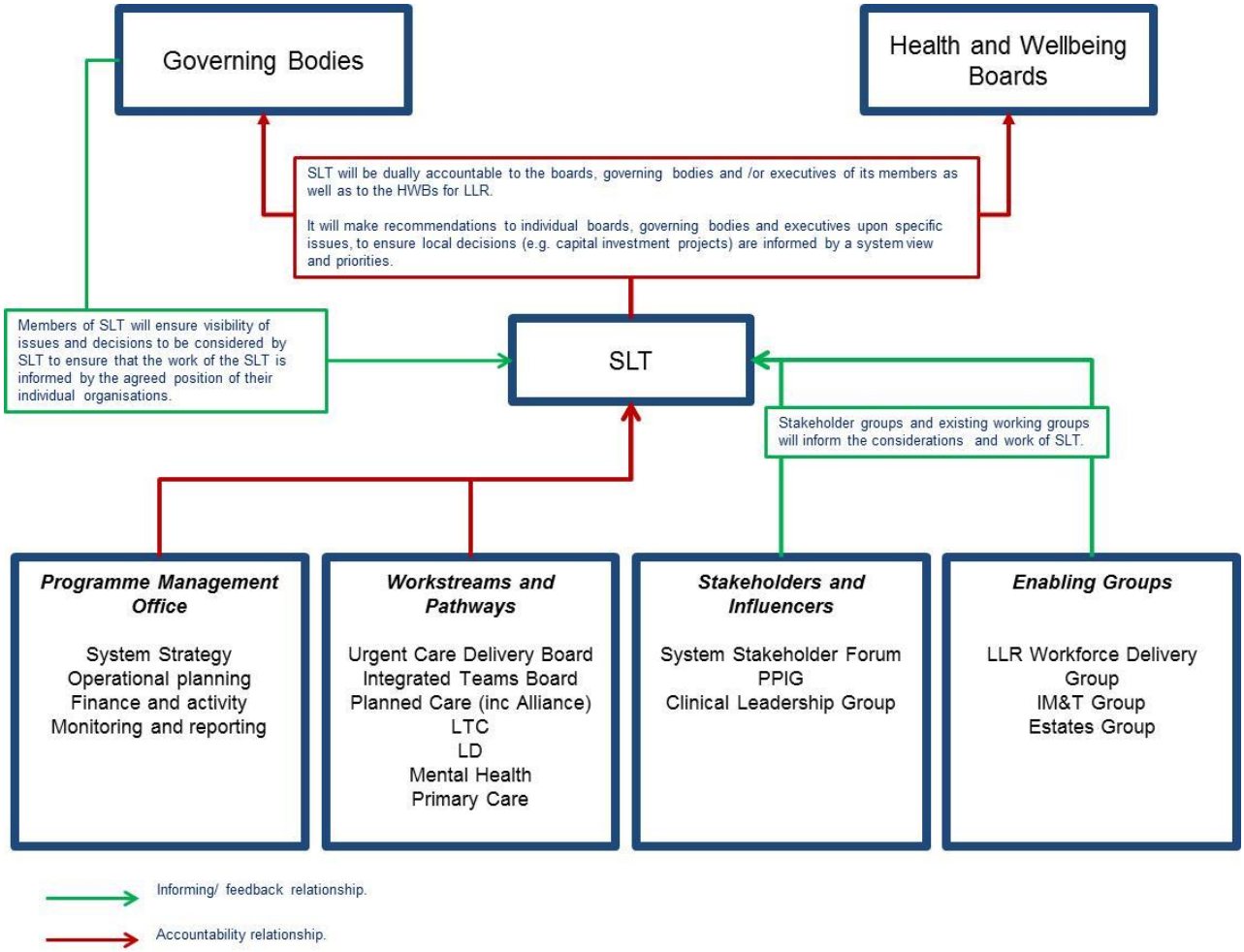
Clear, joint governance with delegated authority

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.

LEICESTER CITY HEALTH AND WELLBEING BOARD:

15 DECEMBER 2016

SUSTAINABILITY AND TRANSFORMATION PLAN: ROLE OF THE HWB

Purpose

1. This paper provides an overview of the proposed role of the three Leicester, Leicestershire and Rutland (LLR) Health and Wellbeing Boards (HWB) within the new Sustainability and Transformation Plan (STP) governance and delivery arrangements.

Background

2. Health and Wellbeing Boards were established by the Health and Social Care Act 2012. They are local authority committees, with statutory membership from partners including the CCGs and Healthwatch, as well as the option to appoint additional members through local choice.

3. The primary purpose of the Health and Wellbeing Board is to prepare and publish a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy for the local area. The Boards have a wider role to improve the health and wellbeing of the local population through the development of improved and integrated health and social care services.

4. In recognition of this role, it is proposed that the three LLR Health and Wellbeing Boards support the delivery of the STP. This develops the Better Care Together governance arrangements and recognises that, in order to drive forward implementation to make a real difference for local people there is a clear need for more formal, focused and accountable collaborative working and decision making arrangements.

5. The governance arrangements for the STP are illustrated in the diagram attached as Annex A. Key to these new arrangements is the System Leadership Team (SLT) which met for the first time in shadow form in November. This is a joint committee of the three LLR CCGs. The SLT also includes the chief executives or equivalent from the three LLR local authorities and the NHS statutory providers as 'non decision making members' to ensure that the considerations and decisions of the SLT are fully informed by views from across the health and social care system.

6. The SLT will oversee all aspects of the development and delivery of the STP for the LLR footprint and provide collective leadership and problem solving to address barriers to implementation. Members of the SLT will meet together to discuss and agree the direction of the STP and of any specific areas of work required to meet the aims of the Plan. However, where an issue requires a specific decision by a provider organisation or a local authority, the remit of the SLT will be to develop a shared

recommendation, on which all members of the SLT agree, to be presented for consideration and approval by the relevant board or governing body.

Role of the Health and Wellbeing Board

7. It is recognised that additional governance arrangements for the STP are needed to deliver improved clarity and connection between the local place and the LLR tier with more visibility, shaping and recognition of the wider determinants of health in all aspects of strategic planning. It is proposed that the three LLR Health and Wellbeing Boards take on this role, which aligns with their existing responsibilities as set out in their Terms of Reference and summarised in the table below:

Area	Leicester City	Leicestershire County	Rutland
Identifying Needs	Working jointly to identify current and future health and wellbeing needs across Leicester City through revising the JSNA. Develop and agree the priorities for improving the health and wellbeing of the people of Leicester and tackling health inequalities.	Identify current and future health and wellbeing needs across Leicestershire and publishing and refreshing the Leicestershire JSNA so that future commissioning/policy decisions and priorities are based evidence. Reach a shared understanding of the health needs, inequalities and risk factors in local populations, based on the JNSA and other evidence.	Identify current and future health and wellbeing needs across Rutland through revising the Joint Strategic Needs Assessment (JSNA) as and when required.
Strategy	Prepare and publish a JHWS that is evidence based… and support by all stakeholders. Oversee progress against the health and wellbeing strategy and other supporting plans and ensure action is taken to improve outcomes.	Retain a strategic overview of the work of commissioners to further the Board's strategic objectives. Focus collective efforts and resources on the agreed set of strategic priorities…	Prepare and publish a Joint Health and Wellbeing Strategy (JHWS) that is evidence based (through the work of the JSNA) and supported by all stakeholders. This will set out our objectives, trajectory for achievement and how we will be jointly held account for delivery.
Implementation	Ensure that all commissioners of services relevant to health and wellbeing demonstrate how the JHWS has been implemented in the commissioning decisions.	Ensure that the County Council and Clinical Commissioning Groups demonstrate how the JHWS has been used in their commissioning decisions.	Ensure governance arrangements, strategic partnerships and relationships are in place to progress the JHWS, address any barriers to success.
Alignment and integration	Ensure that all commissioners of services relevant to health and wellbeing take appropriate account of the findings of the JSNA, and demonstrate strategic alignment between the JHWS and each organisation's commissioning plans.	Having oversight of the use of relevant public sector resources to identify opportunities for the further integration of health and social care service. Provide system level oversight to the totality of commissioning expenditure in Leicestershire which is relevant to achieving the	Facilitate partnership working across health and social care to ensure that services are joined up around the needs of service users. Encourage persons who arrange for the provision of health-related services in its area to work closely with the health and wellbeing board.

		Board's strategic priorities and the plans for changing the health and social system across LLR.	

8. The HWBs will provide a 'confirm and challenge' function, ensuring that the STP is aligned with the priorities set out within both the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment. The HWBs will also apply this confirm and challenge approach to the implementation of the STP, particularly with regard to the pace and readiness of the individual programmes of work within it.

9. It is proposed that each HWB would provide an open and transparent forum in which to:

   I. Take responsibility for ensuring that the STP priorities address the key place based health and care needs of each HWB area for adults and children
   II. Assure itself that HWB partners have adequate plans in place to deliver their required local contribution to implementing the STP
   III. Assure itself, where specific proposals exist for service reconfiguration within their geographic area, that the case for change in terms of clinical model and patient benefit is clear and processes for securing patient and public involvement are robust.
   IV. Take a lead role for one of the agreed STP new model of care transformation priorities. This would be on behalf of the whole of LLR, not just the specific HWB, and would involve more frequent review, testing and leadership for the implementation plans for that specific aspect of the STP.
   V. Agree any concerns or issues which the HWB wishes to escalate to the STP or refer to or inform the executive of the relevant NHS body or local authority

10. This 'division of labour' is not intended to constitute a formal delegation of accountability or statutory responsibilities from one body to another, but rather ensure that there is consistent challenge being applied across the system in a way which avoids duplication and creates the time and space for more detailed consideration.

11. In terms of what this would practically mean, under these arrangements in addition to taking an overall interest in the whole of the STP, each HWB would have the following specific areas of focus:

	Leicester City	**Leicestershire**	**Rutland**
New models of care	Primary care	Integrated teams	Community rehabilitation
Service reconfiguration	UHL acute hospital sites	Community hospitals (excluding Rutland Memorial)	Rutland Memorial

12. To assist the HWB in this role, the STP programme office will provide a monthly report programme report which will be circulated electronically to Board members, in addition to a bi-annual report for discussion at a Board meeting providing a more in-depth consideration of specific issues. It is recommended that the specific areas of

focus form a standing item on the agenda for each HWB, although this is clearly a matter for local choice.

13. In addition to the above greater role for HWBs in respect of the STP it is worth noting four key areas that these proposed governance arrangements would not change or replace:
    - Responsibility of each statutory NHS organisation to sign off of the STP and supporting financial plan.
    - Accountability arrangements for delivery of the STP by statutory NHS organisations which will remain through NHS England (for CCGs) and NHS Improvement (for UHL and LPT).
    - The role of health scrutiny in respect of the STP which will remain separate and distinct through the local authority statutory OSC arrangements, particularly in respect of formal service reconfiguration proposals, consultation and decision making arrangements.
    - Relevant responsibilities of each local authority executive body.

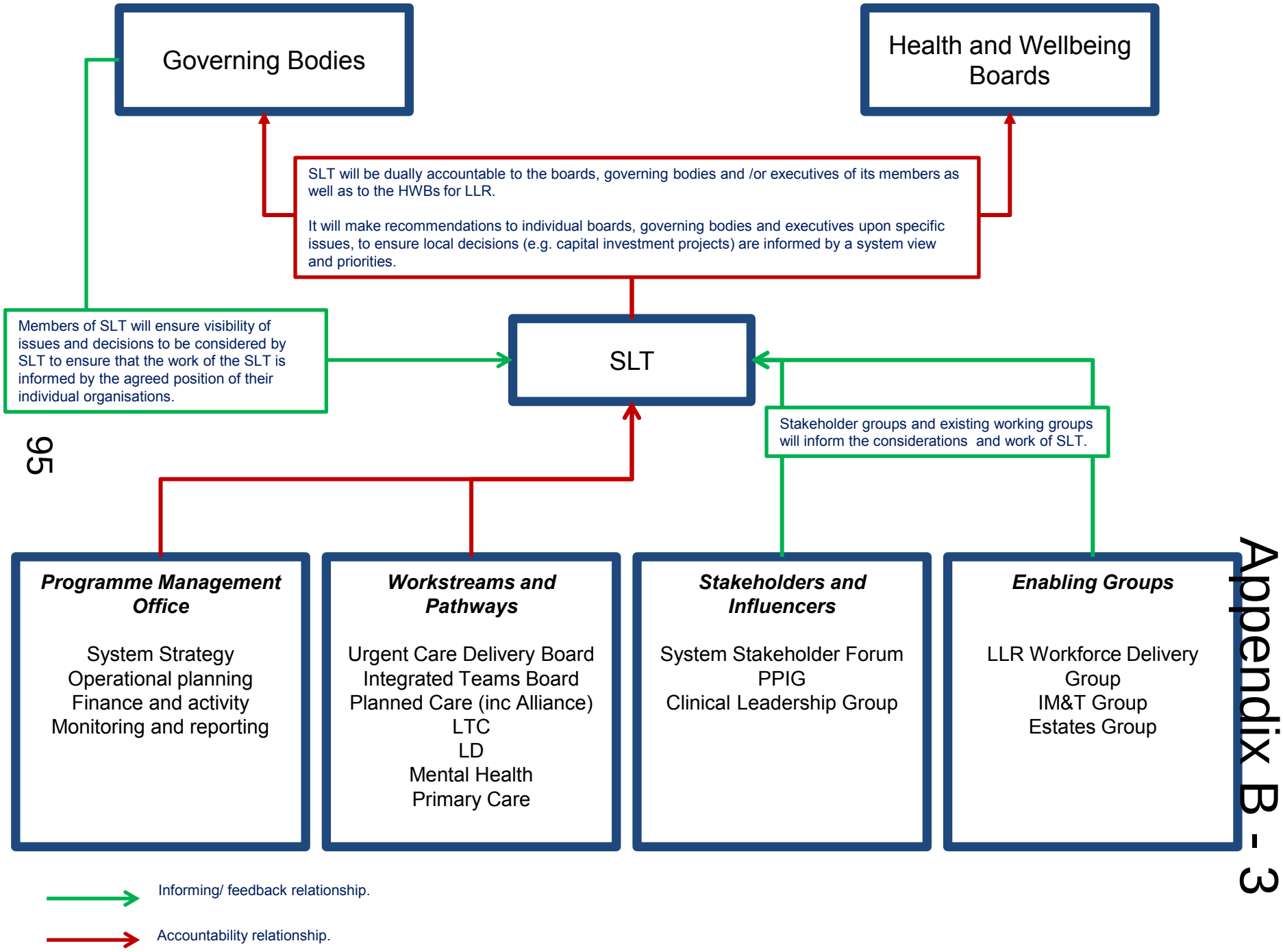
Role of Health Overview and Scrutiny Committees

14. Health Overview and Scrutiny Committees are local authority committees comprising democratically elected councillors. They are responsible for reviewing and scrutinising any matter relating to the planning, provision and operation of health services within the area administered by the relevant Council with social care responsibilities.

15. Where major or significant changes to health services are proposed, there is a statutory requirement for Health Overview and Scrutiny Committees to be consulted. This can be through a Joint Committee if the changes affect an area larger than one local authority. The Committee(s) remit is to ensure that adequate consultation has been undertaken and that the changes proposed are in the best interests of the local area and they will provide a formal response to the consultation addressing these points. Members will seek to work collaboratively with the NHS and seek to resolve any issues at a local level; however, if after this the Committee(s) still considers the changes not to be in the best interests for the local population they can refer the matter to the Secretary of State for Health (Leicestershire County and Rutland require their full Councils to agree to this).

16. It is not proposed that the HWBs would undertake any activities which would fall within the statutory responsibilities of the HOSCs.

    Recommendations
    The HWB is asked to:
    - **Approve** – taking on a greater role in relation to the STP as set out in the paper
    - **Approve** – the five specific functions outlined in paragraph nine.
    - **Approve** – the specific areas of service reconfiguration and new models of care focus for each HWB set out in the table at paragraph eleven
    - **Note** – the areas that would remain within the governance of other parts of the system.


Governing Bodies
Health and Wellbeing Boards
SLT will be dually accountable to the boards, governing bodies and /or executives of its members as well as to the HWBs for LLR.
It will make recommendations to individual boards, governing bodies and executives upon specific issues, to ensure local decisions (e.g. capital investment projects) are informed by a system view and priorities.
Members of SLT will ensure visibility of issues and decisions to be considered by SLT to ensure that the work of the SLT is informed by the agreed position of their individual organisations.
SLT
Stakeholder groups and existing working groups will inform the considerations and work of SLT.
Programme Management Office
System Strategy
Operational planning
Finance and activity
Monitoring and reporting
Workstreams and Pathways
Urgent Care Delivery Board
Integrated Teams Board
Planned Care (inc Alliance)
LTC
LD
Mental Health
Primary Care
Stakeholders and Influencers
System Stakeholder Forum
PPIG
Clinical Leadership Group
Enabling Groups
LLR Workforce Delivery Group
IM&T Group
Estates Group
Informing/ feedback relationship.
Accountability relationship.

Appendix C

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE 15th December 2016

Subject:	The 2016 Adult Autism Self-Assessment – Evaluating Progress in Local Authorities along with Partner Agencies
Presented by:	Yasmin Surti - Lead Commissioner LD and MH John Singh - Strategy & Implementation Manager Leicester City Clinical Commissioning Group
Author:	Jane Forte – Commissioning Manager LD, MH & Autism

EXECUTIVE SUMMARY:

National Context
The Autism Act became law in 2009, and a National Strategy, *Fulfilling and Rewarding Lives* was published 2010. This was followed up with *Implementing Fulfilling and Rewarding Lives* (DH 2010), which gave a set of mandatory recommendations regarding what action CCG's and Local authorities should take to develop services for people with Autistic Spectrum Disorder (ASD). This was refreshed by a National Strategy published in April 2014 - *Think Autism Fulfilling and Rewarding Lives, the strategy for adults with Autism in England: an update.*

Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy was published in March 2015.

The guidance refers to the legal duties imposed upon local authorities and NHS bodies by the Autism Act 2009. It includes the Care Act 2014, and the Children and Families Act 2014. The Transforming Care programme has also raised the profile of autism in respect of appropriate community support to avoid hospital admission and ensure timely hospital discharges.

Local Context
This places a legal requirement on Clinical Commissioning Groups, under Section 7 of the Local Authority Social Service Act (1970). If local services are not in line with statutory guidance, service users could request a judicial review.

The autism guidance not only refers to what "must" be done to comply with legislation but also says what local authorities and NHS bodies "should" do with regard to the way in which they exercise their functions with a view to securing the implementation of the autism strategy.

The last Autism Self-Assessment Framework was completed in 2014. RAG ratings indicate green where we exceed the requirements, amber in areas where there is work in progress and red in areas which are future priorities.

The 2016 Autism Self-Assessment Framework is designed to assess the progress made by the Local Authority and its partners over the last two years. It was submitted on 17th October. The number of RAG rated areas has increased from 20 to 31 so not all are comparative. The local authority is the designated lead for collating and submitting the Autism Self-Assessment Framework. Below are details of what we submitted and what we need to do to improve things.

Progress

RAG ratings indicate green in twelve areas where we exceed the requirements, amber in fifteen areas where there is work in progress and red in three areas, which are future priorities. See table below.

Sections with RAG rated answers		Red	Amber	Green
Planning	11	0	7	4
Training	2	0	0	2
Diagnosis	9	3	2	4
Care & support	4	0	4	0
Housing	1	0	0	1
Employment	2	0	2	0
Criminal Justice system	2	0	1	1

Areas where we are doing particularly well and some listed as local innovations in the Self –Assessment are:-

The Carers Support group is hosted bi-monthly by the carers centre and has enabled carers to feel their voice is now being heard. As Autism is a hidden disability, they feel very isolated and that the 'authorities' do not understand.
Their views have been collated over time and have provided valuable evidence for responses to the assessment.

Accommodation for supported living has been developed with autism specific design features, with tenants successfully moved in.

The Monday Club provides prevention and emotional wellbeing support to a growing number of people with autism, within a community setting enabling a range of opportunities for activity and development.

The development and maintenance of the LLR Autism Partnership Board, linking into both City LD and MH Partnership Boards.

General progress

- A Multi-disciplinary Autism Diagnostic and Support Pathway has been maintained and refreshed for Children, Transition and Adults with partners across health and social care in Leicester, Leicestershire and Rutland has been for people with a learning disability. Those with no learning disability currently only have a diagnostic pathway.

- This is underpinned by an LLR Delivery Action plan linked to the Statutory guidance published in March 2015 for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy.

- A comprehensive training programme is available, some of which is mandatory for ASC staff. Some components are currently being revised by a multiagency LLR group.

- Regular self-advocate and carers feedback has provided evidence of progress and highlighted gaps.

- Criminal Justice System –awareness raising is making progress across the whole system to recognise Autism, and responding more appropriately across the courts, prison and probation services.

Areas for development

- The three red areas relate to the lack of post diagnostic support in Adult Mental Health. There is currently no health service provision. A business plan has been submitted by LPT to the CCG's, as to how this service may be best delivered, but there is currently no additional funding. This links with the Transforming Care programme

- Data collection has improved but can still be difficult from a range of sources that do not cross reference, therefore the quality and quantity affects the ability to analyse it. However Information sharing protocols have assisted in progressing this work.

- Understanding how Autism affects different groups in society, women, older people and people from different BME groups.

- Improve the transition experience for young people in preparing for Adulthood including employment.

- Improve carers experience and support for non-learning disability cases and ensure their voice is heard.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

- Accept and Validate the Autism Self-Assessment submission
- Support the recommendations for future work to ensure the Council along with partner agencies are able to meet their legal responsibilities and raise standards.

- To note the governance for sign off

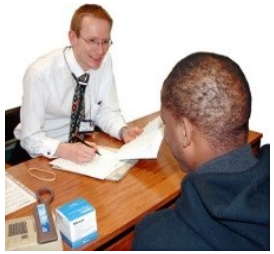
    Joint Integrated Commissioning Board – 17/11/16
    ASC Scrutiny Commission– 12/12/16

    The Autism Partnership Board has discussed and agreed the outcomes at their last meeting.

John Singh, Leicester City CCG will take it to the CCG bodies for information and to the Commissioning Collaborative Group.

Leicester City
Autism Self-Assessment
2016

What we are checking



The Autism Self-Assessment Framework is a list of questions that help to check how local services are doing for people with Autism and their families.

There are seven areas that we are checking

- How things are Planned
- Training people
- Diagnosis and health support
- Care and support
- Housing and Accommodation
- Employment
- Criminal Justice System

and examples of local activity

- New things happening
- What you and your carers think

RAG Rating

- **How good is the support that people are getting**

- For each question we had to decide if we were
- Red – need to do a lot better
- Amber – doing Ok, but could do more
- Green – things are working well

- We were given an explanation of what we needed to have to be red, amber or green.

Autism Self-Assessment scoring

This is how we scored:

- In 12 areas we are good
- In 16 areas we are okay and need to do more
- In 3 areas we are poor and need to do a lot more work.

Last time there were only 20 areas, this time there are 33 areas, so it is difficult to compare them.

People on the Autistic Spectrum and their carers also shared their stories to show how what we are doing supports them.

We already have plans in place to show how we will improve on the areas we are not so good at and how we will build on the areas we are good at.

This is how we scored

		Poor	OK	Good
Planning	11	0	7	4
Training	2	0	0	2
Diagnosis	9	3	2	4
Care & support	4	0	4	0
Housing	1	0	0	1
Employment	2	0	2	0
Criminal Justice system	2	0	1	1

Areas where we are good

- Partnership work - working together with Clinical Commissioning Group, Leicestershire Partnership Trust and other Local Authorities
- Involving people - working with users and carers for planning
- Training
- Diagnostic pathway
- Housing and accommodation
- Information sharing
- Joint Strategic Needs Assessment
- Working with the Police

Areas where we can do better

- Planning for future services
- Communication and Assessing peoples needs
- Information & data quality
- Advocacy
- Employment
- Support and access
- Preparing for adult hood
- Reasonable adjustments
- Criminal justice system – raise awareness / train staff, in courts, prison and probation

Areas we are not good

- We need to know more about women with autism
- We need to know more about older people with autism
- Access to a range of mental health support post diagnosis and when in hospital.
- Access to psychology support (MH)
- Access to occupational therapy support (MH)
- Access to speech and language therapy support (MH)

Areas for development for Autism

- It is difficult to collect some data and information from different organisations which do not match. The quality and quantity of data and information affects the ability to properly understand and use it.

- Post diagnostic support in Adult Mental Health – A business case was first presented by Leicestershire Partnership Trust to the Clinical Commissioning Group in 2014. There is currently no service in place, and no decision has been reached yet.

- Knowing our people and how autism affects them and their loved ones, eg: women, older people and people from different BME groups

- Understand autism support needs within the criminal justice system

The future – things to do

- Get better at recording and being able to analyse data and information from partners
- Make sure there is a range of support services available for every one after diagnosis
- Improve knowledge within the courts, probation and prison service
- Meet with specific groups of people to understand their experiences and needs
- We will update the action plan to show how we will make things better on the areas where we have not done so well in the Self-Assessment.

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE 15th December 2016

Subject:	Loneliness and social isolation
Presented to the Health and Wellbeing Board by:	John Mair-Jenkins
Author:	John Mair-Jenkins

EXECUTIVE SUMMARY:

This paper aims to provide information about the risks, impacts and interventions for loneliness and social isolation, highlight the position in Leicester and inform discussion about options for further work.

Key messages:

- Social isolation is as a complex issue affecting individuals, but also influenced by local community and wider society. It is often considered an issue of older age, however people can experience social isolation at any age or stage of life.
- Reducing loneliness and social isolation at individual and community level across the City of Leicester will contribute to improving overall health and wellbeing.
- Risk factors of loneliness and isolation are often linked to deprivation therefore action on isolation will also help reduce health inequalities.
- Many interventions (including those not targeted at preventing loneliness and isolation) and Leicester City Council services may increase social connectivity and reduce isolation. However, there is often a lack of clear evaluation of these interventions in terms of their effect on isolation, poor health and health inequalities.
- A rapid evidence review of interventions has been completed and found evidence of effective group and individual interventions to tackle isolation and loneliness, however there is a lack of consensus about which interventions are best suited for cities like Leicester. Effective interventions tend to be adaptable, take a community based approach and encourage productive engagement of users.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to accept this briefing in order to inform multiagency discussion about isolation and loneliness in Leicester.

Appendix D - 1

Health and Wellbeing Board

Date: 12th December 2016

Title: Loneliness and social isolation

Lead director: Ruth Tennant

Useful information

- Ward(s) affected: None
- Report author: John Mair-Jenkins
- Author contact details: john.mair-jenkins@leicester.gov.uk
- Report version number: 1.1

1. Purpose

Provide information about the risks, impacts and interventions for loneliness and social isolation, highlight the position in Leicester and inform discussion about options for further work.

2. Key messages

- Social isolation is as a complex issue affecting individuals, but also influenced by local community and wider society. It is often considered and issue of older age, however people can experience social isolation at any age or stage of life.
- Reducing loneliness and social isolation at individual and community level across the City of Leicester will contribute to improving overall health and wellbeing.
- Risk factors of loneliness and isolation are often linked to deprivation therefore action on isolation will also help reduce health inequalities.
- Many interventions (including those not targeted at preventing loneliness and isolation) and Leicester City Council services may increase social connectivity and reduce isolation. However, there is often a lack of clear evaluation of these interventions in terms of their effect on isolation, poor health and health inequalities.
- A rapid evidence review of interventions has been completed and found evidence of effective group and individual interventions to tackle isolation and loneliness, however there is a lack of consensus about which interventions are best suited for cities like Leicester. Effective interventions tend to be adaptable, take a community based approach and encourage productive engagement of users.

3. Background

Loneliness and social isolation may be experienced together with one driving the other or they may act independently. Either issue may be experienced at any age and discrete periods of isolation or loneliness can be viewed as a normal part of life. However, many people experience long periods of loneliness throughout life, or periods of greater isolation after life events, such as retirement. This chronic loneliness or isolation can have lasting impacts on health and wellbeing. The following definitions have been taken from the wider literature and have been adopted by Public Health England. [1]

- Social isolation can be defined as multilevel issue: *the inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment).*

- Loneliness has been defined as: *an emotional perception that can be experienced by individuals regardless of the breadth of their social networks.*

Many people working in the field find it useful to combine these two issues and see a more practical definition of problematic isolation and loneliness as 'being at the bottom of the well' – a situation in which others in society do not even know one's distressing and worsening predicament, much less move swiftly to redress it.

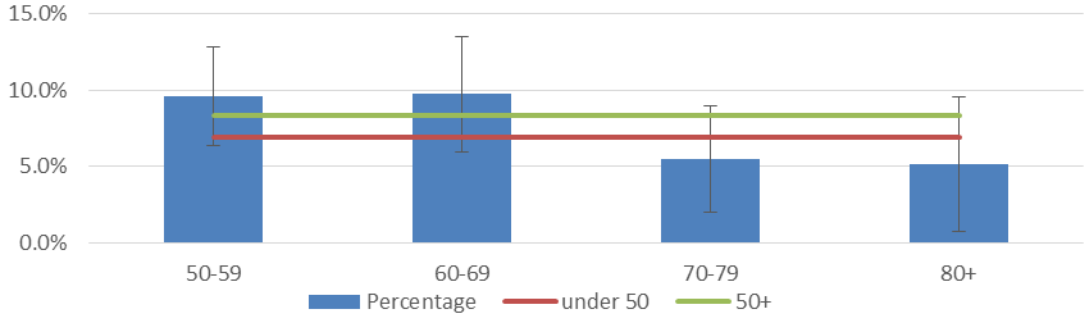
4. Size of the problem in Leicester

The 2015 Leicester Health and Wellbeing Survey asked how often people felt excluded, lonely or alone. Results show that 10% of people reported feeling this way often or all of the time, suggesting over 30,000 lonely people in Leicester and this was similar across age groups.

This result is similar to national findings with different studies suggesting 6-15% of the population are always or often lonely. It has been suggested that an approximate figure of 10% is representative of loneliness in the older population. Remarkably this national trend has been consistent over time with the extent of loneliness in older people being constant over the past 60 years. [2]

The Leicester Health and Wellbeing Survey also asked about isolation with 7% of respondents across Leicester report feeling isolated often or all of the time. Figure 1 highlights that residents in the 50-69 years age group had the highest reports of isolation. Differences between age groups were not statistically significant.

Figure 1: Percentage of respondents feeling isolated from others all of the time or often, by age group, Leicester Health and Wellbeing survey 2015



Whilst the older population of Leicester is not growing as quickly as some areas of the country the general increase in life expectancy suggests increasing numbers of older lonely people in the future.

The diverse population in Leicester may mean that national data is not fully applicable to the city. Levels of loneliness among ethnic minority elders who migrated to the UK are generally higher than for the rest of the population (15% report that they always or often feel lonely). It is also important to note that this varies by different ethnic group, for example older people from the Indian subcontinent report being less lonely than people born in the UK.[2]

These patterns are also likely to change over time as subsequent generations have different lived experiences from their parents. Younger people from ethnic minority groups, those in the 45–64 age group, report lower levels of loneliness than those aged

over 65.[2]

Two other key indicators are included in the Public Health Outcomes and Adult Social Care Outcomes Frameworks, both of which are taken from national survey data. Leicester has significantly worse indicators of isolation than the England, but they are similar to other cities in the East Midlands.

- The percentage of adult social care users who have as much social contact as they would like (36%)

- The percentage of adult carers who have as much social contact as they would like (32%)

5. What increases the risk of loneliness and isolation?

Loneliness and isolation occur throughout life and may increase at particular transition points, such as moving schools, leaving home, starting a family, migrating, or becoming a carer. In particular retirement has been highlighted as one of the most important life transitions in terms of loneliness and isolation risk. Other influences include ethnicity, gender, living alone, never being married, widowhood, support network type, poor health, cognitive impairment or poor mental health. [3–5] Lower socioeconomic status is associated with a higher incidence of loneliness, suggesting more deprived populations in Leicester may be at higher risk. [6]

The effects of social isolation may accumulate over time with the risk of impacts on health and wellbeing increasing with age. Therefore, by tackling social isolation among residents aged 50+ it may be possible to prevent health effects experienced by people as they get older.

Isolation and loneliness are driven by a range of factors at different levels. Figure 2 provides a conceptual model of isolation showing how individual, community and social aspects combine and influence the risk of social isolation. Many of the factors in this model correlate with deprivation and highlight potential for loneliness and isolation to be highest in some of the most deprived communities. This highlights the need for this issue to be tackled as part of the agenda to reduce health and social inequalities across the life course.

This model may also be beneficial in understanding how current Council services, functions and policies could be better co-ordinated to tackle isolation and loneliness. In particular it is clear that different sections of the population, such as older people, people livening in deprived areas and ethnic minority groups are at higher risk.

6. Impact on health and wellbeing

The effect of social isolation and loneliness on physical health have been widely studied and there is a clear impact on physical and mental health.[7] A recent systematic review included 70 studies and found an increase in the odds of death of 30% compared to those who were not lonely. Counter intuitively middle-age adults were at greater risk of death than older adults when lonely or living alone. Several reasons where suggested for this including the transition from full-time employment to retirement, and it is plausible

Figure 2: Social isolation a contextual overview, source: Bristol City Council

that individuals who are alone or lonely before retirement age may be more likely to engage in risky health behaviours such as smoking, [8] both of which may be amenable to change though preventative interventions.[9] These findings are supported by other work which has also suggested loneliness may a greater impact than other risk factors such as physical inactivity and obesity and be comparable to smoking 15 cigarettes per day. [10, 11]

Poor social relationships and isolation also increase the risk of illness.[12] Recent systematic reviews suggest individual conditions linked to loneliness and isolation include hypertension, CHD, heart failure, stroke, diabetes and chronic lung disease. [6]

These conditions may also act as risk factors with the risk of isolation increasing post stroke. This highlights the need for health and social care staff and carers of people with long term conditions to be aware of the risks of social isolation and be able to sign post to interventions to prevent or reduce isolation.[13]

There is recent evidence from a systematic review that sleep disturbance, depressive symptoms, and fatigue may all be increased in isolated or lonely older adults. Furthermore, loneliness in particular may have an impact on mental health.[14] There is limited evidence suggesting loneliness is associated with lower cognitive function such as general cognitive ability, processing speed, immediate, and delayed recall. However further research is needed in this area.[15] Social isolation may also have damaging effects resulting in depression, anxiety, fatigue and social stigma.[16] Recent work has suggested lonely people are over three times more likely to suffer depression and nearly twice as likely to develop dementia in the following 15 years.[17]

7. Impact on services

There is a lack of work looking at the impact of isolation and loneliness on services. A recent economic model built on the literature of health effects and suggested loneliness leads to increased service use with people:

- 1.8 times more likely to visit their GP;
- 1.6 times more likely to visit A&E;
- 1.3 times more likely to have emergency admissions; and
- 3.5 times more likely to enter local authority-funded residential care. Some indirect costs are a result of loneliness which causes ill-health. [17]

In turn it has been estimated that increased in demand for public services by lonely older adults could cost £12,000 per person over 15 years. By intervening to eliminate or reduce loneliness in older adults it could reduce these costs by between £770 and £2,040 over this period.

When these estimates are applied to the crude figure of 30,000 lonely or isolated people in Leicester it suggests costs of these services could be as high as £24 million per year and an effective intervention could potential save £1.5 – £5.1 million per year across health and social care services. [17] However it should be noted that these headline figures are based on a simple application of outputs from an economic model developed for Warwickshire and may not be fully representative of Leicester.

8. Interventions

Whilst loneliness and isolation is having an impact on people's health and wellbeing and has high personal and societal costs people can recover from loneliness. A range of interventions exist to tackle social isolation at individual, community and societal level.

A useful framework for these interventions has been suggested by the Campaign to End Loneliness. This suggests there are foundation services aiming to reach, understand and support lonely people, for example public sector workers, such as health staff, housing officers or the police. These services should be able to signpost or refer to direct services, such as group or individual interventions usually found in the literature and discussed below. The report also talked about gateway services such as technology or community transport and structural enablers. These can best be thought of as the

community and societal factors detailed in Figure 2, where local and central government policy can have wide ranging impacts. Examples include planning an environment which encourages older people to get out of the house, and sufficient public or community transport. [18]

Unfortunately, there is a lack of robust evidence about direct interventions. Where evidence syntheses are available they tend to show mixed results with no overall consensus on what interventions are most effective. [19] However a recent wide ranging systematic review found the following factors which were associated with the most effective interventions. [20]

- Adaptability (eg. flexibility can also mean services and support can meet the individual needs of older people)
- Community approach (eg Interventions that involved users in the design and implementation were more successful)
- Productive engagement (eg. 'Doing' things accumulates more social contacts than watching or listening to things).

We searched for recent systematic reviews of interventions and other reports and identified the following categories of interventions.

8.1. Group interventions

Group interventions have been broadly supported in the wider literature, have historically had the strongest evidence of effectiveness, and have been supported by experts where group activities engage with peoples interests.[18]

Group interventions focused on leisure activities and/or skill development including gardening, voluntary work, holidays and sports programmes. However, there was a distinction between passive (eg. watching TV or listening to the radio) and active interventions which were more effective.[20] Specific examples of effective group interventions for older populations were indoor gardening [21] or use of technology in group settings, such as playing Nintendo Wii decreased loneliness. [22]

Group-based psychological therapies such as humour therapy, mindfulness and stress reduction, cognitive and social support interventions and group reminiscence therapy, were reported as successful on the whole in reducing loneliness and in some cases social isolation in older people. Although the evidence from other studies suggests the effectiveness of reminiscence therapy is mixed.[20, 23–25]

8.2. Individual interventions

Befriending interventions can be defined as a form of social facilitation with the aim of formulating new friendships. Both person-to-person and telephone befriending (such as Silver Line) have been found to be effective in reducing loneliness. However there can often be associated challenges such as volunteer recruitment.[20] Owning animals or other animal interventions have also been found to be effective. This includes use of robotic animals; however these were less effective than live pets. [20, 26]

Further individual interventions include volunteering which is associated with better health, lower mortality, better functioning, life satisfaction and decrease in depression.

The National Institute for Health and Care Excellence (NICE) guidance endorses community engagement as a strategy for health improvement. However whilst this is likely to reduce loneliness there is not a guarantee of reduced isolation for participants.[27]

8.3. Use of technology

The growth of the internet has altered how people communicate and may be linked with increased loneliness. However, information communication technology (ICT) may also reduce isolation where people have access to the internet. An AGE UK survey found that 28% of responders over 65 years who were lonely said that keeping in contact with family and friends via the internet helped reduce isolation.

The wider literature on ICT is limited with a recent systematic finding only four high quality studies. ICT had a mixed effect on loneliness but reduced isolation in the elderly through four mechanisms: connecting to the outside world, gaining social support, engaging in activities of interests, and boosting self-confidence. However the authors noted that not all elderly groups responded to technology in the same way and more evidence is needed to target appropriate interventions effectively.[26, 28]

8.4. Health and social care provision

These interventions involved health, allied health and/or social care professionals supporting older people and usually enrolment in a formal programme of care or support with most proving effective at reducing isolation and loneliness. [20] Other examples include social prescribing; where primary health care staff can direct lonely or isolated people to effective interventions.

8.5. Local work

A wide range of services and direct interventions exist in Leicester. A key example is the Lottery Funded Leicester Aging Together Group which is working to co-ordinate and evaluate 16 interventions to reduce isolation across three Wards in Leicester, with city wide delivery to older people with hearing loss, African Caribbean older people and older people who find it difficult to leave their homes. The evaluation is being conducted by The University of Nottingham; however results are not yet available. Initial findings from the first year of the five-year project suggest reaching isolated individuals can be challenging as many lack the confidence to engage with services.

In summary interventions that build community based social networks and promote shared values and trust within the community have been shown to benefit individuals, communities, and service providers. A recent Public Health England report highlighted the lack of a menu of effective interventions however it did make that point that successful interventions to tackle social isolation reduce the burden on health and social care services. As such they are typically cost-effective.[5]

9. Conclusions

Social isolation and loneliness both impact on the health and wellbeing of people livening in Leicester, increase health inequalities and drive service use. At least some of this burden is avoidable if it is recognised that loneliness and isolation are inter-related to broader questions about community and participation and building resilience in neighbourhoods.

Within the current context of limited resources work on social isolation and loneliness needs to be part of wider local authority efforts to build on existing social networks and

resilience within communities. This may be best achieved by targeting current policies and initiatives that may impact on areas highlighted in Figure 2 to address social isolation and loneliness. Helping to build a better environment, with active communities.

The delivery of direct interventions could also be altered to adopt a new structure where council staff and other public, private and voluntary sector works who are public facing aim to reach, understand and support lonely people, especially those who appear lonely or isolated and lack confidence to engage services. These workers could then be encouraged to refer people to a menu of services available in the public and voluntary sectors within Leicester.

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5. Financial, legal and other implications

5.1 Financial implications

For information only – no financial implications

5.2 Legal implications

For information only – no legal implications

5.3 Climate Change and Carbon Reduction implications

For information only – no climate change implications

5.4 Equalities Implications

As detailed above loneliness and isolation impact different sections of the population to different extents. Reducing the health and wellbeing impact of loneliness and isolation will reduce health inequalities and improve equality in the population.

5.5 Other Implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

No other implications

Appendix: Search Methods
The search strategy aimed to identify high quality recent systematic reviews with or without meta-analyses of interventions aimed at reducing loneliness or isolation. The Cochrane Library and PubMed data bases were searched on 26th October 2016.

Both free text and controlled vocabulary searches were conducted using terms for loneliness and social isolation. Search terms were adapted for each database and a non-systematic grey literature search was also conducted. An example search string is provided below:

(social AND (isolate[Title/Abstract] OR isolation[Title/Abstract] OR isolated[Title/Abstract])) OR lonely[Title/Abstract] OR loneliness[Title/Abstract] OR "Loneliness"[Mesh] OR "Social Isolation"[Mesh]

Inclusion criteria included:

- Studies publish in previous five years
- Studies in English
- Systematic reviews or evidence reviews, health needs assessments and organisational reports (grey literature).
- Studies looking at interventions effective at reducing isolation or loneliness

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	LSCB Annual Report
Presented to the Health and Wellbeing Board by:	Steven Gauntley, HoS Safeguarding Unit Janet Russell, Interim LSCB Manager
Author:	Janet Russell, Interim LSCB Manager

EXECUTIVE SUMMARY:

This report is presented to the HWBB as:

It is required that the LSCB annual report is presented through the Leicester City Council's own scrutiny arrangements and other strategic partnerships.

The LSCB needs to hold agencies to account and ensure that the delivery of safeguarding services for children and young people in Leicester are effective.

Between the 14 January – 4 February 2015 Leicester City underwent an OFSTED Inspection of services for children in need of help and protection; children looked after and care leavers and Review of the effectiveness of the local safeguarding children board (LSCB). The Overall judgement for Children's Services and the LSCB was inadequate.

An identified area for improvement to be undertaken by the LSCB is as follow:

Produce an Annual Report that is consistent with all the requirements of Working Together (March 2013).

This is the second annual report since the OFSTED inspection 2015. The LSCB annual report reflects on the ongoing developments relating to core business and priorities identified from the outcome of the OFSTED inspection. In 2014/2015 LSCB Annual report and business plan outlined six priorities:

1. Post Ofsted Improvement Plan
2. Core Business and Governance
3. LSCB Identified Themed Priorities
    a. Evaluating Early Help
    b. Strengthening CSE
    c. Female Genital Mutilation
    d. Neglect
    e. Voice of the Child
    f. Domestic Violence
4. Participations and Engagement
    a. Voice of the Child

b. Engagement with Frontline Practice
5. Effectiveness of Multi-agency Practice
6. Children's Workforce Development Issues

Key areas of progress achieved against each of these priorities are as set out in the annual report. In summary this includes the following:-
The LSCB has conducted multi agency audits, increasing the number and quality of audits with the golden thread of early help, voice of the child and views of practitioners integral to the process. The findings have informed training and suggestions regarding practice improvements.

The LSCB has commissioned four serious case reviews during 2015/2016 and an alternative learning review. The learning has been embedded into learning, policy and procedural developments.

Two safeguarding practitioner events in April 2015 and September 2015 took place, with specific emphasis on cascading the learning from audits and reviews which specifically relate to policy and procedural change and embedment into practice on a range of areas. This included:

- Resolving Practitioner Disagreement and Escalation
- Recognition and assessment of Female Genital Mutilation,
    - The completion of refreshed LSCB FGM Safeguarding Procedures and disseminated to frontline practitioners and launch in September 2015
    - FGM Training and briefings to frontline practitioners
    - Schools and public awareness campaign and Dr Sethi's YouTube video.
    - Mini 'Engagement Summit' with young women from the Somali community.
- Managing Risks associated with CSE, Trafficked and Missing
    - Including campaign work schools; theatrical programme - 'Chelsea's Choice'
    - A local authority data set has been established and key information is emerging.
    - A successful partnership bid of £1.23 million to the Strategic Partnership Development Fund (SPDF) of the Police and Crime Commissioner
- Responding to Neglect
    - Update of the LLR LSCB neglect procedure
    - Development of a multi-agency Neglect Strategy and Toolkit and training programme
    - Practitioner survey undertaken re confidence in identifying and responding to neglect
    - Inclusion of child's views of neglect and services
    - MACFA undertaken

Significant work has been undertaken to ensure the robustness in the LSCBs assurance and effectiveness work. A quality assurance and performance management framework was developed. LSCB partners agreed a core dataset and the process for managing data returns by their agency. Work continues to be progressed to ensure partners remain able to provide consistent information to assure the Board of the impact services are having on outcomes for children.

Participation and Engagement

Significant work has been undertaken to ensure that the LSCB has access to the views of children and young people about their experience of services, including those who are involved personally in safeguarding action and also young people in general. This includes:

- Hate Crime Conference and consultation on the LSCB participation strategy
    - Attended by 70 plus children and young persons from across the City
- Development of LSCB Multi-agency Participation and Engagement Strategy
- Children and Young People Shadow Board arrangements developed
- Development of the Multi-Agency Safeguarding Practitioner Development Forum

LSCB Business Delivery Plan 2016-2018

The development of previous LSCB Business Improvement and Delivery Plan 2015-2017 was informed by the outcome of the Ofsted Inspection 2015 and its associated recommendations and a number of priorities identified by the LSCB and its sub-groups. It was identified that there was a need to review the LSCB Business Plan and priorities with an aim of streamlining the LSCBs activity and making it more robust.

The Improvement Notice from the Department for Education has been overseen by the LCC Improvement Board. The current LSCB Business Plan 2016-2018, does take account of the improvement plan, and going forward, the need to ensure it is effectively preparing for the transition of arrangements from the LCCIB to the LSCB.

The LSCB Business Delivery Plan 2016-2018 will be subject to review/renewal in 2018. Keeping to this schedule assures the Board that future business plan development remains aligned to that of the review of the LCC Children's Trust, Children and Young Peoples Plan.

The business plan is much more focussed and presented in a simpler format to allow for effective monitoring and tracking of its implementation. The implementation of the plan will be monitored by the Executive Chairs Group at each meeting. This will include an appropriate RAG rating on progress; where it is identified swift action will be taken on any delays or risks to implementation. A progress report on each priority area will be presented to the LSCB meetings. The sub groups will be responsible for operational delivery of the business plan. Sub-group chairs will devise related delivery plans to ensure the work is driven in line with the business plans expectations.

Strategic Priorities in September 2016 – March 2018

The business priorities for 2016-18 for the LSCB have been agreed in response to the Ofsted Inspection findings, partner engagement in the 'Big Conversation' and from the LSCB Effectiveness Review. In addition to the LSCB's core functions and responsibilities, the LSCB has identified four priorities. They are:

1. *The LSCB is to be assured that there is evidence to consistently demonstrate that children and young people are effectively safeguarded.*

2. *To be assured that 'Early Help' services are accessed and delivered effectively and thresholds are understood and applied consistently.*

3. *LSCB is to be assured that there is a culture of continuous system of single and multi-agency learning and Improvement.*

4. *LSCB is to continue to improve its governance, performance and quality assurance process and to be assured of the effectiveness of the LSCB.*

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

1. To note the content of the report
2. Key messages are disseminated to staff and that a priority is given to discuss the Annual Report in team meetings and service briefings in order to raise the profile of the LSCB and ensure the role of the LSCB is understood.
3. Provide assurance to the LSCB that the above activity has been undertaken.

Leicester City Council

Leicester Safeguarding Children Board

Annual Report

2015-2016

Janet Russell
Report Author & LSCB Interim Manager

Version	Date	Author	Changes
V0.8	27/10/2016	JR	Incorporated suggested changes from LSCB & Ratified 08/09/2016
V0.9	03/11/2016	JR	Incorporate changes from SMT 31/10/2016

CONTENTS

Jenny Myers MA CQSW ASW
Independent Chair Leicester City LSCB

Welcome to the Annual Report of Leicester City LSCB. As the new chair of the Safeguarding Children Board, it is my privilege to have taken over responsibility for chairing the LSCB and to continue the journey of improvement work to ensure that the children of Leicester are effectively safeguarded.

The report presents a summary of the key achievements, challenges and reflections on the work of the Safeguarding Board and wider partnership under the previous chair Dr Jones and ends with a summary of those challenges and revised strategic key priorities that we will be working to over the next year.

1. Foreword

Dr David N Jones
Former Independent Chair, LSCB Leicester

This 2015-16 report is my final annual report; I handed over the Chair in May 2016 having completed two terms of three years. This foreword and report is mainly concerned with the past 12 months, whilst my successor, Jenny Myers, provides the forward view.

The 2014-15 report covered the year which concluded with publication of the Ofsted inspection which judged the LSCB to be 'inadequate'. Have there been significant improvements in 2015-16? Over the 12 months of this report, the LSCB worked closely with the Improvement Board, set up by the Department for Education and chaired by Tony Crane, to monitor and support improvements in multi-agency working in general and Children's Services in particular. I am pleased that we can point to significant service improvements, whilst recognising that there is further to go.

The LSCB did not challenge the judgement of the Ofsted inspection. The main reason for the 'inadequate' judgement was that the LSCB partners had not developed sufficiently robust arrangements for monitoring the quality of safeguarding work across the partnership. The inspection report also noted significant staffing challenges in Children's Services, which contributed to inconsistent and frequently poor assessments and highly inconsistent service quality, and was critical of the lack of engagement with children and young people and with front-line staff. The inspection was complimentary about a number of other elements of the work of the Board, including up-to-date procedures, multi-agency training and good working relationships between Board members and with the Leicestershire and Rutland LSCB.

Some of the weaknesses in service delivery were confirmed in findings of Serious Case Reviews undertaken during the past year, two of which were published in May 2016. Other reports are awaiting the outcome of criminal proceedings. These cases all dated from the period before the inspection. The SCRs highlight the need to strengthen pre-birth assessments; new guidance about this was launched at a multi-agency staff conference in April 2016 and further training is being provided.

As reported last year, the LSCB had identified most of the problems highlighted in the inspection during the months before the inspection, had already reviewed its internal workings and was implementing a work plan to strengthen performance monitoring, but it was too early to be able to demonstrate impact during the inspection. The agencies, which make up the Board were therefore well placed to take up the challenge from the inspection during the early part of 2015. The Board engaged nationally respected consultants to work with us to improve performance monitoring, agreed a new performance monitoring framework and established working groups to promote improved multi-agency working in a number of areas, including cases of neglect, child sexual exploitation, female genital mutilation and assessment of mothers and young babies at risk.

National and international research clearly shows that re-establishing high quality, multi-agency services after significant service problems takes time (Barnes 2003; Barnes and Gurney 2004; Association 2013; Bryant, Parish et al. 2016; Wajzer, Ilott et al. 2016). This requires strong leadership and determined work within each of the individual agencies as well as jointly across the partnership. Over the past year evidence shows that the leadership has been evident and the quality of services for families has improved, but we know that work with families and children is not consistently good and there is more to do, including building a stable and well supported workforce.

The LSCB and its member agencies remain committed to developing the best possible services for children and families in the city. We cannot guarantee that there will never be problems - managing risk in safeguarding services is not a science. Ultimately parents and those caring for children are responsible for keeping them safe, supported by local services when necessary. I have seen that Board members are determined to support continued improvements in services, to do all they can to support Leicester parents to provide good care for their children and to make Leicester a safe city for all.

This report marks the end of my six years of service to the city and people of Leicester. It has not been an easy journey and this report illustrates progress made and the tough challenges still to be overcome. I am grateful for the support provided to me by the City Mayor, the former PCC, the Director of Children's Services alongside chief officers in all the partner agencies and by the two Board Managers with whom I have worked and the staff of the LSCB office. I recognise the commitment of all those working with children and young people in the city who take their safeguarding responsibilities seriously and work round the clock to protect children. Above all, I have been encouraged to see the growing confidence of the young people on the shadow LSCB and supporting the work of the Board in other ways. The strong voice of children and young people is essential to keep the Board focussed and effective. I wish them well, as well as the thousands of people working with children and families across the city.

2. Governance and Accountability Arrangements

The LSCB is a statutory 'partnership arrangement' involving most of the local agencies working in different ways with children and their families. Board members are senior representatives of these organisations and agencies.

The role of the LSCB is to co-ordinate the activity of all agencies in the City aiming to keep children safe in Leicester and monitoring and evaluating how effective this has been. The Board achieves this through: writing, and reviewing policy and procedures and ensuring that these are followed in practice by all those working with children and families in the city; evaluating the work that is undertaken on a single and multiagency basis through quality audits and case reviews as well as gathering statistics and other data within an overarching performance monitoring framework; providing and commissioning multi-agency training; reviewing all child deaths including those where appear to be concerns about practice and providing information for the public. The formal functions of the LSCB are set out in statutory guidance: Working Together to Safeguard Children 2015 (HM Government 2015).

The LSCB is required to publish an annual report to inform the public about the effectiveness of the multi-agency safeguarding arrangements for children in Leicester.

LSCB Independent Chair

The Independent Chair is accountable to the Chief Operating Officer (COO) of Leicester City Council, acting on behalf of and in consultation with the statutory partners. The Chair held regular meetings with the COO, the Assistant Mayor for children and also the Strategic Director of Children's Services, and senior officers from member agencies. The Chair has access to and can hold to account chief officers and strategic leads from all partner agencies as and when this is required.

In March 2015, following the OFSTED inspection, Leicester City Council (LCC) and the LSCB became subject to improvement measures. The Independent Chair is a member of LCC Improvement Board (LCCIB). The LSCB Chair has had regular consultation with the Chair of the LCCIB. The LCCIB received monthly reports on progress from the LSCB.

LSCB Partner Agencies

The statutory and non-statutory agencies represented on the LSCB include City Council representatives from relevant departments, Police, NHS England, Clinical Commissioning Group (NHS), Leicestershire Partnership Trust (NHS), University Hospitals Leicester (NHS), schools and colleges, National Probation Service, CAFCASS, Voluntary and Community Sector representatives and a statutory Lay Member *(See Appendix 1)*. LSCB Members are required to:

- consult with and speak for their organisation with authority
- disseminate information and commit their organisation on policy and practice matters
- hold their organisation to account
- challenge their own and other agency on any issues that impact on the performance of children's safeguarding
- make the LSCB's assessment of performance as objective as possible

Lay Member

The LCC Lay Member is a full member of the LSCB, participating in Board meetings and serving on relevant sub-groups. The Lay Member should help to make links between the LSCB and community groups, support stronger public engagement in local child safety issues and an improved public understanding of the LSCB's child protection work. In the past year, the Lay Member served on the Safeguarding Effectiveness Group as a Non-Executive member.

Joint Working Arrangements

The Leicester City and the Leicestershire and Rutland LSCBs (LLR) continue to work closely on policy, procedures, training and development and work that affect services and practice across the three authorities and the children's workforce. The LLR partnership maintains the development/revision of the multi-agency safeguarding procedures and last year successfully progressed work relating to female genital mutilation, child neglect and child sexual exploitation (CSE) and the views of children and young people. Closer joint working on performance monitoring, assurance and communications was also developed during the year.

Relationship with other Partnership Structures

The LSCB has links and formal protocols with other partnership structures, including the **Children's Trust**, **Health and Wellbeing Board**, **Local Safeguarding Adults Board, Family Justice Board, Young Offender Management Board, Corporate Parenting Board** and **Safer Leicester Partnership** in order to:

- Contribute a safeguarding perspective to the work of that partnership
- Strengthen the effectiveness of the arrangements made by that partnership to safeguard and promote the welfare of children.
- Identify any crossover issues which should be jointly addressed

On the following page you will see a chart which illustrates the LSCBs relationship with other Strategic Partnership Boards in Leicester.

LSCB Relationship with other Strategic Partnership Boards

CHILDREN'S TRUST BOARD

Set the strategic direction for improving outcomes for children and young people. This Board oversee the delivery of the Children & Young People's Plan.

LOCAL SAFEGUARDING ADULT BOARD

Co-ordinate the safeguarding activities of its partner agencies and evaluate what they do

HEALTH & WELLBEING BOARD

Key leaders from health and care system work together to improve the health and wellbeing of the local population and reduce health inequalities

FAMILY JUSTICE BOARD

The FJB aims to work collaboratively to improve performance and efficiency within the local family justice system and beyond

YOUNG OFFENDER MANAGEMENT BOARD

The YOMB is responsible for ensuring that the local YOS partnership fulfils its statutory duties including its Safeguarding responsibilities and any lessons arising from serious incidents involving for children and young people in the criminal justice system.

CORPORATE PARENTING BOARD

Corporate Parenting refers to the partnerships between the local authority departments, services and associated agencies who are collectively responsible for meeting the needs of looked after children, young people and care leavers.

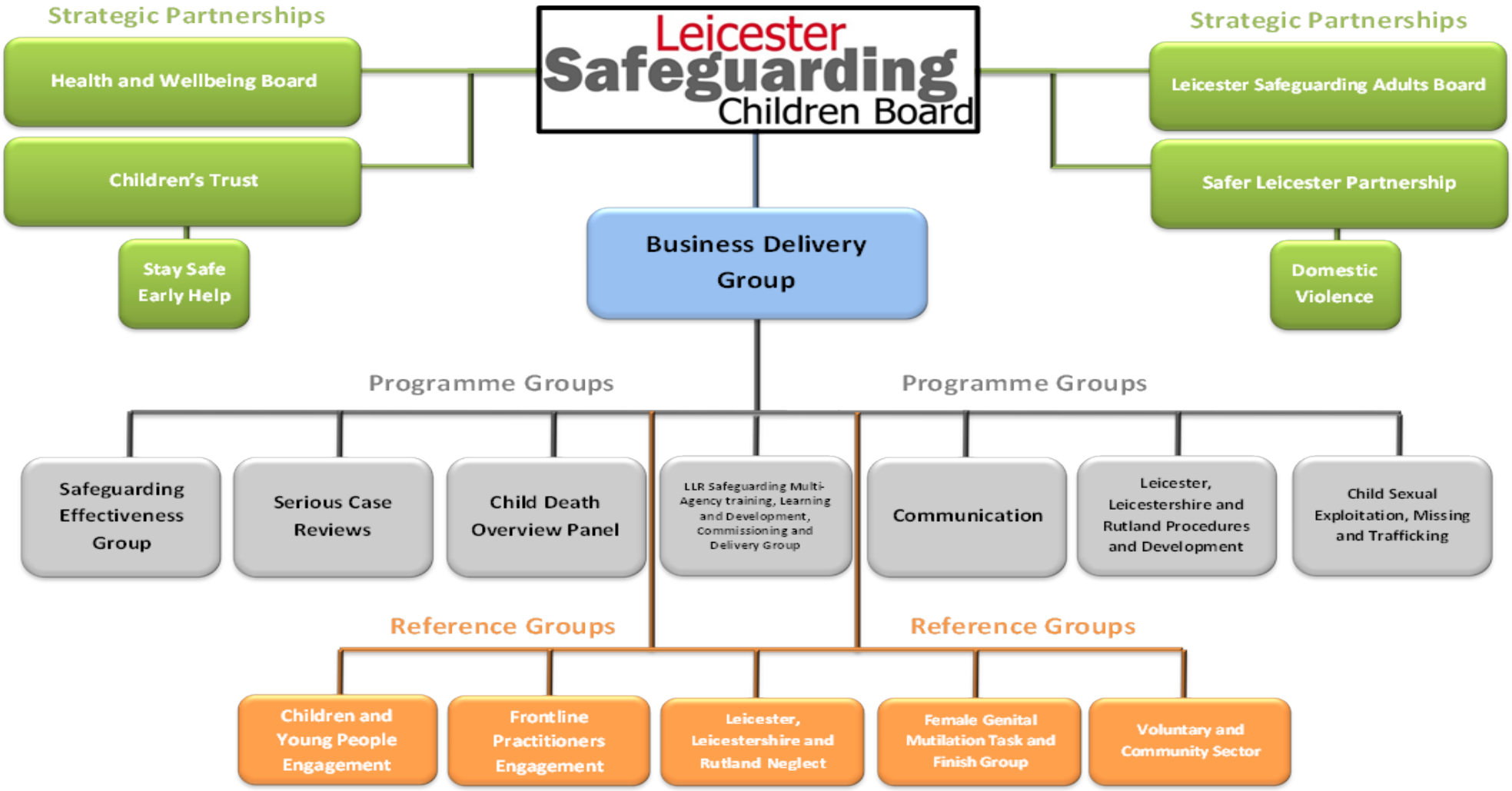
SAFER LEICESTER PARTNERSHIP

Brings together a number of agencies and organisations; its objectives and priorities are to reduce crime and antisocial behaviour, reduce alcohol related harm, domestic violence and sexual abuse and reduce adults and children's re-offending

LEICESTER SAFEGUARDING CHILDREN BOARD

Ensures that all partnership structures work together to safeguard and promote the welfare of children & young people

3. LSCB 2015 - 2016 Structure



4. LSCB Budget 2015 - 2016

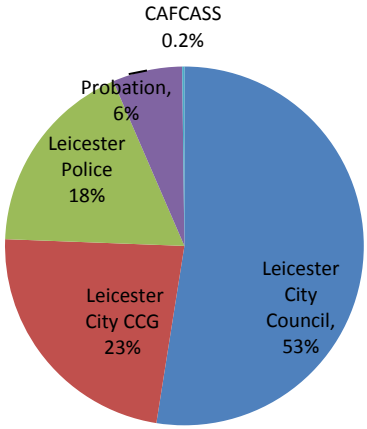
Working Together (2015) details that the budget for each LSCB and the contribution made by each member organisation, should be agreed locally. The member organisations' in Leicester shared responsibility for the discharge of the LSCB's functions includes shared responsibility for determining how the necessary resources are to be provided to support it.

The LSCB requires an annual budget to include the cost of training and development on a multi-agency basis, to enable it to carry out its agreed business plan objectives, which also includes the cost of Serious Case Reviews, where necessary.

The financial year commences on 1st April until 31st March each year.
Leicester City Council is the accounting body for the LSCB Budget
The LCC, Head of Service, Safeguarding Unit is the Cost Centre and Budget holder.

Partner agencies' contributions 2015/2016

	£	%
Leicester City Council	129,030	52.5
Leicester City Clinical Commissioning Group	56,759	23.1
Leicestershire Police Force	43,944	17.9
National Probation Service	15,556	6.3
CAFCASS	550	0.2
TOTAL	**245,839**	



Partner agencies also provide significant support to the LSCB
through contributions in kind, in particular the release of a significant amount of staff time, without which it could not operate.

Expenditure exceeded income for the first time since the City LSCB was formed in 2010.

The overspend was largely funded from accumulated underspends from previous years and additional contributions. The additional expenditure was the result of three main factors. 1) The partners supported five Serious Case Reviews (SCRs) during the year, some of which will be published in 2016-17 (see Section Strategic Priority 5). The need for SCRs is unpredictable and the Board had therefore accumulated reserves to meet additional costs. 2) The Interim Board Manager was appointed in January 2015 and recruitment to a permanent post was delayed to avoid disruption during the early phase of the Improvement programme. It then proved difficult to recruit a suitable candidate, resulting in several months of unplanned additional staffing costs. 3) A small number of consultancy days were commissioned to support the improvement in performance monitoring.

5. What does Leicester look like?

Leicester is the largest city in the East Midlands and the tenth largest in the country. It has a population of 330,000 (509,000 living within the wider urban area). Leicester also has the largest proportion of under 18 year olds in the East Midlands compared to neighbouring cities. There are approximately 80,750 children and young people under the age of 18 years (24% of the total population).

Leicester is an exciting, vibrant and forward looking city with a diverse population and a large and growing number of children and young people. The city and metropolitan area is culturally diverse, 59% of the city population comes from minority ethnic groups, with well-established South Asian and African Caribbean communities, in addition to more recent arrivals from European Community countries, amongst others.

Leicester is the 20th most deprived local authority in England, with almost half of the population living in areas of very high deprivation.

Leicester is a major centre of learning: the University of Leicester is recognised for the quality of its teaching and research; De Montfort University is very well regarded in many of its specialist fields and has worked together with the LSCB and other strategic partnerships to promote partnership working and a whole family approach to the safeguarding agenda.

Sir Peter Soulsby became the first directly elected Mayor of Leicester on 5 May 2011; he was re-elected for a second term in May 2015. Sir Peter Soulsby appointed Rory Palmer as Deputy Mayor and Sarah Russell as Assistant City Mayor for Children.

There are 54 councillors represent 21 wards across the city: they were voted in at local elections. The council is controlled by the Labour Party, which has 52 seats.

Leicestershire Police provides the policing service to the people of Leicester, Leicestershire and Rutland, covering over 2,500 square kilometres (over 965 square miles) and a population of nearly one million. Sir Clive Loader stood down at the end of his four year term as Police and Crime Commissioner in May 2016, having worked with the LSCB to strengthen the response to child sexual exploitation and other aspects of safeguarding.

Health services in the city are commissioned by the Leicester Clinical Commissioning Group with some specialist services commissioned by NHS England. During this period commissioning of health visiting and school nursing transferred from the CCG to the City Council public health service. The main health care providers are Leicestershire Partnership NHS Trust (community services) and University Hospitals of Leicester NHS Trust, all of whom are represented on the LSCB.

A new probation service structure came into being during the year. The National Probation Service is a statutory criminal justice service that supervises high-risk offenders released into the community; it is represented on the LSCB. Community rehabilitation companies (CRCs) manage low and medium risk offenders; the Derbyshire, Leicestershire, Nottinghamshire & Rutland Community Rehabilitation Company is based in Birmingham and was not represented on the LSCB during the year.

6. How did we make a difference to the children and young people of Leicester during 2015/2016?

This is the second annual report since the OFSTED inspection 2015. The LSCB annual report reflects on the ongoing developments relating to core business, priorities identified from the LSCB development day held in September 2014 and the outcome of the OFSTED inspection.

The LSCB Annual Report 2014/2015 outlined six strategic priorities. The LSCB Business and Delivery Plan 2015-2018 incorporates both the recommendations from the OFSTED inspection report and the LSCB strategic priorities.

OFSTED
Priority and immediate actions for the LSCB

1. Establish and implement a robust performance management framework and dataset that can enable the Board to exercise scrutiny of service effectiveness and outcomes for children.
2. Monitor the effectiveness of statutory services and practice provided to children in need of help and protection.
3. Establish a clear line of sight and reporting from front line practice to the Board

Areas for improvement
Scrutiny, awareness and challenge

4. Ensure that the information reported to the Board contains challenging analysis that enables members to identify the key priority areas for improvement and generate an effective Business Plan.
5. Increase the number frequency and range of multi-agency audits initiated by the Board.
6. Produce and implement a plan to engage with children and young people in order to hear and act upon their voice.

Areas for improvement
Quality and evaluation

7. Produce an Annual Report that is consistent with all the requirements of Working Together (March 2013).
8. Evaluate the current operation of the early help offer, including partners understanding and implementation of their early help responsibilities and the understanding and application of service thresholds.
9. Ensure that an evaluation of the impact of recent CSE initiatives relating to prevention, protection, prosecution and disruption is undertaken and that the right support is being made available to victims.

LSCB Strategic Priority Areas
The key priority areas for 2015–17 are:

1. Post Ofsted Improvement Plan
2. Core Business and Governance

The strategic priority areas for 2015–17 cont/d

3. LSCB Identified Themed Priorities
   a. Evaluating Early Help
   b. Strengthening CSE
   c. Female Genital Mutilation
   d. Neglect
   e. Voice of the Child
   f. Domestic violence

The strategic priority areas for 2015–17 cont/d

4. Participations and Engagement
   a. Voice of the Child
   b. Engagement with Frontline Practice
5. Effectiveness of Multi-agency Practice
6. Children's Workforce Development Issues

6.1
STRATEGIC PRIORITY 1

The themes emerging from the Ofsted inspection identified 5 key areas for improvement. They are:

1. **Governance and Board Functions**
2. **Engagement of Children, young people and families/carers**
3. **Engagement with frontline practice**
4. **Early Help**
5. **Performance Management**

The LSCB reviewed its work priorities to ensure that effective oversight of core child protection business was in place and that regular oversight is maintained of the areas for improvement identified by inspection so as to ensure good and timely progress in all areas for improvement.

The priority improvement areas were embedded within the LSCB business plan as well as being subject to a separate improvement plan which was overseen by the Leicester City Council Improvement Board.

6.2
STRATEGIC PRIORITY 2

The core business of the LSCB supports and sustains the strategic priorities which are focussed on the needs of Leicester's children and young people. This section reports on activity to sustain the infrastructure.

An effective LSCB is one where all partner agencies feel able to fully participate and engage in the business of the Board. Following the Ofsted Inspection LSCB Partners has remained committed and motivated to improving the partnerships strategic position and has focussed on improving its challenge and scrutiny of the single and multi-agency response to safeguarding children.

The core business is supported by chairs of sub-groups, key staff from different agencies and the LSCB office staff. The number of sub-groups and project groups which need sustained support is evident in this report; the activity reflects the need to deal with local priorities whilst also responding to emerging national priorities such as FGM. Contributions of senior officer time and the time of safeguarding specialists from all agencies is becoming more difficult as financial pressures and reductions in management severely reduce the capacity of all agencies to contribute to multi-agency working. Partnerships depend on the time of individuals to build relationships and sustain joint work. Effective safeguarding depends on sustained partnership working at all levels and is therefore jeopardised by the reductions in management capacity in all agencies.

The Interim Board Manager was appointed at the beginning of 2015 and continued in post throughout this year. Janet Russell provided knowledgeable, reliable and consistent support to the Board and the Chair. It was judged prudent for her to remain in post for the early part of the post-inspection improvement plan. An attempt to recruit to the permanent post towards the end of the year was not successful. This has had a financial impact on the Board. There were a number of other changes in staffing in the Board office. The LSCB appointed independent consultants who provided helpful assistance with developing the performance monitoring framework and indicator set.

A LSCB Induction Booklet was produced for members and practitioners to ensure that the role and function of the LSCB and expectations on members was fully understood.

The Board has ensured that there is the right representation within the LSCB and its associated sub-groups. The sub-group developments have ensured that there was an improved throughput of delivery on the LSCB Business Plan.

The Board partners have worked closely with the LCC Improvement Board to ensure there is robust oversight and progression of its improvement plan. The LSCB had produced an Improvement and Business Plan which incorporates the OFSTED recommendations.

LSCB Partners have given a particular focus to strengthening the arrangements relating to the 'Performance Management and Quality Assurance Framework. Partners agreed the set of indicators which would be used to measure progress and best suit and inform the identified priorities. A golden thread in this framework is the emphasis on the participation and engagement of Children Young People and their Families and that of Frontline Practitioners.

The Safeguarding Effectiveness Group was chaired by a senior officer from the CCG and was well represented by key statutory partners including Children's Services, Police, Leicester Partnership Trust, CAFCASS and Probation with the full Board being informed of any issues which have arisen.

With reducing budgets, staff instability one of the greatest challenges to LSCB partners is to assure themselves that what they are doing is done well and is really making a positive difference to children's lives.

6.3
STRATEGIC PRIORITY 3

This section provides an overview of information that relates to all children in Leicester. Some of these children and young people will have multiple needs and vulnerabilities, those worth noting will be highlighted below. In addition these children may feature amongst the cohort of children of which the LSCB as identified as a themed priority.

The priorities include focus on the themes stated below which have been identified from a range of sources, such as 'National' agendas, learning from reviews, local practice issues and local performance and assurance data.

a. Evaluating Early Help
b. Strengthening CSE
c. Female Genital Mutilation
d. Neglect
e. Voice of the Child
f. Domestic violence

Overview

The Office for National Statistics mid-year population estimate (2014) for 0-17 year-olds in Leicester was 80,750.

The January 2016 school census identified around 55,900 pupils in schools.

Around 17% in primary were eligible for free school meals and 52% had a primary language other than English. Corresponding figures for secondary were 18% and 50%.

2.6% of all pupils had a statement of special educational need or an Education, Health and Care plan, slightly higher than the regional average but comparable to the level in statistical neighbours.
17.7 % of children are in receipt of free school meals
51% of children have English as an additional language
10.5% of reception children are identified as being obese
22.1% of year 6 children are identified as being obese

Levels of young people not in education, employment or training (NEET) 6.3% were higher than national, regional and statistical neighbours.

413 children and young people were identified as being disabled during this period.

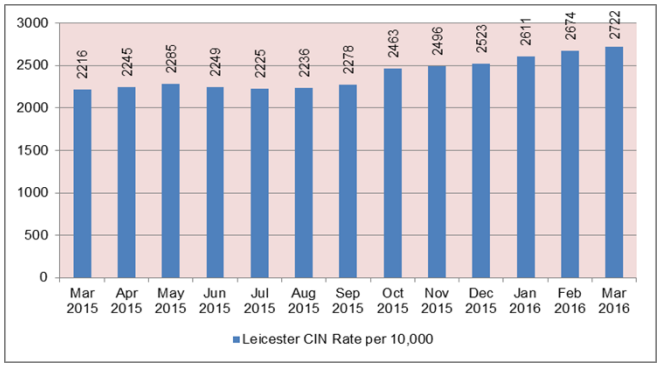
Vulnerable Children and Young People

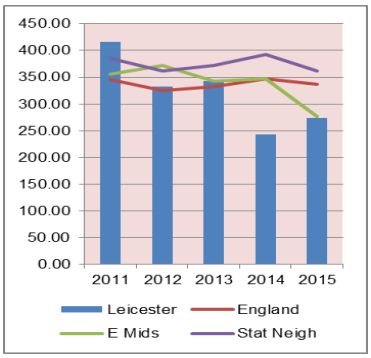
Working with the most vulnerable children - tracking the experiences of children through the journey of safeguarding systems and processes, beginning from Early Help, Child in Need, Child Protection, Looked After Children (LAC), leaving care and post care support.

Children in Need

Internal figures showed that there were 2,722 children in need at the end of March 2016. In addition to children being supported through a CIN plan, this includes children on child protection plans, looked after children, care leavers and those working with the Disabled Children's Service. The year-on-year change of 500 showed a 23% increase. The end of March figure is equivalent to 337 per 10,000 children.

Levels have risen throughout the year after DfE validated figures showing a downward trend between 2011 and 2015. 2016 comparable rates are not yet available.



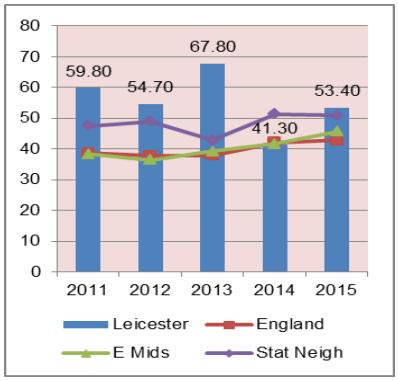


Over the year the cohort included 5,372 children and young people. There were over 3,200 starts and around 2,650 episodes ended during the year. Some of these were multiple starts/ends for the same child.

Children subject to Child Protection Plan (CPP)

Children who have a Child Protection Plan (CPP) are considered by Partner Agencies to be in need of protection from either neglect, physical, sexual or emotional abuse, or a combination of one or more of these. The CPP details the main areas of concern, what action will be taken by the family, social worker and supporting agencies to reduce these concerns and, how we will know when progress is being made.

At the end of March 2016, 518 children and young people were the subject of a child protection plan. This is an increase of 19.9% from 432 at 31 March 2015.



Whilst being volatile, levels in Leicester were previously on a slight downwards trend since 2011. 2015 rates were higher than national, regional and statistical neighbour levels. 2016 comparable rates are not yet available.

Neglect (43%) remained the most prevalent category of abuse for all 949 cases open over the year, followed by emotional (32%) and physical (22%).

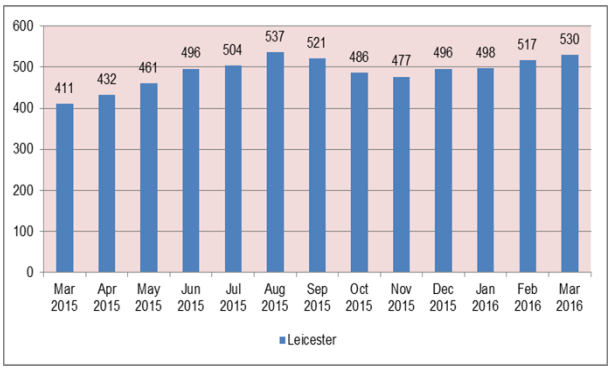
Between April 01 2015 and March 31 2016 521 child protection plans were started, with just under 22% for children previously on a plan and just over 4% for children previously subject to a plan within the last 12 months. Each group of those aged 1-4, 5-9 and 10-15 contributed around a quarter of all started plans. Girls (53%) were more likely to have a plan started than boys.

Between April 01 2015 and March 31 2016 431 child protection plans were ended. The average length of ended plan was 270 days. Girls (49%) were less likely to have plans ended than boys.

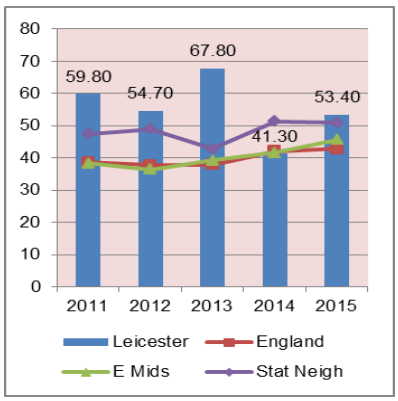
Looked After Children (LAC)

Looked After Children are those looked after by the Local Authority. Only after exploring every possibility of protecting a child at home will the Local Authority seek a parent's consent or a Court decision to move a child away from his or her family. Such decisions, whilst incredibly difficult, are made when it is in the best interest of the child.

Internal figures showed that there were 638 Looked After Children at the end of March 2016. This is up by 73 from the DfE validated figure of 565 on March 31 2015; an increase of nearly 13%. The final figure is equivalent to 79 LAC per 10,000 children.



Levels have risen consistently over the year after DfE validated figures being relatively stable between 2011 and 2014. 2016 comparable rates are not yet available.



There has been a rise in the numbers of Looked After Children. Reasons include the Local Authority continuing to applying for more Care Orders and the number of children and young people leaving care decreasing. There a high numbers coming into care between 12 and 16 years. This mirrors the national trend. External inspection, the courts and our own audit have concluded that the threshold applied for care is correct at the time of children and young people becoming Looked After.

Children Leaving Care

From 1st April 2015 to 31st March 2016:

- 42 children were adopted
- 26 children became subjects of special guardianship orders
- 205 children ceased to be looked after, of whom 11 (5%) subsequently returned to be looked after
- 103 children and young people ceased to be looked after and
- moved on to independent living
- four children and young people ceased to be looked after and are now living in houses of multiple occupation.

Privately Fostered Children

Despite efforts by the Local authority and LSCB to raise awareness of the need to notify children's services of when these arrangements are in place the reported numbers remain low. In total there have been 18 private fostering arrangements known to the Local Authority in the year 2015/2016. There remains a need to consider how to increase the reporting of private fostering arrangements as these children are living in unregulated placements and are potentially open to exploitation and subject to risk. Increasing the reporting of private fostering arrangements remains a key focus for the Local Authority and this will continue to require a multi-agency approach.

Partners are reminded that parents may make their own arrangements for their children to live away from home.

A privately fostered child is a child under 16 (or under 18 if the child has a disability) who is being cared for and is living with someone else.

The carer for the child is someone who is not:

- A parent, or other person who holds parental responsibility for the child
- A close relative; for example, a grandparent, step-parent, brother or sister, uncle or aunt. (This includes relatives who are half blood, full blood or by marriage.)

Private Fostering is an arrangement where care is intended to last more than **27 days**.

Any person who is looking after someone else's child, or knows of someone who does should talk to Children's Services.

Children with Poor Emotional and Mental Health

The Child and Adolescent Mental Health Services (CAMHS) offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.

CAMHS can diagnose and treat conditions as indicated:

- Depression in children and young people (NICE guidance CG28)
- Eating Disorders (NICE guidance CG9)
- Self-harm(NICE guidance CG16)
- Post-Traumatic Stress disorder (NICE guidance CG26)
- Obsessive Compulsive Disorder (OCD) and Body Dysmorphic Disorder (BDD) (NICE guidance CG31)
- Bipolar Disorder (NICE guidance CG38)
- Attention Deficit Hyperactivity Disorder (ADHD) (NICE guidance CG72)
- Anxiety (NICE guidance CG11)
- Social and emotional wellbeing in primary schools PH12
- Social and emotional wellbeing in secondary schools PH20
- CAMHS can also diagnose and treat serious mental health problems such as bipolar disorder and schizophrenia.

There are different ways to get an appointment with CAMHS. The most common is by referral from the child's GP. Others who may be able to make a referral to CAMHS include:

- Health visitors - following discussion with GP
- School nurses - following incidents of self-harm or discussion with GP
- Social workers

CAMHs has, from the 1st June 2016, a single point of access (SPA) called 'Access' for all referrals. The centralised system has rationalised the point of access to enable improvements in multi-disciplinary, multi-agency facing hub for the management, processing and assessing of needs of children and young people.

6.3.1 Evaluation of Early Help

Interaction between early help services, child protection investigations (Section 47) and admissions to care

The LSCB has recognised the following inter-related elements from performance and assurance data:

i. Very low proportion of early help lead practitioners from agencies other than the City Council - this has remained the case for several quarters
ii. Number of Section 47 investigations – these continue to be above the average for similar areas
iii. Looked after children rate per 10,000 – there is a very significant increase in the number of looked after children and new admissions to care, with concern about the number of those aged 0-3.
iv. Pre-Birth Assessments – concerns about weaknesses in arrangements for these assessments have been identified in an audit of pre-birth assessments, a number of Serious Case Reviews and in feedback from frontline staff. Evidence from assessments shows that there are greater numbers of children requiring specialist intervention and lesser number requiring minimum intervention.

This suggests a need for more effective support to families and children at an earlier stage to prevent the escalation of problems which result in Section 47 investigations. The internal audit evidence and judicial feedback suggests that those cases which do go to court are appropriate, but that more effective intervention at an earlier stage might have reduced the risk and would probably have enabled more children to remain at home. This hypothesis requires further testing but is a sufficient basis for planning multi-agency service improvement.

The need to strengthen multi-agency understanding of and engagement with the integrated delivery of early help to families is accepted by all agencies. The City Council is engaged in active discussions with partner agencies and there have been specific discussions among head teachers and within Leicester Partnership Trust about how best to engage with this priority and the implications for service delivery.

The LSCB evaluates that there is evidence of service weaknesses in relation to early help across the partnership; this has also been identified in the LCC Improvement Board. This themed priority needs continued attention and must be addressed on a multi-agency basis.

Children's Social Care Early Help

The Council's Early Help Targeted service (Children centres, Family Support and oversees the Early Help Assessment process) monitors performance and outputs in the following ways:

a) Numbers of service users accessing the Early Help Targeted Service via the CYP&F Centres. This includes

- contacts (numbers of times the Early Help Targeted service is contacted by service users once in a set period, e.g. 12 months);
- reach (numbers of service users that made at least one contact with the service); and
- engagement (numbers of service users that have made at least 3 meaningful contacts which would result in a positive impact).

b) Numbers of short term (e.g. Home Learning/Family Support) and long term (e.g. Early Help Assessment) casework involving families who are at risk of requiring a statutory social care intervention.
c) Quantitative and qualitative data evidencing the outcomes achieved by families who have had their needs met through the early help service.
Numbers of contacts made to the Advice Point and what happened to them

Numbers of contacts made to the Advice Point and what happened to them[1]

	Numbers of contacts to the Council's Advice Point in the Early Help Targeted service	**2014/15**	**Numbers of contacts 2015/16**	**Notes**
1	Total numbers of contacts to the advice point (telephone, drop in, outreach for up to 2 sessions)	Not collected	20,236	Equates to 4,780 families 24% of contacts were made by professionals
2	Of total contacts to the Advice Point, number and percentage of total contacts resulting in no further action (NFA) Number and percentage of contacts dealt with by the Advice Point	Not collected	3,175	Equates to 791 families NFA is determined as not a relevant query or meets threshold for service e.g.) adults only, no children involved or no service required
3	Of total contacts to the Advice Point Numbers and percentage of total contacts resulting in some form of action by Advice Point (low level advice, short term work without it becoming a case)	Not collected	11,097	Equates to 2,606 families e.g. supporting with housing applications, accessing foodbank, one off session in the home on parenting techniques.

The creation of the **'Advice Points'** has been very successful for the service and popular for professionals who want to access information or gain advice about how to support a family or refer for targeted early help support. Of the **20,236** contacts made to the service via the Advice Point:

a) **50%** of families were dealt with by the Advice Point enabling families to access support at an earlier stage to **stop issues from escalating or require further support,** helping them to meet their own needs independently.
b) **16%** resulted in **no further action** due to a variety of reasons, e.g. family did not meet the Priority List criteria (refer to Appendix E) or there were no children involved in the case.

[1] Contacts refer to individual contacts but some of these could have been made by the same person a number of times.

Contacts resulting in casework and what happened to them 2015-16

	Casework Files	Individual children	Equates to no of Families	Notes
1	Total numbers of **individuals** and **families** subject to casework	5,964	1,098	
2	Numbers of individuals and families supported by **Early Help Response** (short term casework files - 6 weeks)	1,572 (26%)	376 (34%)	Of the total numbers identified in row 1.
3	Numbers of casework files **stepped up to Children's Social Care**	67 (1.12%)	20 (1.82%)	Of the total numbers identified in row 1.
4	Numbers of **Single Agency** casework files (short term casework files - 12 weeks)	3,927 (66%)	604 (55%)	Of the total numbers identified in row 1.
5	Numbers of open **multi agency Early Help Assessments** (long term casework files - 9 months +)	398 (6.7%)	98 (9%)	Of the total numbers identified in row 1.
6	Of the cases closed **(605)** by the Early Help Targeted service, percentage of families evidencing their needs were met.	n/a	454 (75%)	Families identified their needs at the start of intervention and measured distance travelled at closure.

The table above provides a range of information about **case work files** and the key points are highlighted below:

a) **Case work files can refer to three different types of work:**

- **(Refer to 2 above):** Supported by **Early Help Response** to complete a very short piece of work (less than 6 weeks), for a case stepped down from social care that requires a brief intervention, directed from the court or for young people who are missing and at risk of exploitation.

- **(Refer to 4 above): Single Agency** – 1 or 2 issues that can be supported by one worker for a short period of time (no more than 12 weeks)

- **(Refer to 5 above): Early Help Assessment**, 3 issues or more, requiring longer term support, more than one agency involved and requiring someone to be the named contact for the family to co-ordinate the support plan.

b) **29%** of all contacts to this service (as outlined in table 6, page 12) resulted in a single agency response of short term (12 weeks) or long term (9 months+) Early Help Assessment.

c) Only 67 individuals (**1.12%** of all individuals subject to casework) were **stepped up to Children's Social Care.** This suggests that the Early Help Targeted service is managing

thresholds well and that its support of families is preventing the escalation of need and the requirement for a statutory social care intervention.

d) In reviewing all case work files open to the Early Help Targeted Service, 16% came from Children's Social Care, which suggests confidence in the Early Help Targeted service to support families transitioning from social care to universal services and targeted support. This results in cases being closed by Children's Social Care.

e) **66%** of individuals subject to casework were supported through **short term work** with the minority of families being supported by a **longer term** multi agency intervention lasting approx. 9 months or more.

f) Of the **605 cases closed** to early help services, **75%** of families stated that their **needs had been met**. Data is not available to determine if any of these closed cases were subsequently **re-referred** to the Early Help Targeted service or Children's Social Care.

Interface between Early Help and Social Care

	Direct impact on Children's Social Care	2015-16	Decrease or increase[2]	Comment
1	Number of cases stepped down from social care to early help services (for either casework or centre services).	934	↑	73% increase on 2014-15 16% of all cases open to early help are from social care.
2	Percentage of all single assessments undertaken by social care that were stepped down to early help services.	12%	↑	Equates to 272 statutory single assessments which required action and support to prevent escalation to statutory CIN, CP, LAC plans.
3	Percentage decrease in the number of contacts made to Children's Social Care.	5%	↓	Equates to 600 contacts
4	Percentage increase in the numbers of children subject to a statutory social care plan.	23% (av)	↑	Equates to 546 children. However, in reviewing the data more closely, 300 children are from the Disabled Children's Service who have not been included in previous datasets and reflects national trend.
5	Percentage decrease in repeat referrals to Children's Social Care	9.6%	↓	In looking at re-referrals data, there were 712 cases closed by social care where issues escalated but they were supported by targeted EH services rather than escalated to social care.

Significant progress has been made over the past 12 months in responding to Ofsted's feedback on where the Early Help Targeted service could do better. Whilst work had already started to review the current early help offer, the Ofsted inspection provided leverage to transform the current delivery model and accountability arrangements. The Early Help and Prevention Strategy & Protocol was refreshed in consultation with the LSCB, Children's Trust and Early Help Strategy Board, which resulted in the changes outlined in table below.

[2] Green = favourable increase/decrease, Red = unfavourable increase/decrease.

Work undertaken as part of the refresh of the Early Help and Prevention Strategy & Protocol

	What we did	What has been the impact and how does it support remodelling of services?
1	**Merging of workforce development budgets** to develop one annual multi-agency workforce plan. Voluntary Action Leicestershire plans and co-ordinates delivery and evaluates learning and impact.	• Quarterly evaluation demonstrates the impact of knowledge gained, shared understanding and standardised processes on improving the quality of service provision. • External partners have improved their knowledge and skills enabling them to support families and prevent escalation of need for local authority services.
2	**Implementation of the new Early Help Assessment (EHA)**; new eligibility criteria and definitions agreed by partners. Supported by a full day training course and e-learning module for staff and partners.	• Clearer pathway to access support and ensure multi agency working. • Improved understanding of early help and how to access services, reduction of duplication and inappropriate referrals to both early help and social care.
3	**Development of 'Advice Points'** in each cluster across the city to provide low level advice, signposting or one off interventions without becoming a case.	• Decrease in inappropriate referrals to early help and social care and a reduction in issues escalating or requiring longer term, high cost interventions. • Learning and outcomes from this work can be applied to the creation of the single Advice Point, proposed in the models described in this report.
4	**A partnership communication strategy** with a new website, e-newsletter and regular evaluation with staff and partners re :'Early Help'	• Over 600 individuals are registered for the Early Help Newsletter; over 800 individuals access the Early Help website per quarter resulting in 1,300 page views. • Improved communication and knowledge for external partners allowing them to facilitate a range of support for families. • Established media network supports the Early Help Targeted service to communicate with its partners and will facilitate service transformation in the future.
5	**Updated key protocols/thresholds aligned to the new offer**	• Robust process in place for step up/step down of cases between early help and social care. • Review of thresholds from 4 to 3 levels to reflect the work of early help services with complex families. • Clear pathway for cases transferring between social care and early help leading to a direct reduction in the number of cases being open to social care. Staff and partners' increased understanding of thresholds is leading to a reduction in inappropriate referrals to both early help and social care.
6	**Merging of referral and assessment paperwork,** incorporating '**Troubled Families'** objectives and a focus on evidencing outcomes	• Reduction of 4 referral forms into one form; a clearer focus on reflecting the voice of the child; the difference made by early help interventions now evidenced by outcomes. • Robust process allows early help to demonstrate impact and as a result make successful payment by results claims for TF funding.
7	**The creation of the 'Early Help Response Team'** collocated with Social Care, screening all requests for targeted early help, allocation of casework, managing step up step down and completion of returning from missing interviews.	• All requests for early help support come to one team, rather than 6 teams based out in localities. • Smoother process for referrals and interface with social care, which supports step down of cases and joint working. Weekly surgeries to discuss potential early help support. This process has ensured that we have accurate performance data, can prevent cases from 'drifting' and can provide standardised, effective advice. Reduction from 6 teams to 1 has improved service consistency and efficiency (i.e. the new team is less resource intensive).

	What we did	What has been the impact and how does it support remodelling of services?
8	**Roll out of the 'Rickter Scale' (RS)** outcomes tool which resulted in a major investment of RS training for all staff and partners delivering early help services to evidence impact and distance travelled through the 'Families Outcome Plan' - for all families and not just those identified as 'TF'.	• Families Outcomes Plan in place to clearly outline expectations and measure outcomes. The use of one main user friendly evidenced based tool has enabled early help services to effectively demonstrate service user progress and the impact of interventions. • Analysis of Q1 2016-17 data showed that of the 81 Rickter scale evaluations completed, there has been a 94% improvement in distance travelled for improved parenting.
9	**A new electronic case recording system** 'Liquid Logic' Early Help Module, which is accessed by all LCC staff to record their single agency and EHA work, and partners who are Lead Practitioners on EHA's. The system is also shared with Children's Social Care operating a one record per child model.	• A single entry for each child and family has improved information sharing between early help and social care and improved data accuracy. • The Council's Partners can now view information about children and lead and/or contribute to 'team around the family action plans' • Early help, social care and partners now have a clear 'whole view of each family' allowing them to better identify and address needs. • Time is saved by reducing manual paperwork and ending the recording of information on multiple information management systems. • Information is now easily accessed through a secure internet connection, speeding up assessments and support. • A feeling of shared ownership between the Council and its partners has been developed and will assist the council to develop partner involvement in taking on the lead practitioner role in early help assessments.
10	**Development of a 'Step up Step down protocol** for all open cases between early help and social care.	• As a result of a clear protocol and pathway there has been a 73% increase in social care cases stepping down to early help.
11	**Stakeholder Analysis** with staff and partners to assess the development of the early help offer and a full 'Health Check' completed with families, staff and partners, which resulted in an action plan that is currently being implemented.	• This action plan resulted in the development and approval of a charging policy for partners using CYP&F centres, enabling Early Help Targeted to generate additional income. Actions completed included a staff health and wellbeing survey, which had a 64% response rate, and a user and partner survey, which informed service development.

12	**Development of a multi-agency response** at a senior management level to any open case that is stuck, high cost or escalating across early help and social care services.	• 49 cases were presented to the Multi Agency Support Panel (MASP). Of these cases, 20% were escalated to social care for a single assessment resulting in a statutory social care plan. This panel has enabled a partnership response to presented cases, a pooling of resources and robust decision making. There is now an opportunity for practitioners to flag and present cases that they are concerned about at an earlier stage to prevent children and young people coming into care. • There are also 6 early help locality partnerships across the city supported by the council and represented by operational leads in services located in clusters. These partnership boards have become established demonstrating a localised response of joint initiatives responding to demand and priorities eg) breakfast clubs, summer programmes, reduction of asb.
13	**Robust governance arrangements** through the Early Help Strategy Board reporting to the Children's Trust.	• Strong partnership engagement representing the majority of key partners from across the City. This has improved joint working, increased understanding and resulted in the development of the first early help partnership quarterly performance report and 3 year strategy.

6.3.2 *Child Sexual Exploitation (CSE), Trafficked and Missing*

Why did we do it? How did we know there was a need to do it?

CSE remains a key strategic priority for the Local Safeguarding Children Board (LSCB) reflecting its national and local status. The government has elevated CSE to the level of a national threat and established an Independent Inquiry into Child Sexual Abuse which will investigate whether public bodies and other non-state institutions have taken seriously their duty of care to protect children from sexual abuse including CSE. CSE is deemed to be a local threat evidenced through high profile cases across Leicester, Leicestershire and Rutland and also demonstrated in the Leicestershire Police problem profile (using 2014-15 data) for CSE, Missing from Home and the Paedophile & Online Line Investigation Team that highlights a number of threat and risk areas.

How much have we done in the last 12 months up to March 2016?

A joint LSCB CSE, Missing and Trafficking Subgroup covering Leicester, Leicestershire and Rutland, established in August 2012, is tasked with coordinating the local response.

During this business year key principles established last year to strengthen the local response have been progressed:

- Consolidation of a single Leicester, Leicestershire and Rutland (LLR) approach to tackling the issues of CSE, trafficked and missing children
- Sharing, pooling and an equitable distribution of resources within a single multi-agency specialist CSE team in line with emerging threat and need

In June 2015 a CSE Coordinator for Leicester, Leicestershire and Rutland was appointed to support the work of the LSCB subgroup and focus on a number of identified priorities:

- Support the implementation of the local action plan
- Ensure protocols, policies and procedures are up to date and effective
- Co-ordinate partnership activity with the aim of creating an accurate and up to date multi-agency CSE problem profile
- Monitor the effectiveness of practice, to protect and support children and young people at risk of CSE and make recommendations for improvement
- Ensure effective information sharing between partners and at a local level

Progress has been made on a number of the identified priorities:

- A local authority data set has been established and key information is emerging. It has resulted in improved profiling of victims and those at risk of CSE and risky persons and peers. The appointment of a multi-agency intelligence analyst through the Strategic Partnership Development Fund (SPDF) CSE Project (see below) will bolster this area of work and support the development of a comprehensive multi-agency data set
- Children and young people at risk of or subjected to CSE are now flagged on their health records and available to front line health services
- Frontline police officers are now using a CSE checklist when completing a Vulnerable Children's Report to support identification, prevention and timely referrals

- An operating protocol for the multi-agency specialist CSE team has been developed

The growth and development of the specialist multi-agency team response to CSE has continued apace with confirmation of investment from the NHS and Leicester City Council to add to the existing contributions from Leicestershire Police, Leicestershire County Council and Rutland County Council.

The development has been further bolstered by a successful partnership bid of £1.23 million to the Strategic Partnership Development Fund (SPDF) of the Police and Crime Commissioner aimed at funding provision over the next two financial years. The aim is to utilise the funding to build capacity, capability and improve the effectiveness of the partnership in preventing, identifying and tackling CSE. The SPDF CSE Project is intended to fund both one-off and non-recurring initiatives, as well as extending existing initiatives and good practice. In addition, it will provide a temporary increase in structures and staffing. Planned initiatives include the extension of Warning Zone provision to include an innovative e-Safety programme and the development of a comprehensive school prevention activity programme including re-commissioning 'Chelsea's Choice'. Additional posts include the recruitment of a multi-agency CSE analyst, a forensic psychologist, parenting support coordinator and specialist health professionals into the multi-agency team. The CSE Coordinator is the nominated project manager for the SPDF CSE Project.

One of the initiatives C.E.A.S.E. (Commitment to Eradicate Abuse and Sexual Exploitation), was launched at an event in February 2016. At the event partner agencies publicly pledged their commitment to tackle CSE by signing-up to C.E.A.S.E. This marked the start of an internal and external awareness raising campaign designed to complement the communications activity already being delivered under phase three of the wider 'Spot the Signs' campaign led by the LSCB Subgroup. Phase two of C.E.A.S.E. includes the launch of an educational film focusing on e-Safety based on a recent local case.

Multi-agency work to identify children and young people who may be at risk of Child Sexual Exploitation (CSE) in Leicester is jointly coordinated with Leicestershire and Rutland (LLR).
During the year, 362 children in total across LLR were identified as at risk of or subjected to abuse through sexual exploitation

- (125) Leicester City, 34%
- (233) Leicestershire, 65%
- (4) 1% Rutland
- 12% (44) of referrals are for boys (for the City 15 boys)
- 18% (67) are LAC children (for the City 7 LAC)

This was a significant increase from the previous year's figures and is most likely owing to the awareness raising and targeted communications campaign across LLR.

How well did we do it? Is anyone better off? How do we know they are better off? What is the evidence for that?

Leicestershire agreed to participate in trialling the development of a new inspection regime. The two day Joint Targeted Area Inspection trial held in September 2015 involved the inspectorates for children's services (Ofsted), police (HMIC) , health (CQC) and probation (HMIP) - combining their resources to undertake a multi-agency inspection focusing on the theme of CSE and missing children. Following feedback provided by the inspectors a number of actions have been progressed through the LLR LSCB CSE subgroup. This includes ensuring CSE concerns are flagged on health records.
A seminar hosted by the East Midlands Assistant Directors of Children's Services (ADCS) Group was held in October 2015 involving senior leaders from a wide range of agencies from across the region.

Keynote contributors included Ofsted and Crown Prosecution Service. The event provided an opportunity to reflect on CSE practice and critical issues, highlighted improvement themes and engaged delegates in a discussion about regional approaches. The local approach in achieving a unified approach to tackling CSE across three local authorities and two LSCBs was cited as an example of good practice. A regional CSE framework, encompassing a range of regional principles and standards, has been finalised and endorsed by the regional ADCS group.

Work of the Subgroup

In order to effectively respond to the developments outlined above the pace and trajectory of the work of the Subgroup has been increased and accelerated during this business year. A wider range of agencies are now represented on the Subgroup reflecting the increased scope and breadth of the agenda.

What are the priorities for the work over the next 12 months from April 2016?

A development day took place in February 2016 to focus on development and delivery of the business plan for 2016-17. A member of the National Working Group (for Sexually Exploited Children) attended to help inform the discussion. Priorities identified included:

- Developing our response to online CSE
- Developing our approach to risky persons offenders and serious and organised crime groups
- Broadening awareness raising activity in relation to CSE, trafficking and missing whilst targeting identified underrepresented groups
- Seeking assurance that the implementation of the Strategic Partnership Development Fund CSE Project leads to enhanced safeguarding outcomes for children

Missing Children

Missing – Ofsted found that many children known to children's services do not benefit from return interviews when they go missing. As a result, plans to reduce further missing episodes and tackle risks associated with and reasons for going missing are not in place. When young people are known to be at risk of child sexual exploitation, robust multi-agency action occurs to reduce these risks. However, for other young people, opportunities are missed or intervention does not always happen when potential risks are first identified, and concerns escalate.

6.3.3 Female Genital Mutilation

Why did we do it? How did we know there was a need to do it?

In the UK FGM is more common among communities from Kenya, Somalia, northern Nigeria, Sierra Leone, and Egypt. Over 100,000 women are living with the consequences of FGM in the UK, with 60,000 girls are at risk.[3]

A report[4] on FGM prevalence in England and Wales showed areas such as Manchester, Slough, Bristol, Leicester and Birmingham have rates ranging from 12 to 16 per 1000 women. The report found the communities in which FGM is practiced in the UK tend to be urban, but that it is likely to affect women and girls from every local authority including Leicestershire and Rutland.

Although FGM is illegal in the UK,[5] it is unlikely to be reported to the Police. This is likely to change, especially as since November 2015 the Serious Crime Act for England and Wales, requires teachers and regulated health and social care professionals to report to the police cases of FGM in females aged less than 18 years. In addition, collection and submission of a new FGM Enhanced Dataset became mandatory for all NHS acute trusts from July 2015, and all Mental Health Trusts and General Practices from October 2015. This will improve the NHS response to FGM and facilitate better commissioned services to safeguard and support women and girls.

Local

The demographics In Leicester, Leicestershire and Rutland indicate that there is a substantial representation of the communities identified in at least three of the communities identified in the national overview. Despite the requirement for social workers, teachers, doctors, nurse and midwives to report FGM, many cases are continuing to go unnoticed because FGM happened at a young age and/or abroad.

The experimental statistics released by the Health and Social Care Information Centre on 21 July 2016 show 30 newly identified FGM cases in Leicester City. 25 of the 30 were advised of the health implications and the illegality of FGM.

There is a need for more community engagement on FGM to ensure it is understood as child abuse, to improve parental understanding of FGM as a harmful practice and the need to prevent it and to better educate communities on the health implications of FGM.

How much have we done in the last 12 months up to March 2016?

The LSCB FGM Task and Finish Group commenced work in September 2014. In accordance with the Terms of Reference the group has ensured the delivery of refreshed LSCB FGM Procedures and opportunities for frontline practitioner to access training in recognising and responding to FGM.

This has been achieved by:

- The completion of refreshed LSCB FGM Safeguarding Procedures and disseminated to frontline practitioners and launch in September 2015
- FGM Training and briefings to frontline practitioners

[3] Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk Interim report on provisional estimates, City University London, 2013

[4] MacFarlane et al. (2015). Prevalence of Female Genital Mutilation in England and Wales. National and Local estimates. Available at: http://www.trustforlondon.org.uk/wp-content/uploads/2015/07/FGM-statistics-final-report-21-07-15-released-text.pdf

[5] Female Genital Mutilation Act (2003) http://www.legislation.gov.uk/ukpga/2003/31/contents

- Supporting the July 2015 FGM awareness communications to all LLR schools pre summer holiday

- Supporting a You Tube FGM awareness video

- Bespoke FGM web pages/areas created on each of the two LSCB websites linking to procedures and media articles and signposting to reporting http://lrsb.org.uk/fgm-female-genital-mutilation

- Creation of a new LLR leaflet http://lrsb.org.uk/uploads/fgm-leaflet.pdf

A successful mini 'Engagement Summit' involving member of the Somali community took place on 14th October 2015. It is the hoped that further development work involving community champions in the design and development of resources to inform their own community about FGM. This model of community engagement could be replicated across relevant communities.

How well did we do it? Is anyone better off? How do we know they are better off? What is the evidence for that?

Impact of the LSCB FGM Procedures and Training

The impact of the work undertaken to raise awareness of FGM by the refreshed LSCB FGM Procedures and Training to frontline staff will be evidenced by:

- The number of FGM cases reported to 101 by practitioners included in the October 2015 Mandatory reporting arrangements

- The number of FGM cases reported by the public or professionals not included in the Mandatory reporting arrangements

- Clear referral pathways have been established and a flow chart jointly devised with Social Care, Police and Early Help to provide practitioners with clear direction on roles and responsibilities from initial reporting to intervention

- There has been some analysis to identify the number of women in the county that have had FGM and to identify those most at risk

The current LLR LSCB FGM Task and Finish Group has been discontinued in its current format as the core tasks identified have been completed. A key area of work which remained outstanding related to the operational delivery of messages into communities affected by FGM through a sensitive communication and engagement plan.

The LLR LSCB FGM Task and Finish Group has recommended that there is a development of a FGM Community Engagement Group and FGM Community Engagement Plan. The intention would be to sensitively raise the awareness of the refreshed FGM Procedures and new legislative frameworks in communities affected by FGM and there is a proposal that this work should be undertaken within another strategic partnerships which has a greater expertise in the management of potentially sensitive communications and awareness raising of the legislative requirements of FGM in affected communities across Leicester, Leicestershire and Rutland.

The FGM Group also recognise the role of Public Health to enable data and scoping of the potential number of girls and women in additional communities, other than the Somali community, who are likely to be affected by FGM.

What are the priorities for the work over the next 12 months from April 2016?

Ensure a comprehensive community awareness and communications campaign is in place that links in with opportunities to work locally to compliment national campaigns.

Continue to map FGM, use partner to develop a local profile to inform targeted work with public and practitioners and inform service development across the LLR.

6.3.4 Neglect

Why did we do it? How did we know there was a need to do it?

Neglect had been identified as a feature in national and local SCRs, and locally in learning reviews and multi-agency audits, resulting in neglect being identified as a priority by the Leicester LSCB and the Leicestershire & Rutland LSCB.

Neglect may be a factor or a direct cause of death or severe injury in children and young people, and it has been identified as a prevailing or risk factor when there is hidden harm relating to physical and sexual abuse. Current evidence strongly suggests that all forms of neglect are particularly associated with damage to the child's lived experience and their physical and emotional wellbeing.

It is important that professionals/practitioners understand that neglect is a safeguarding issue as every child has the right to develop healthily, and to do this their basic needs must be met. A link can be made between impairment of the child's health and development and neglect of aspects of their care provided by their parents or carers. A pre-requisite in recognising neglect in general terms, is a knowledge and understanding of children's development, of their families, their life events and experiences. This does not initially imply 'expert knowledge', although in some instances urgent expert assessment may be needed.

The Department for Education, National Statistics - Characteristics of children in need in England, 2013-14, show that nationally (in England) “abuse or neglect” was again the most common primary need at first assessment with 47.2% of cases recorded “abuse or neglect” as the child’s primary need. The proportion of cases with “abuse or neglect” as their primary need is broadly similar to last year (however, as earlier years contain missing or unknown values it makes it difficult to draw conclusions from the longer time series).
Locally, the numbers of children in need recorded as ‘abuse or neglect’ show that in Rutland and Leicestershire there has been a decrease in the numbers recorded from 2014 to 2015 whilst there has been an increase in Leicester City. In Leicester City the number recorded in 2013 was 1398, decreasing to 1011 in 2014 and increasing to 1,256 in 2015. In Rutland County the number recorded in 2013 was 92, increasing to 99 in 2014 and decreasing to 76 in 2015. In Leicestershire County the number in 2013 was 1503, increasing to 2088 and decreasing significantly to 876 in 2015.

In December 2015, a survey to ascertain practitioners’ knowledge and confidence in identifying and assessing neglect was conducted to inform the development of the neglect strategy and toolkit, found that out of the 96 surveys that were completed across Leicester, Leicestershire and Rutland, 75% were completed by frontline workers. Confidence in identifying neglect was at 81%, but assessing levels of neglect was at 51%. A wide range of tools and guidance were used to inform assessments, but practitioners wanted a universal cross-agency toolkit and guidance. Over half of those who responded to the survey were unware of the LLR LSCB multi-agency Threshold document and over three quarters did not use it.

How much have we done in the last 12 months up to March 2016?

The LLR LSCBs commissioned a reference group in June 2015 in order to understand the scale of, and improve the multi-agency response to neglect of children across Leicester, Leicestershire and Rutland.

The LLR LSCB Neglect Reference group created an action plan of the tasks that need completing in order to take forward the work around neglect. Several task and finish groups were set up to take forward the following: :

- Development of the LLR LSCB neglect strategy.

- Development LLR LSCB neglect tool kit.
- Update of the LLR LSCB neglect procedure.
- Communication of the neglect documents at the safeguarding learning event on 4th May and a further launch of the strategy, tool kit and updated procedure on 7th July.
- Practitioner survey on neglect.
- Inclusion of children and young people's views (by the NSPCC) about neglect in the neglect strategy.
- LSCB neglect audit: a dip-test and deep dive audit tool place during 2015

How well did we do it?

The LLR neglect reference group was established with representation from key agencies/services across LLR, including the Voluntary and Independent Sector. The group met from June 2015-May 2016 and during this period a number task and finish groups were set up to develop the strategy, toolkit and update the practice guidance.

The views of children and young people as well as practitioners were also sought and incorporated into the development of the resources on neglect.

Neglect was an aspect that was covered in the safeguarding learning event that took place on 4th May 2016, which was attended by 240 people from agencies/services across Leicester, Leicestershire and Rutland. The toolkit was particularly welcomed by practitioners who attend the event as shown by the evaluation of the event.

An event to launch the LLR LSCB neglect strategy and toolkit will take place on 7th July 2016, and the resources developed on neglect include a briefing paper on neglect. Three further workshops on neglect for staff across Leicester, Leicestershire and Rutland have been organised to take place during 2016.

Is anyone better off? How do we know they are better off?

Practitioners working across Leicester, Leicestershire and Rutland are better informed about neglect impact of neglect on children and the resources that are available to support staff working with children. The intended outcome of that is through practitioners' improved understanding of neglect the outcomes of children at risk of neglect are better understood and actions taken to address this.

What is the evidence for that?

The implementation plan for the work on neglect includes evaluation of the neglect tool kit and an online survey is planned for the end of the year which should evidence use of the toolkit and improvement in practice.

What are the priorities for the work over the next 12 months from April 2016?

During the next 12 months the LLR neglect strategy and toolkit will be launched and implemented. The use of the toolkit will be evaluated and will include an online survey of practitioners across Leicester, Leicestershire and Rutland. There will be a further audit to assure the quality of multi-agency practice.

6.3.5 Domestic Violence

Why did we do it? How did we know there was a need to do it?

Domestic violence is a high volume and high harm issue, with significant cross over for child protection;

- 66% of adult victims known to our services have children
- Domestic violence continues to be a feature of local and national serious case reviews

How much have we done in the last 12 months up to March 2016?

Consulted, procured and implemented a new service model for specialist sexual and domestic violence services, with a specific view to increase the access of young people and to broaden the support available

- Established a service user scrutiny and reference group
- Started a health led working group to increase GP engagement
- Built on established research partnerships with DMU and Leicester University to expand the evidence base
- Opened a new sexual assault referral centre (over 50% of rapes occur within a domestic violence context)

How well did we do it?

120 perpetrators were referred to the perpetrator interventions service

- 875 people accessed support from the safe home service
- 43 people had additional security at home to prevent repeated moves
- 470 children and young people were referred to the family service
- 649 support cases were opened for adult victims
- 6002 helpline calls were received

Is anyone better off? How do we know they are better off?

- 80% of adult victims felt safer following intervention
- 94% of children felt safer following intervention
- 86% of children and young people supported improved attendance and performance in education

What is the evidence for that?

- Provider returns; helpline data sheets; case files
- Insights monitoring data

What are the priorities for the work over the next 12 months from April 2016?

- Be able to identify priority and serial domestic violence perpetrators
- Embed the new services and ensure local practitioners and families know of their existence and how they can help
- Learn more about the families who do not successfully secure support
- Review and re-profile the training package for local practitioners
- Embed Children's Insights dataset to have more child specific information and to compare performance against other similar services

6.3.6 Voice of Children

What did children and young people tell us?

The Leicester Safeguarding Children Board (LSCB) had within its 2015/16 Business Plan a strategic priority to increase children and young people's participation. The purpose of this was to ensure that CYP were listened to and consulted on safeguarding issues, and that their views and opinions were taken into account.

Through 2015/2016 the LSCB has maintained a focus on driving children and young people's voices in the work of the Board. The LSCB had identified the need to incorporate children and young people's views in all areas of its work. LSCB Partners have worked hard to develop the CYP Participation and Engagement Strategy and ensure that all agencies/organisations are mindful to implement and sustain the strategy and a vehicle for CYP to share their views and more importantly that those views are used to inform the way in which services are delivered and improved upon.

The Voice of Children and Young People

The LSCB is committed to developing a safeguarding system that supports children and young people to be engaged participants in intervention and decisions that affects their own lives. Participation is viewed as a right, not an option and children report that we could do it better. Although it can be a challenge to balance children's and young people's protective needs with their need to have a say, it is crucial that the voice of the child is central in Board business and safeguarding practice.

The LSCB has commenced work to progress on bringing together a sub-group to deliver on the Voice of the Child, which will develop a joint working approach to engagement and participation with Children, Young Persons and Families and to develop a methodology which is consistent in capturing the voice of the child across the partnership.

The Young Advisors Group was commissioned to deliver a Shadow Board made up of Children and Young Persons. The group has recruited young people through various methods including contacting several organisations that they work closely with such as the Young People's Council, The Big Mouth Forum, The Children in Care Council and active and enthusiastic young people in youth centres across the city. Work has been undertaken to ensure the shadow board members are aware of what their roles are as well as what the role of the organisation. A key task for the shadow board members is to identify what their priorities are and understand the local agenda and priorities of the LSCB. The Young Advisers Group is engaged with safeguarding issues and will support the CYP Shadow Board to undertake specific commissions on behalf of the LSCB.

Hate Crime Conference and Consultation on the LSCB Multi-Agency Participation and Engagement Strategy

The Participation Federation and the LSCB hosted an event for children and young people across the city. The aims of the event was twofold; to facilitate consultation with them about hate crime and to provide young people with an introduction to the work of the LSCB. Of the latter aim the role of the LSCB was explained to CYP delegates and they then were asked to take part in an interactive session (participated in a mock auction to give them a real understanding of the Board's work, defining the makeup of the Board and its business). The children and young persons were hugely enthusiastic and demonstrated that the most important value to them from the Boards work was, 'to be heard'; the voice of the child was an auction item and sold at a price of £26k.

The children and Young Persons also gave views in regards to the draft LSCB Participation and Engagement Strategy which had subsequently been taken into consideration when finalising the document.

Following the HATE crime conference the young persons who were instrumental in the design and delivery of the event were nominated for awards at the National Young Advisors conference event in August 2015. The young advisors won the best partnership award in recognition of their work.

LADO Arrangements Children's feedback

The Children's Rights and Participation Service were requested to consult with young people who have made allegations and been investigated by the Local Authority Designated Officer. The purpose of this consultation was to ensure that young people have confidence to raise concerns about adults working around them if they feel unsafe. It is also to identify young people's views and understanding of the LADO role.

From the list of 51 referrals made to the LADO service (8.12.14 – 3.12.15), many were unsuitable to engage in this consultation due to a very young age, young person being unidentified and a young person having a complex learning disability. There were some young people who it was felt the consultation would be inappropriate due to their current circumstances.

There were two young people who were consulted with. One male (JB) and one female (US). One aged 12 and the other aged 16, one lives in foster care and the other has recently moved from foster care to a residential placement.

Both young people were unaware of the LADO role or that the investigations into their concerns were managed by someone independent. Both of the young people thought that other LAC young people should be aware of this role whether they had raised concerns or not. One young person suggested that an information leaflet should be made available which would inform them of the LADO role and how their concerns would be looked into. I discussed this suggestion with the second young person and they agreed that this would be a good idea.

Both young people felt listened to, that their concerns were taken seriously and dealt with. Both young people felt confident that they would raise concerns again about adults working with them if they felt unsafe. Both young people also said that they currently feel safe in their placements.

Both young people were asked if they were given feedback. One young person didn't answer, choosing to change the subject and the other young person said they didn't. The young person who didn't receive feedback didn't feel that he needed or wanted feedback as he was moved as a result of raising concerns and now felt safe.

6.4
STRATEGIC PRIORITY 4

One of the LSCB's statutory functions is to communicate to persons and bodies in Leicester the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so.
The LSCB through 2015/2016 continued to develop on the partnerships communications pathways, this included.

- The ongoing development of the LSCB website to make the work of the Board more transparent and accessible to all partners, parents/carers, communities and children and young people
- Bespoke website pages linking to key procedures and media articles relating to CSE, Trafficked and Missing's
- Multiagency meeting to engage community and faith leads in the multi-agency response to CSE
- Promotional material relating to Female Genital Mutilation (FGM to support the FGM annual 'Schools Out for Summer' campaign, to alert education staff to identify pre and post-holiday children who are most at risk of FGM) and including publication information 'You-tube' video
- A mini 'Engagement Summit' involving members of the Somali community work took place in October 2015

Views of Frontline Practitioners

The OFSTED inspection outcome identified the LSCB needed to "Establish a clear line of sight and reporting from frontline practice to the Board". Partners accepted the LSCB work collectively and as individual agencies was not well sighted on the views of frontline practitioners consistently in order to inform the development of safeguarding services.

A new multi-agency group was set up in response to the Ofsted outcome with representation from agencies across Leicester. The group was originally chaired by an Independent Reviewing Officer, Janice Bryan and now is chaired by the Councils Principle Social Worker.

6.5
STRATEGIC PRIORITY 5

Safeguarding Effectiveness Group (SEG)

Why did we do it? How did we know there was a need to do it?

LSCBs have a duty to monitor and challenge the effectiveness of local safeguarding arrangements (Working Together 2015). This work was undertaken in Leicester by the Safeguarding Effectiveness Group (SEG), which is responsible for monitoring and challenging the effectiveness of safeguarding arrangements of partners of the Leicester Safeguarding Children Board.

The OFTSED inspection found the quarterly monitoring framework was not robust enough and the *"Board had not been receiving adequate performance management data of safeguarding activity from partners and it is therefore unable to hold agencies effectively to account".*

How much have we done in the last 12 months up to March 2016?

The activity of the Safeguarding Effectiveness Group (SEG) through partner agencies and with support from the Board for 2015-2016 included:

Quality Assurance and performance Framework (QAPMF)

- The review of the LSCB Quality Assurance and Performance Monitoring Framework (QAPMF) following the Ofsted's judgement that the LSCB performance framework (Indicators report) was rich in data but lacking in analysis. The revised QAPMF was implemented for quarterly performance monitoring of data from for Q1 to Q4. During the year the data set and analysis from partner agencies was further refined. There was an increased commitment to this area of work from partner agencies with submission of data within the given timeframes however, the quality of analysis and appropriate commentary still require improvement.

- A revised performance quality assurance process based on Results Based Accountability/Outcomes Based Accountability was introduced for considering the performance monitoring data and analysis.

- The process for obtaining performance data and analysis from partner agencies on a quarterly basis was reconsidered and support with obtaining the data/analysis and producing a dash book was provided by the Local Authority Performance Team. This support is intended to be on-going.

- For the data and analysis provided by partner agencies to both the City and Leicestershire & Rutland LSCBs there were discussions and negotiations with LSCB Partners to amalgamate the collection of partner agency LSCB performance data from 2016-2017.

Audits

- Section 11 audit was conducted. A joint Leicester, Leicestershire and Rutland (LLR) online audit was also conducted with a sample of frontline and supervisory staff in agencies that are members of the LSCB and had previously responded to the strategic Section 11 2014-2015 audit. 145 returns were completed, 102 (70%) by frontline workers. City council returns came from Children and Family Services, Enforcement and Community Safety Services, Cultural (including leisure) and Neighbourhood Services, Adult Services and Housing Services, with other returns from police, CCG, UHL, LPT Fire and Rescue, probation

and CAFCASS. The findings show that there is high level of awareness amongst staff of what they should do when safeguarding children, particularly in relation to specific issues such as Domestic Violence, CSE, Neglect, FGM, Adult Mental Health and 'Prevent'. The audit also identified that there is a need to improve staff awareness of how to escalate a safeguarding concern and resolve practitioner disagreements, using the escalation procedure, and to disseminate learning from SCRs more widely.

- Single agency audit schedules and outcome of single agency audits undertaken by partner agencies were received. However, it was identified that not all partner agencies had single agency audit schedules and where audits took place these were submitted to the Safeguarding Effectiveness Group for consideration.
- A schedule of multi-agency themed audits on the LSCB priorities areas was created to increase the number and quality of audits undertaken. However, there was a delay in implementing the audit schedule due to the review and implementation of the multi-agency audit process and capacity of auditors to conduct the audits. During 2015-2016 audits were conducted on neglect and Child Sexual Exploitation. The neglect audit involved a dip-test of 42 different cases and a deep-dive audit on 2 of the same cases. The CSE audit comprised of 10 of the same cases and a deep-dive audit on 1 case.

How well did we do it?

Performance data and analysis was provided by partner agencies for Q1 to Q4 in 2015/2016. During the year the data measure and analysis was refined and by Q4 there was timely submission of data. To compliment the data collection and provide assurance to be Board an assurance process was proposed and agreed which entailed partner agencies providing assurance on topics such as neglect and CSE. However, commentary and analysis from the performance monitoring information and also the assurance questions did not fully provide the Board with assurance on the effectiveness of safeguarding children, and it was proposed that the group's structure is reviewed.

The system to collect LSCB performance data and analysis was established by the local authority performance team resulting in the production of a dash book for consideration by SEG.

Is anyone better off? How do we know they are better off?

LSCB Partners are fully committed to the work relating to their own agencies performance and assurance and have worked hard develop systems and processes to inform analytical reporting to the Board. With an improving performance and assurance system the LSCB are in are better placed to scrutinize and challenge the effectiveness of the multiagency safeguarding arrangements across Leicester. For children young people and families this will result in an informed comprehensive picture of service delivery. Children and families should see an improving picture and better experience of agency intervention which is consistent, timely and of improved quality.

What is the evidence for that?

During 2015-2016 the LSCB concentrated on developing and embedding a robust Quality Assurance and Performance Framework, which included confirming and defining the measures included in the LSCB quality monitoring framework, to ensure that the LSCB received consistently good information to prioritise safeguarding activity. Performance data and information is received from partner agencies in a timely way which allows for discussion and identification of what works well and where improvements are required for example there was identification of:

- Open single assessments open beyond 45 days (overdue)
- Looked after children rate per 10,000
- Children in care with three or more placements in the past year
- Initial health Assessments

- Foster Carer reviews overdue
- Social worker sickness rates
- Case work supervision
- LPT-CAMHS/UHL CYP with mental health issues increase in CYP using acute services/referral rates to CAMHS and waiting times

These areas were considered by the LSCB and some of these areas were being considered through the Leicester City Council Improvement Board.

Significant time has been committed by member agencies to developing more robust analysis of and informed understanding about the quality of multi-agency practice, which has been monitored by the Improvement Board and LSCB. The LSCB has been actively supported by the Children's Services data analysts with input from analysts in partner agencies. Quarter 4 returns showed an improvement in the timeliness and completeness of submissions of agency data. The Board, working primarily through the Safeguarding Effectiveness Group, is working to strengthen the integration, analysis and understanding of the data from these different sources across the partnership.

The LSCB has received reports on the deliberations of the Improvement Board, which mirror the remit of the LSCB. Examples include the development of more effective, multi-agency early help services, more timely initial health assessments for children looked after, reduced numbers of repeat child protection plans and strategies to develop a more stable workforce. The Board, through the Safeguarding Effectiveness Group, is also sighted on the rise in the numbers of looked after children, the need to improve the timeliness of return interviews for missing children and the development of more consistent CSE services. There is a need to strengthen connections between the support structures to both Boards to ensure consistency and coherence, especially in respect of the analysis of priority areas of focus for both Boards.

What are the priorities for the work over the next 12 months from April 2016?

The priorities for the work around safeguarding effectiveness for 2016-2017 include:

- Review of SEG arrangements to include review of the name of the group, Terms of Reference, membership and reporting structure.

- Implementation of the aligned partner agency LSCB data set from Q1 and it is intended that improved analysis will be received to provide assurance to the Board.

- Performance returns from partner agencies to include data/analysis in relation to the voice of the child.

- Review the arrangements for multi-agency audits and create a schedule in line with the LSCB priorities for 2016-2017.

LLR Procedure and Development Group

Why did we do it? How did we know there was a need to do it?

The Leicester, Leicestershire and Rutland (LLR) LSCB Development and Procedures Group oversee the development of multi-agency safeguarding procedures and ensure that procedures are up-to-date and compliant with Working Together 2015.
The procedures are available through the Leicester and Leicestershire & Rutland Safeguarding Children Boards website and 'hosted' by Tri-x Child Care Ltd, accessible at:

http://llrscb.proceduresonline.com/chapters/contents.html

The Development and Procedures Group meets four times a year to coordinate the revision and addition of new procedures to ensure that they reflect national and local changes as necessary.
The need for updating procedures or creating new ones is identified through legislative/statutory changes, national and local policy and operational changes and/or from partner agency or practitioner suggestions, learning from Serious Case Reviews, Learning Reviews and audits, and suggestions from Trix on policy issues.
Leicester SCB continues to commission arrangements jointly with Leicestershire and Rutland LSCBs to ensure there is a consistent approach to safeguarding children across LLR. The LSCB identified within its Business Plan has a core business action within Strategic Priority 2 continue to develop and maintain policies and procedures for safeguarding and promoting the welfare of children in the area.
The purpose of the LLR Procedure and Development Group is to:

- Agree the content of the multi-agency LSCB procedures across the agencies
- Ensure their easy access and dissemination amongst organisations / agencies including the private, independent and voluntary sectors.

How much have we done in the last 12 months up to March 2016?

Two updates have taken place in 2015/2016 on procedures that were subject to review and/or development as identified by the sub-group, and these took place in September 2015 and March 2016. Task and finish groups consisting of representatives from relevant partner agencies across LLR were established to assist with updating key procedures and developing new ones, which were consulted upon prior to being signed off by the group.

How well did we do it?

A number of procedures were updated (or developed) with partner agency involvement across Leicester, Leicestershire and Rutland resulting in updated LLR LSCB multiagency safeguarding procedures being made available to staff across Leicester, Leicestershire and Rutland.
A procedure launch event comprising two sessions for practitioners across Leicester, Leicestershire and Rutland was held on 29th September 2015, and attended by approximately 160 people. The sessions focused on the following: Training Competency Framework, Information Sharing, FGM, Resolving Practitioner Disputes & Escalation of concern, and Self-harm and Suicide.
The group agreed that such events should be arranged following the procedure updates (6 monthly).
A safeguarding learning event was planned for 4th May 2016. The event will focus on Neglect (neglect toolkit), Learning from Serious Case Reviews, Managing Allegations Against Professionals (Role of the LADO), Practitioner Forum and Safeguarding Babies.

Is anyone better off? How do we know they are better off?

Updated guidance is available to staff to inform their practice in line with national and local policy so that practice across agencies in safeguarding children is consistent and within expected practice under the relevant statutory framework and guidance.

Children and young people will be better safeguarded as a result of updated multi-agency safeguarding procedures/guidance being available to practitioners so that their practice is in line with national and local policy. This should help achieve consistent practice across the LSCB partnership in safeguarding children. Assurance activity regarding compliance to procedures is a golden thread in the LSCB multi-agency audit process. In addition the Training and Development Group are leading on work to embed the competency framework.

What is the evidence for that?

Google analytical data shows that there has been an increase in 2015-2016 in the sessions, users, and page views compared to 2014-2015. There were 23,182 users, 29, 825 session and 61,367 page views from April 2015-March 2016, in comparison to 17,489 users, 23,067 sessions and 53,798 page views from April 2015-March 2015. There were slightly more retuning visitors (75.2%) and fewer new visitors (24.8%) in 2015-2016 compared to 73.5% and 26.5% in 2014-2015.

There is work underway to promote the use to the LLR LSCB multi-agency procedures as local SCR/Learning reviews and multiagency audits show that whist there is some use of the procedures more work is required for practitioners to be compliant with procedures in their practice. Safeguarding learning events have been planned following procedure updates to promote the use of procedures. Practitioners' compliance to procedures is a 'standing question' in multi-agency case file audits, which should identify whether practice is informed by procedures.

What are the priorities for the work over the next 12 months from April 2016?

Deliver the Safeguarding Learning Event in May 2016.

Launch the LLR LSCB Neglect strategy and toolkit on 7th July 2016. Implement and evaluate the LLR LSCB Neglect strategy and toolkit.

Procedures identified for review or for developing new ones for 2016-2017 include the following:

Bruising and injuries in Babies and Children who are not independently mobile	**Threshold for access to Services for Children & Families in Leicester, Leicestershire & Rutland Social Care**	**Think Family/Whole Family Approach**	**Learning and Improvement Framework**	**Safeguarding Children Vulnerable to Violent Extremism (PREVENT)**
Pre-birth assessments	**Children Using Sexually Abusive Behaviour**	**CSE, trafficked and Missing**	**Neglect guidance**	**Complex (Organised or Multiple) Abuse**

Serious Case Review Group

Why did we do it? How did we know there was a need to do it?

The Serious Case Review programme group is responsible for coordinating serious case reviews and learning reviews.

A Serious Case is one where

(a) abuse or neglect of a child is known or suspected;

and

(b) either –

(i) the child has died; or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board partners or other relevant persons have worked together to safeguard the child.

Where the criteria for a Serious Case Review (SCR) are met, the LSCB always commissions an external independent author to conduct a review. The remit in all cases is to review and analyse the learning from the circumstances that resulted in a SCR, so that all partnerships can jointly own the outcome of the report and deliver improvements.

How much have we done in the last 12 months up to March 2016?

Between 1st April 2015 and 31st March 2016 the SCR Group commissioned four SCRs. The findings from the reviews are considered by all agencies. The SCR group has oversight and monitors the completion the related action plans to address any areas that require improvement to prevent further serious incidents. The SCR outcome findings have resulted in a number of policy, practice and training developments.

Is anyone better off? How do we know they are better off? What is the evidence for that?

The learning from SCRs has led to practice improvements and policy development in a number of key areas; they include:

- Failure to identify persistent re-occurring incidences as Neglectful care
- Pre-birth assessments including issues relating to concealed pregnancy
- Bruising and injuries in non-mobile babies with directive to refer all injuries to babies
- Practitioner compliance with the application of multi-agency procedures
- Improvement to assessment of need and risks and particular focus on
    - Lack of identification of the need for early help services,
    - Information sharing and practitioners taking on the lead practitioner role to coordinate assessment and support planning
    - Fathers and / or reconstituted families
    - Use of chronologies and historical information to inform presenting risks/need assessments
    - Parental capacity and whole family approach
    - Assuring the voice and lived experience of the Child
- Resolving practitioner disagreement and Escalation
- Appetite to give consideration to MASH principles in the development and delivery of safeguarding services.

Child Death Overview Panel

Why did we do it? How did we know there was a need to do it?

The Child Death Overview Panel is a Sub Group of the LLR LSCBs. LLR CDOP is required to review ALL child deaths (from 0 up to 18 years) of any child who is resident within Leicester, Leicestershire and Rutland. It undertakes a systematic review of child deaths to help understand why children die. By focusing on the unexpected deaths of children, it can recommend any interventions it considers appropriate to help improve child safety and welfare to prevent future deaths. When a child dies unexpectedly, a process is set in motion to review the circumstances of the child's death, which includes the support in place for the family.

How much have we done in the last 12 months up to March 2016?

A key objective for CDOP was to undertake and complete a 6 year analysis (from 2009/2010 – 2014/2015) of all completed child death reviews. The findings were presented to the respective LSCBs and the recommendations have been noted. Currently there are no residual issues that have been identified as part of the 6 year analysis. All areas of work have a pathway for progression.
The analysis has allowed key recommendations to be drawn out which were segregated into recommendations for partners and recommendations for CDOP.

Is anyone better off? How do we know they are better off? What is the evidence for that?

In terms of Partners, there was evidence of a disproportionate number of child deaths in the more deprived areas. All partners were asked to assess the work currently in place to target vulnerable groups and develop an action plan to identify how the number of deaths can be reduced.

It is a consistent feature both locally and nationally that children under the age of 1 account for the majority of child deaths. These deaths have common features which include:

- low birth weight,
- prematurity and maternal smoking and associated issues of hypertension,
- Diabetes and obesity and their links to poverty and infant nutrition.

Given that year on year the percentage of deaths remains high, all partners have been asked to ensure that appropriate action plans are in place to address the areas identified.

It was agreed that a community engagement exercise would be commissioned by Public Health to explore certain ethnic Groups' views on consanguinity and access to universal and specialist services.

CDOP have recently submitted their data findings to the Department for Education (DfE) for 2015/2016 – this data has yet to be verified; once verification has been completed the DfE will produce a statistical analysis for circulation.

Data was submitted to the DfE based on the 102 cases that were reviewed. The Panel process identifies factors which may have contributed to the death of the child and which, by means of locally or nationally achievable interventions could be modified to reduce the risk of future child deaths.

Listed below are the modifiable factors identified.

- Smoking by mother in pregnancy
- Smoking by parent/carer in household
- Accessing health care sooner
- Co sleeping
- Substance misuse (by parent)
- Domestic violence
- Consanguinity

All of the factors are considered at panel and a discussion is undertaken in order to ascertain whether they are currently within an ongoing work stream or whether additional work is required.

As well as identifying modifiable factors, CDOP seek to identify learning that has occurred during the review process.

Key areas identified within the cases reviewed related to

- Access to healthcare
- Escalation of care
- Cross site coverage for neonates
- Communication
  - Professional to professional
  - Professional to patient/client

In all cases where panel identify modifiable factors, panel members are asked to consider what action (if any) is required. As part of the decision making process professionals from partner agencies may be asked to provide additional information in order to help form a 'wider picture'.

What are the priorities for the work over the next 12 months from April 2016?

CDOP are currently in the process of producing their annual report. It is recognised that the current timescales do not synchronise with the LSCB reporting timetable and this will be addressed for next year. CDOP now have the support of a public health analyst who is working alongside the CDOP manager in order to use the available data to identify meaningful and achievable work streams for CDOP (and potentially partners) for 2017.

Statutory Complaints, Commendations and Representations

The Complaints Manager is part of the Children's Safeguarding and Quality Assurance Unit of the Children, Young People and Families Division and is responsible for customer feedback and managing the process for children's statutory complaints.

The statutory complaints procedure has three stages

- Stage 1 Local Resolution by Team or Service Manager
- Stage 2 Formal Independent Investigations
- Stage 3 Independent Review Panel

Why did we do it? How did we know there was a need to do it?

It is a statutory responsibility to respond to complaints within 20 working days at stage 1 and 65 working days at stage 2.

How much have we done in the last 12 months up to March 2016?

Responded to 85 Statutory complaints.
84 of which started at stage 1,
1 complaint was accepted at stage 2.
2 of the stage 1 complaints progressed to stage 2.
1 of the stage 2 complaints progressed to stage 3.

How well did we do it?

38 of the 84 stage 1 complaints were responded to within statutory timescales (45%). The average number of days to respond was 34.
Of the 3 complaints responded to a stage 2, one was outside the statutory timescales and 2 within. The average number of days to respond at stage 2 was 58.

Is anyone better off? How do we know they are better off? What is the evidence for that?

85 complaints were responded to, 11 were upheld, 49 were not upheld and 25 were partially upheld.
The majority of complainants were offered, and accepted an apology for any areas upheld.
Learning has been identified that will improve the service in the future. Some examples of practice improvements are:

- The 16+ team have produced a Care leaver's entitlement booklet which workers in the team handout to their young people when the case is allocated and is available on the team's website.
- Social Workers are now fully aware of the timeframes for when a care leaver is proposing to go to university, to ensure that all information is available to this group of young people and to ensure that they have completed the Higher Education financial support paper in time in time with the young person.
- Better use of case summaries so that duty workers can see current situation and update in order to respond to queries in absence of SW.
- Immediate action to be taken with any placement to address our concerns and set an improvement plan
- SW's and TM's to thoroughly check for the accuracy and quality of written work, which is jargon free with acronyms explained.

- Improved communication to ensure that Young people understand even if they don't agree why the LA has followed a particular course of action
- When we ask a parent to leave their home, we should pro-actively engage with Housing/Housing Associations on their behalf to identify alternative accommodation.
- The creation of the Single Assessment Team has addressed a number of complaints made.
- Staff across the service has been given guidance on when a placement with a relative is a Family Arrangement or Regulation24, when the child becomes LAC.
- That as an Organisation, we need to be more mindful of high turnover of staff and recordings need to be monitored closely to ensure that workers do not leave Department without recording all the information regarding their involvement with families.

What are the priorities for the work over the next 12 months from April 2016?

Ensuring new Team Managers and Service Managers fully understand and adhere to the statutory timescales and responsibilities around complaints.
This should result in a higher percentage of complaints being responded to on time and improved learning from complaints identified.

6.6
STRATEGIC PRIORITY 6

Leicester, Leicestershire & Rutland Safeguarding Multi Agency Training, Learning and Development Commissioning & Delivery Group

Overview of the group:

The Multi-Agency Safeguarding Learning, Training and Development Commissioning and Delivery Group supports and encourages safeguarding learning for the children's workforce across Leicester, Leicestershire & Rutland. The group's primary functions are: supporting the implementation of the 2014 Safeguarding Learning Strategy, working to the Leicester City and Leicestershire & Rutland LSCB Business Plans, and developing and supporting multi agency learning (including an Interagency Training Programme) for both Leicester City and Leicestershire and Rutland LSCBs. The group has membership from strategic training and workforce development leads and representatives from agencies across the two LSCB areas.

The work of the Group is driven by the Safeguarding Learning, Development and Training Strategy and the Competency Framework, launched in April 2014, following an eighteen-month period of consultation with partners. The strategy outlines the LSCB minimum standards for expected knowledge and delivery of safeguarding learning and the processes for quality assurance – all of which support the LSCB role and activity around assurance. A **Competency**-based approach has been a change of focus and supports the principle that learning should be **relevant, proportionate and meaningful**, and supports **confident, competent** practitioners, who demonstrate a **commitment** to safeguarding in line with their **role and responsibilities.** *All strategy documents are available on the LSCB website:*

http://lrsb.org.uk/safeguarding-children-learning.

Why did we do it? How did we know there was a need to do it?

The work of the strategic group supports the responsibilities as identified by Working Together 2015 and Regulation 5 of the Local Safeguarding Children Boards Regulations 2006:
The LSCB has a responsibility to develop policies and procedures in relation to:
1 (a)(ii) training of persons who work with children or in services affecting the safety and welfare of children; **(Regulation 5)**

This includes a duty to 'monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children.' **Working Together 2015**

The group's work also supports the principles for learning and improvement:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice - **Working Together 2015**

The principles of the 2014 Safeguarding Learning, Development & Training Strategy support this approach, with an increased focus on the impact of learning being transferred into practice to support improved outcomes for children and families.

How much have we done in the last 12 months up to March 2016?

In 2015/16 The LSCB has;

- Continued to promote understanding and application of the revised 2014 strategy and minimum standards for all (single and multi-agency) safeguarding learning, including standards for delivery (Best Practice in Safeguarding Training) and knowledge (LLR LSCB Competency Framework). The LSCB funds briefing sessions on the strategy, (over 800 workforce leads / managers / trainers briefed to date). The LSCB has also funded a package of specialist training to support managers / organisational leads in 'assessing competency and effectiveness' and the website offering information and resources. A range of practical tools and guidance notes is available to support organisations in the application of the strategy.
- Continued to engage with a range of organisations and sectors, applying the strategy and processes. Learning from this process is shared and has assisted review activity. This implementation plan has increased the LSCB 'reach', 'impact' and 'engagement' with partner and non-partner organisations – including private early years and standalone practitioners (eg childminders).
- Increased the emphasis on gaining assurance and evidence of application of use of framework and competency based-approach on an operational level.
- Supported local trainers and commissioners in the delivery of safeguarding learning via a Trainers Network and delivered events and guidance.
- Strengthened links and supported the work of the Procedures group and delivery of large scale awareness-raising and learning events.
- Provided and funded 'essential awareness' training for the Private, Voluntary and Independent Sector.
- Work has also continued with partners from adult services, trainers and the wider workforce, to align training and learning, where possible, to support a whole family approach being embedded into safeguarding learning; this partnership work will continue in 2016/17.
- The group developed a revised process for sharing and embedding learning and key messages, and now provides an auditable process for the LSCB. Following this process brings together the work of the Serious Case Review, Training and Communication groups and will also provide a consistency of message. It allows for training and messages to be targeted and focussed on different areas of the workforce. This process will support Serious Case Review action plans, assurance processes and the training group, and work will be undertaken and supported by the communication group.

Interagency training

The LSCB has continued to deliver a multi-agency programme of Learning, Training and Development, which reflects the requirements of the Business Plan, including the Competency Framework, the findings of Serious Case Reviews and revisions to legislation and guidance.

The Group has adopted a themed programme of multi-agency courses and events, delivered largely by a 'mixed economy' of provision - partner agencies providing training and venues to multi-agency groups at no cost at the point of delivery; each agency aiming to balance the provision and receipt of training by its employees. A brief analysis during the year suggests that this 'balance' is generally maintained. Some specialist provision is brought in, where necessary. A 'Partnership Agreement' underpins this collaborative approach.

In 2015/16 – 1600 delegate spaces were offered, 1,286 people participated in the 46 events in the programme, with an overall attendance rate of 80%. In addition to this there were an extra 140 delegates who attended the L&R LSCB SCR event. These events have offered over 1426 spaces this year. Participation generally reflects the size of the relevant workforce in the partner organisation.

How well did we do it?

The work of the group and continued activity throughout this year, and strengthened links with other strategic groups indicates that the work of the group has been successful in supporting the children's workforce and adult and wider workforce. The continued support to learning across the partnership by commitment of joint resources and the development of work streams is notable, particularly in the current financial climate. The continued positive partnership work within the group has supported LSCB in this process.

Is anyone better off? How do we know they are better off?

The strategy and work of the group aims to support and strengthen practice around safeguarding, and assurance work starts to gather information about this process and activity. It is acknowledged that the training group and strategy will support evidence about improved practice and impact of learning into practice.

The group has access to qualitative and quantitative data, collated and analysed by VAL, which demonstrates the ongoing impact of the group's activity. In addition to this, the group has made requests for more formal data collection by safeguarding effectiveness groups, to look at the use of the strategy and including this in data collection processes and audits (S11 audits and 4 stage evaluation process for the interagency programme.)

What is the evidence for that?

- An increase in awareness in of the training strategy and competency framework – demonstrated by quantitative data and qualitative data from interagency programme and briefing sessions and a survey undertaken by the training group.
- Increased attendance of wider workforce and non-statutory partners on interagency programme.
- The funded essential awareness programme has been consistently oversubscribed, well attended and positively evaluated.
- Continued attendance and positive evaluations on the briefing sessions: The specialist sessions for the competency framework have been well received and positively evaluated. Increased engagement with the non-statutory sector, which has increased the LSCB reach and impact with these smaller organisations. This work has promoted best practice, given advice about standards, policy and procedures and underpinned and strengthened organisational practice.

Interagency programme

There is a four-stage process of pre, post, three-month and six-month course evaluation for the multi-agency programme, the findings from which are incorporated into easily-readable quarterly reports, which the Group considers and uses to refine the programme and feed to strategic leads for safeguarding learning. These reports are now forming the basis for information on improved outcomes for children and young people.

- In 2015/16 – 1600 delegate spaces were offered with, 1,286 people participated in the 46 events in the programme, with an overall attendance rate of 80%. In addition to this there were an extra 140 delegates who attended the L&R LSCB SCR event. These events have offered over 1426 spaces this year. Participation generally reflects the size of the relevant workforce in the partner organisation.
- Levels of satisfaction were high, with participants identifying improvements in knowledge, skill and confidence arising from the programmed events. Details are collated, analysed and included in quarterly update reports produced to the Sub-Group by Voluntary Action Leicester and Leicestershire (VAL).
- An increase was seen in attendance of delegates from the wider workforce

What are the priorities for the work over the next 12 months from April 2016?

The group will have an increased focus on supporting the use of the strategy in the third and final year of implementation, and also focus on assurance; this includes including working alongside other strategic groups and organisations from a range of sectors to see the application of the strategy in practice, and also inform assurance work.

This will include also:

- Supporting learning from reviews being embedded into practice.
- The need to promote and support organisational support for training, development and learning, both to enable people to attend and in providing courses/events for the programme, in line with the training strategy.
- The need for more work to identify and respond to the voice of the child.
- The increased focus and requirement of assurance for partner and non-partner agencies about the application of the strategy and framework. This work will be a priority for LSCB and should begin to provide evidence of how they are applying the strategy in the final year of application.

7. Allegations Against People who work with Children

Why did we do it? How did we know there was a need to do it?

Working Together (2015) refers to local authorities having a Designated Officer or a team of Designated Officers involved in the management and oversight of allegations against people that work with children (LADO).

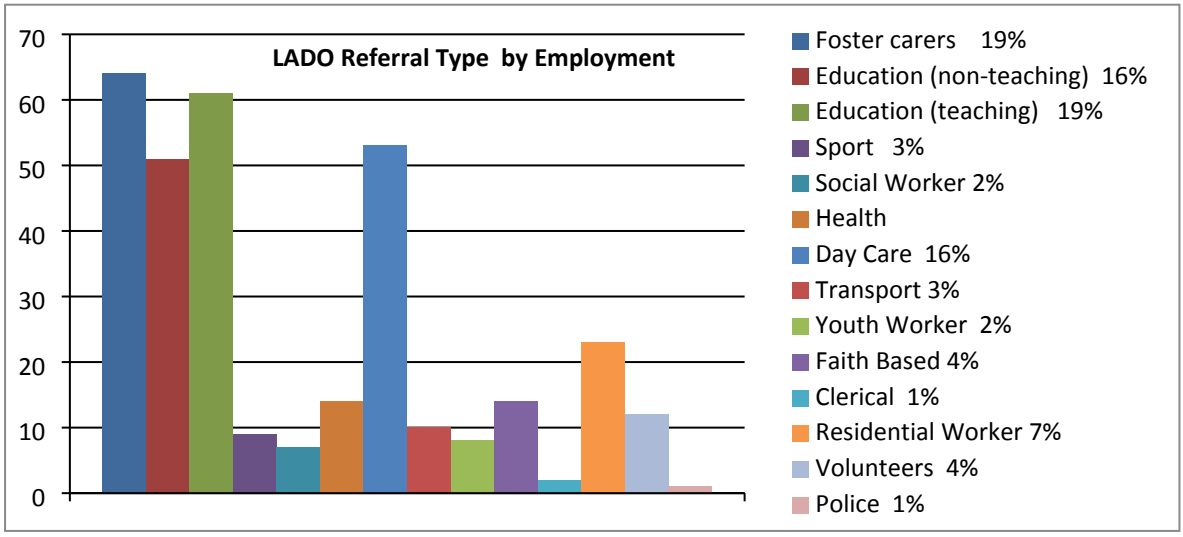
How much have we done in the last 12 months up to March 2016?

The Local Authority collates data which shows us emerging trends, consequently this can lead to targeted support for practitioners including, training, safety actions and improvements in frontline practice and agencies recruitment and supervision practices.

Referrals

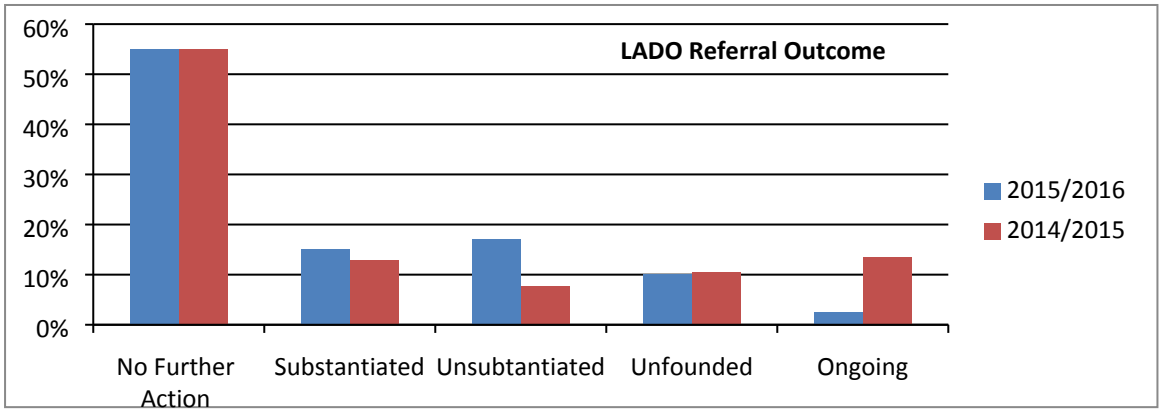
329 referrals have been received during this period; this is an increase of 115 referrals / 53% of the last year's referrals.

Chart 1 Referrals received by employment type



Data in 2015/2016 very similar to last year except for day care provision, with the number of referrals have doubled over the course of the year. During the 2014/2015 nursery provision was a key focus of the LADO training. This could account for the increase of referrals, alongside the awareness raised by the publication and National interest in the Nursery Z serious case review. Given the vulnerability of children in day care this will now lead to a focused piece of work over the next year in relation to a more in depth audit of the allegations in nurseries to identify any actions required.

Chart 2 Referral Outcome



Analysis

- 55% - 181 of referrals resulted in no further action. This is a similar figure to last year and suggests that a consistent threshold is being applied.
- 15% - 51 of referrals were substantiated. In 2014/15 12.8% were substantiated –the definition is that there is sufficient evidence to prove the allegation. This again is a similar figure as that of last year.
- 17% - 56 of referrals were unsubstantiated. In 2014/15 - 7.6% unsubstantiated, the definition is that there is insufficient evidence to either prove or disprove the allegation. It is beneficial for this to be a lower figure so as clearer decision making is reached about risk of harm from adults who work with children.
- 10% - 33 of referrals were unfounded. In 2014/15 10.5 % were unfounded-the definition is that there is sufficient evidence to disprove the allegation
- 2.4% - 8 of referrals were categorised as ongoing. In 2014/15 there were 13.5 % of cases ongoing. A lower figure is good as shows referrals are being progressed timely.

The outcomes from the LADO processes are as seen in the main not resulting in a substantiated concern.15 % resulted in this and the rest were manged by internal processes, advice and guidance, disciplinary measures. Referrals to regulatory bodies and DBS are routinely referred to within the LADO work and are recommendations from meetings when the allegation is substantiated and alongside this the suitability of the person is called into question.

How well did we do it?

- The LSCB has provided feedback to large scale events on LADO activity and provide additional publicity and awareness raising amongst agencies and practitioners. There is a rolling programme for Leicester city agencies of LADO training. This includes embedding the safeguarding principles in the competence framework with an aim to strengthen practice and support safer organisations.

The Fostering Service has strengthened the following areas, in response to the review:

- Fostering Service recognise when Foster Carers manage difficult behaviour, this increases the risk of conflict and allegations of physical harm being made.
  - SSW will be helping Foster Carers identify ways to avoid aggressive confrontations.
  - Foster Carers will be provided with training about managing difficult behaviour.

- The Support Network of the Foster Carer will be a continue area of further assessment in supervision and reviews of the Foster Carers.
- Foster Carers will be provided with work and training about managing their expectations and disappointment when they feel that a child is rejecting them.
- Foster Carers will be provided with training on attachment.

- Where appropriate Foster Carers views will be obtained during the allegations process. Support will also be given to enable them to prepare for related meetings.

Case Example
December 2014, a female young person (CW) aged 17, living in a residential placement, had raised a concern regarding an adult in her placement to the Children's Right's Officer. She didn't feel that her social worker had given her an adequate explanation following the concerns she had raised. With support of the Children's Right's Officer, she requested this from the LADO which was provided. This young person was then satisfied with the response and how her concerns had been addressed.

What is the evidence for that?

Strategy meetings are attended by the Police Child Abuse Investigation Unit, Fostering Supervising Social Worker, Fostering Team Manager, allocated Social Worker to the child and Team Manager for the child. Strategy meetings are always chaired by an Independent Chair or LADO. The meetings are generally well attended with good engagement from professionals.

The evidence is the outcome of the review and actions taken by fostering to show the benefits of using the information to improve service delivery for the benefit of children's safety.

The information from the training events gives a reflection of the learning that individuals take back to their work place to safeguard children. The following are quotes from the feedback from training and actions that delegates would take forward.

8. Challenges and Conclusion 2015-2016

The LSCB has made significant progress over the last year and a summary of that progress was presented to the Leicester City Council Improvement Board in May 2016 by former Independent, Chair Dr David Jones.

All LSCB partners have worked very hard over the last year to support the improvement plan. Progress has been made in a number of key areas, including Neglect, CSE and Missing. We have also actively engaged with front line practitioners and with young people.

Significant challenges remain; partners are working at full capacity in a climate of inspection, austerity cuts and increased pressure but there is a renewed commitment to working together to safeguard children in the most effect and efficient way possible.

As the new LSCB Chair I want to work on continuing to drive improvements. I have undertaken an effectiveness review and made a number of changes to structure *(See Appendix 2 – LSCB Structure Chart from September 2016)*, constitution and processes going forward to ensure we continue to build on the progress made. With partner agency support we have re-defined the LSCB strategic priorities for the next 18 months illustrated below. Our forthcoming LSCB business plan 2016-2018 outlines the detail of this work and can be found on our website - www.lcitylscb.org

I am looking forward to reporting on this further next year.

LSCB Strategic Priority - 1

The LSCB is to be assured that there is evidence to consistently demonstrate that children and young people are effectively safeguarded.

LSCB Strategic Priority – 2

To be assured that 'Early Help' services are accessed and delivered effectively and thresholds are understood and consistently applied.

LSCB Strategic Priority - 3

LSCB is to be assured that there is a culture of continuous system of single and multi-agency learning and Improvement.

LSCB Strategic Priority - 4

LSCB is to continue to improve its governance, performance and quality assurance process and to be assured of the effectiveness of the LSCB.

9. Appendices

Appendix 1 - LSCB Members List 2016
Appendix 2 - LSCB Structure Chart 2016