Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **THURSDAY, 30 JANUARY 2020**

TIME: **5:30 pm**

PLACE: **Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Commission

Councillor Kitterick (Chair)
Councillor Fonseca (Vice-Chair)

Councillors Aldred, Chamund, March, Dr Sangster and Westley

1 unallocated Non-Group place.

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

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester

For Monitoring Officer

Officer contacts:
Jason Tyler (Democratic Support Officer):
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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information

If you have any queries about any of the above or the business to be discussed, please contact:
Jason Tyler, Democratic Support on (0116) 454 6359 or email jason.tyler@leicester.gov.uk
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USEFUL ACRONYMS RELATING TO
HEALTH AND WELLBEING SCRUTINY COMMISSION

Acronym	Meaning
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
BCF	Better Care Fund
BCT	Better Care Together
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
CCG	Clinical Commissioning Group
LCCCG	Leicester City Clinical Commissioning Group
ELCCG	East Leicestershire Clinical Commissioning Group
WLCCG	West Leicestershire Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DAFNE	Diabetes Adjusted Food and Nutrition Education
DES	Directly Enhanced Service
DMIRS	Digital Minor Illness Referral Service
DoSA	Diabetes for South Asians
DTOC	Delayed Transfers of Care
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EDEN	Effective Diabetes Education Now!
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
FBC	Full Business Case
FIT	Faecal Immunochemical Test
GPAU	General Practitioner Assessment Unit
GPFV	General Practice Forward View

HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HEEM	Health Education East Midlands
HWLL	Healthwatch Leicester and Leicestershire
ICS	Integrated Care System
IDT	Improved discharge pathways
ISHS	Integrated Sexual Health Service
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LTP	Long Term Plan
MECC	Making Every Contact Count
MDT	Multi-Disciplinary Team
NDPP	National Diabetes Prevention Pathway
NICE	National Institute for Health and Care Excellence
NHSE	NHS England
NQB	National Quality Board
OBC	Outline Business Case
OPEL	Operational Pressures Escalation Levels
PCN	Primary Care Network
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
QNIC	Quality Network for Inpatient CAMHS
RCR	Royal College of Radiologists
RN	Registered Nurses
RSE	Relationship and Sex Education
STI	Sexually Transmitted Infection
STP	Sustainability Transformation Plan
TasP	Treatment as Prevention
TASL	Thames Ambulance Services Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

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 on the agenda.

3. MINUTES OF PREVIOUS MEETING **Appendix A (Pages 1 - 8)**

The minutes of the meeting held on 5 December 2019 are attached and the Commission is asked to confirm them as a correct record.

4. UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT A PREVIOUS MEETING

To receive updates on any matters that were considered at previous meetings of the Commission.

5. PETITIONS

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

6. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

The following question has been received from Jean Burbridge:

"Will the University Hospitals of Leicester NHS Trust place its Pre-Consultation Business Case, financial plan and any other relevant detailed plans on the re-configuration of its three hospitals into the public domain at least two months in advance of any formal 'consultation' process?

Will they also explain details of how its plan fits in with the wider Better Care Together Long Term Plan for Leicester City, Leicestershire County and Rutland County (LLR) including details of Community (Health) Services Review."

An electronic copy of a petition has been sent to the Joint Health Overview Scrutiny Commission signed by 369 residents of LLR requesting similar to the above. The wording of this petition is:

PETITION TO LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

We, the undersigned, are concerned about the ongoing refusal by University Hospitals of Leicester to share detailed information about their plans to reconfigure acute hospital services, which include the closure of the Leicester General Hospital as an acute hospital. Only this month, UHL has refused again a Freedom of Information request for this document. When health leaders elsewhere in England are content to place the pre-consultation business cases (including updated versions) for other health reconfigurations in the public domain for the months or years leading up to consultation (such as South Tyneside and Sunderland, and Surrey Downs and Sutton, South West London), we do not understand the persistent refusal to share the equivalent document with the public in Leicester, Leicestershire and Rutland. The CEO of UHL states a wish to embark on formal consultation as soon as March this year and yet just two months beforehand, the public still know very little of the details and assumptions underpinning the plan. Given the mixed track record of capacity planning in the local NHS, we believe it is essential this document and other relevant documents now be placed in the public domain well ahead of the start of consultation so that the public have the opportunity to make informed responses in the first wave of consultation responses, which tends to occur in the early phase of the consultation period. We also fear that UHL's failure to engage the public on the basis of adequate information renders the forthcoming consultation vulnerable to legal action.

We call upon the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee to ask for this document to be placed in the public domain now as a condition for future agreement to formal consultation and to consider availing itself of expert advice regarding what the public can reasonably expect and what needs to be in place to ensure there are no grounds for a successful future legal challenge.

7. OVERVIEW OF LEICESTER MATERNITY SERVICES **Appendix B (Pages 9 - 12)**

The Director of Strategy and Communications (UHL NHS Trust) submits a briefing paper on the overview of Leicester's Maternity Services.

8. CCGs CONFIGURATION **Appendix C (Pages 13 - 40)**

The CCGs submit the consultation document "The role and form of a single strategic commissioner for an Integrated Care System in Leicester, Leicestershire and Rutland".

9. LOCAL PLAN AND HEALTH JOURNEY **Appendix D (Pages 41 - 48)**

The Director of Public Health submits a report, which provides information on the health-related input to the Local Plan and the relationship built between the Public Health and Planning departments over the past years.

10. GENERAL FUND REVENUE BUDGET 2020/21 TO 2021/22 **Appendix E (Pages 49 - 78)**

The Director of Finance submits a report setting out the City Mayor's proposed budget for 2020/21 to 2021/22. The Commission is recommended to consider and comment on the Health and Wellbeing elements of the budget. The Commission's comments will be forwarded to the Overview Select Committee as part of its consideration of the report before it is presented to the Council meeting on 19 February 2020.

11. LEICESTER'S FOOD PLAN 2020-25 **Appendix F (Pages 79 - 86)**

The Director of Public Health submits a report, which provides a summary as to the development of the Food Plan 2020 - 2025 and other associated initiatives.

12. WORK PROGRAMME **Appendix G (Pages 87 - 88)**

The Commission's Work Programme for 2020/21 is attached for information and comment.

13. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: THURSDAY, 5 DECEMBER 2019 at 5:30 pm

P R E S E N T :

Councillor Kitterick (Chair)
Councillor Fonseca (Vice-Chair)

Councillor March Councillor Dr Sangster

In Attendance:

Councillor Dempster, Assistant City Mayor - Health

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40. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Aldred, Chamund and Westley.

41. DECLARATIONS OF INTEREST

There were no Declarations of Interest.

42. MINUTES OF PREVIOUS MEETING

AGREED:

that the Minutes of the meeting of the Health and Wellbeing Scrutiny Commission held on 10 October 2019 be confirmed as a correct record.

43. UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT THE PREVIOUS MEETING

The Commission received an update on the following items that had been considered at a previous meeting:-

The Chair reported on the outcome of recent meetings with traffic & highways regarding parking permits at hospital sites, including a proposal for two-hour permits for visiting health care providers and workers.

It was also reported that the consultation on the UHL plans were delayed due to recent communications deferring the Joint HOSC with the County Council. It was expected that the delay would mean that discussions would not commence for several months.

The following three items had been added to the work programme for future meetings:

- LLR Urgent & Emergency Care Transformation Plan
- Manifesto commitments
- Access to leisure services

44. CHAIR'S ANNOUNCEMENTS

The Chair reported that he had no other specific announcements as current issues were covered in subsequent agenda items.

45. PETITIONS

The Monitoring Officer reported that no petitions had been submitted in accordance with the Council's procedures.

46. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations or statements of case had been submitted in accordance with the Council's procedures.

The Chair indicated that items would be considered out of the order listed in the agenda as follows:

47. PRESCRIBING - UPDATE ON THIRD PARTY ORDERING OF REPEAT PRESCRIPTIONS

Lesley Gant (Head of Medicines Optimisation) presented the report of the Leicester City CCG.

It was reported that the CCG had a team of experienced Clinical Pharmacists and Pharmacy Technicians that lead the Medicines Optimisation Agenda (also supporting GP practices to do so). This team also looked at the value that medicines deliver, making sure they are clinically effective and cost efficient, and safeguards the best use of the prescribing budget for the CCG. The report also defined the aims and importance of the Medicines Optimisation agenda at national, regional and local level.

Details of the current third party ordering and repeat prescription processes were reported including risks that had been recognised . In response to this issue it was reported that the CCG had reviewed the whole process of repeat prescription ordering as well as the management and patient self-care around repeat medication and long-term conditions.

The CCG has put forward to practices a number of recommended actions, which culminates in changes to third party ordering of prescriptions, as follows:

- Practices will be encouraged to undertake a review of current processes of repeat prescription management. This involves general housekeeping to ensure current systems are safe, appropriate and follow national and local best practice.
- Practices are encouraged to further promote and support the use of online services for patients to order their repeat medication, where they are able to do so, and provide patient training to facilitate this.
- Support greater use of electronic transfer of prescriptions (EPS) and Electronic Repeat Dispensing (eRD) (batch prescriptions for consistent repeat orders).
- The final stage of this process would be a carefully managed implementation programme to reduce patient reliance on third party ordering across Leicester City taking account of learning from areas where this has already being implemented.

Commission members were invited to ask questions and comment on the report and its findings.

Members referred to the concerns raised by constituents relating to the confusion they experienced, particular with the move to online services. It was noted that many vulnerable and elderly patients experienced problems. The issues concerning language gaps was also raised, it being noted that the support of some local pharmacies was crucial.

In response, reassurance was provided that paper prescriptions would continue to be available for vulnerable patients, and it was expected that the move to the electronic transfer would also benefit many vulnerable and elderly patients.

Initiatives including the availability of support packs to practices and increased mailshots to advise of the changes were reported and noted. The availability of information printed in various languages was also recognised. In respect of the consultation process and the number of respondents providing the sample information, it was noted that although 169 respondents seemed a low number, the CCG had been informed that this was a suitable level of response to help to inform future policy.

Comment was raised on the numbers of complaints that had been received to date and the need to support those affected by the proposed changes was emphasised, including the concerns raised by pharmacies. The CCG considered that the levels of comments and complaints were relatively low and that full consideration was given to the process in responding to and learning from comments.

The Assistant City Mayor (Health) was invited to comment. Councillor Dempster referred to the need to ensure effective training to pharmacy staff and GPs. She also expressed concern at the delays that may result in accessing the electronic system.

In reply it was reported that the training was provided as part of the national scheme and that many GPs and staff had supported the move to electronic services as it was in the practice interest to allow greater time for other patients. It was also noted that the information held electronically would ensure that harm could not be caused with the wrong medication being prescribed.

It was reported an noted that a number of actions are now being taken to support practices with implementation, including a communications campaign, updates to the CCG website, social media accounts, messages displayed via GP practice TV screens, and traditional media.

There would also be continued full dialogue with the Local Pharmaceutical Committee to ensure that all community pharmacy and other third party providers are aware of
Scheme and support to member practices to help identify vulnerable patients who will still require help with ordering their prescriptions.

In conclusion, it was reported that the CCG had provided support from September 2019 and practices had been able to implement the initiative within their own timelines from October 2019, up until March 2020.

The Chair commented that members of the Commission would welcome any information on the proposed evaluation process before it was implemented.

AGREED:

1) That the report and update be noted,

2) That a further report on the evaluation be submitted to the Commission following implementation to March 2020.

48. 0-19 CHILDREN'S OFFER

The Director of Public Health submitted a report, which gave details of the 0-19 Healthy Child Programme, the key aspects of which were as follows:

- Commissioned by Public Health, on behalf of Leicester City Council.
- Based on a national specification, shaped by local need.
- Is an early intervention and prevention programme that is offered to every family with children and young people aged between 0-19 years living in Leicester city.
- Offers evidence-based developmental reviews, information and interventions to support the healthy development of children and young people.
- Provides support to children and young people in a confidential, visible, engaging and accessible way.
- Identifies levels of need and those who need more help will be provided with additional, evidence-based support, appropriate to their needs.

It was reported that the 0-19 Healthy Child Programme (0-19HCP) was known locally as Healthy Together and was delivered by the Families, Young People's and Children's (FYPC) Division of Leicestershire Partnership NHS Trust (LPT), who also deliver across Leicestershire and Rutland. It was also reported that Healthy Together is a high performing service with national performance data showing that the service delivered above the England average for Health Visiting metrics with the recent CQC inspection had rated the service as Good – Outstanding.

Clare Mills (Childrens Commissioner, Public Health) and Janet Houseman (LPT) gave a presentation outlining the details of the current provision, data and inspection statistics. The presentation also outlined key aspects of future proposals.

The Chair invited Commission members to comment on the report and presentation.

Members questioned the information concerning health visits and referred to individual experiences where visits had led to distress and anxiety. In response it was explained that the service was developing systems and processes that would improve the outcomes. Councillor March requested that information concerning the continuity of the service and health visits be forwarded to her, which was accepted by the LPT.

Further comments were made in regard to oral health and dentistry, obesity, and the perception of parents that they were being 'judged' by schools and health visitors.

It was accepted that further information on obesity with any data mapping would be useful for members. In respect of area mapping of data, the success of the recent Eyres Monsell breast feeding initiative was highlighted and it was

suggested that information on this, and any other similar community-based approaches to programmes could also be circulated to the Commission members by the LPT, together with any ethnicity breakdown.

In response to a further question it was agreed that any local data on the oral hygiene of children be circulated.

The demands on resources of all services was recognised and the issues of 'health literacy' were raised, with the work of the school nurses being cited as an example of good practice. It was noted that there were limits on the service and pressures were always evident on capacity to meet demands.

In conclusion, the Assistant City Mayor (Health) advised that as part of current legislation (Section 75 of the Act), a discussion would be held with the current provider of school nursing services and advised that the involvement of scrutiny would be key to that process.
AGREED:

1) That the report and update be noted and that a further update be submitted in due course, particularly concerning the provision of school nurses.

2) That in the interim the information concerning data mapping of dental health, obesity, ethnicity breakdowns and any information concerning community-based approaches be circulated to Commission members separately, with a view to specific reports on issues being submitted in due course.

3) That information concerning the continuity of health visitors work be circulated.

Councillor Sangster left the meeting at 7.10pm.

49. ALL-AGE MENTAL HEALTH TRANSFORMATION PROGRAMME

Gordon King (Director of Mental Health Services, LPT) and John Edwards (Associate Director of Transformation, LPT) gave a presentation to outline the key aspects of the Mental Health Transformation Programme.

It was noted that using best practice evidence, strong analysis and extensive co-design with partners and staff, an overhaul of the mental health system had been proposed to deliver direct access and be more responsive. The revised system would be aligned towards integration in the community to tackle long waits and to standardise processes and to increase facilitated discharge.

In terms of the next steps, it was reported that engagement with public and stakeholders around the whole co-designed plan in early 2020.

A targeted engagement would be part of each change and the implementation programme would increase in size and pace across 2020 and beyond to 2022 and would maintain the involvement of service users and carers

The Chair requested that the Commission be kept informed of developments throughout the consultation process to ensure proper scrutiny of the programme.

Commission members commented on the initial programme and made comments concerning bed numbers and it was reported that the number and availability of beds was unchanged, but the programme led to an improved method of managing the movement of patients through the process. It was accepted that the strategic business case concerning pathways would be submitted in due course.

The Assistant City Mayor (Health) welcomed the initiative to involve partners in the discussion on the transformation programme and suggested that wider representatives of the Adult Social Care arena could be included. This view was supported by Healthwatch.

AGREED: That the presentation be noted and that further updates be submitted to the Commission in due course.

50. STRATEGIC OUTLINE CASE FOR THE REBUILD OF THE BRADGATE UNIT

Further to the presentation and debate at Minute 49 above, Gordon King (Director of Mental Health Services, LPT) circulated a briefing paper which provided an update on the Strategic Outline Case for the new-build mental health inpatient unit at the Bradgate Unit.

AGREED: That the briefing paper be noted.

51. PUBLIC HEALTH CONTRIBUTION TO SPACE STANDARDS

The Director of Public Health submitted a report, which provided a view on factors that make for healthier homes and neighbourhoods and the specific role of residential space standards. The report also provided details of collaboration between the Public Health and Planning Departments, in respect of residential space standards.

In terms of the ongoing liaison with the Panning Departments it was confirmed that the public health concerns of over-crowded accommodation had been considered in the new draft Local Plan.

The importance of adequate space to address mental health issues had also been highlighted.

The Chair reminded the Commission of the historical issue of space standards and commented on previous negotiations and discussions with property developers on the subject. It was noted that the draft Local Plan would be considered by the Commission at its next meeting on 30 January 2020.

AGREED: That the report and position be noted.

52. WORK PROGRAMME

The Commission's Work Programme was submitted for information and comment.

AGREED: That the Work Programme be noted and the progress on those items listed at Minute 43 above be added.

53. CLOSE OF MEETING

The meeting closed at 8.00pm.

Appendix B

Overview of Leicester Maternity services for Leicester City Health and Wellbeing Scrutiny

Leicester Maternity services provides Obstetric care on two acute sites LRI and LGH, both have alongside midwifery lead units for women who have no risk factors. There is also a standalone birthing unit at St Mary's in Melton Mowbray and a large community midwifery service incorporating the Home Birth team.

A number of external reviews of the maternity service have identified the need for co-location owing to fragility in staffing structures. Until recently there has not been the financial support to reconfigure the services, therefore a number of interim steps have been identified to mitigate the risks of sustaining the services on two sites until colocation can take place.

- Separate the elective obstetric pathway at LGH to provide another Consultant on site and take pressure off the emergency pathway and decongest the delivery suite.
- In order to develop a robust elective pathway, capital is required to improve the current LGH maternity theatre and to upgrade the adjacent procedure room to create a second facility (theatre) suitable for the elective pathway.
- Increase the out of hours support for emergency theatre activity at the LGH.
- Increase senior consultant obstetrician presence and decision making for the Maternity Assessment Units and Ward cover on both the LRI and LGH sites.
- Develop a Day Care antenatal assessment service on both sites working alongside MAU and Fetal and Maternal Medicine; largely midwifery provided but supported by increased Consultant commitment to MAU and the Wards.
- Enhance the triage service in Antenatal Assessment (MAU and Day Care) and Ultrasound

Performance
In 2017 Maternity services at UHL were rated 'good' overall and we are currently awaiting the final CQC report from the latest inspection carried out in September 2019.

In 2019 at the National Maternity and Midwifery Festival, the maternity team from UHL were awarded the team award for outstanding contribution to maternity and midwifery services.

Within the East midlands UHL maternity services have the lowest smoking at delivery rate and the best breast feeding initiation rates. The LGH, St Marys and community midwifery were awarded level 3 Baby friendly status in July 2019 and the infant feeding team are now working towards the assessment for LRI, who are currently level 2.

National Requirements

In October 2016 the DOH published Safer Maternity care-Next steps followed by Safer Maternity care-Progress and Next steps in November 2017. This report describes the actions of the UHL Maternity Service in response to the National focus on Maternity care particularly in relation to safer care.

The recommendations of the National Maternity review (Better Births) describes the vision to be delivered through locally led transformation, supported at regional and National level, which incorporates all the commitments of the Each Baby Counts programme and the National ambition and these are all brought together locally in the Maternity Transformation plan which is monitored and reviewed at the local Maternity and Neonatal System (LMNS) and regionally in the clinical networks.

Each Baby Counts was launched in 2014 with the aim to achieve a 50% reduction by 2020 in incidents during term labour that lead to stillbirth, early neonatal death or severe brain injury.

The objectives of this were

- To establish on-going UK-wide surveillance of intrapartum stillbirth, early neonatal death or severe brain injury at term
- To undertake on-going analysis of local governance and risk management reviews of these babies' care
- To develop a rolling action plan based on these findings that is suitable for local implementation
- To monitor the impact of the action plan by measuring the effects and side-effects of any interventions.

Leicester Maternity services have reported to Each Baby Counts and completed the national perinatal review tool since the launch, to ensure consistency of reporting nationally

The National Maternity review-Better Births published in March 2016 produced many recommendations, personalised care and continuity of care are a priority focus. There are now 44 local Maternity and Neonatal systems nationally who have developed plans for implementation of all the recommendations but mainly setting out how they will deliver safer and more personalised care by the end of 2020/2021. Locally the Maternity Transformation plan has included

- All women having a personalised care plan
- Most women having continuity of carer
- More women giving birth in midwifery settings
- Reducing the rates of stillbirth and brain injury
- Multidisciplinary teams thoroughly investigating incidents and sharing knowledge and learning with all the service and the Local Maternity and Neonatal system (LMNS)
- Improve situational awareness among all health professionals, encouraging raising concerns
- Multidisciplinary teams develop the knowledge and skills in quality improvement

The **Saving Babies Lives** care bundle-Version 1 was implemented as required by March 2019, the launch of Version 2 then took place which has 5 elements to implement as oppose to 4. The elements of the care bundle have all been found to contribute to reducing stillbirth, neonatal death and brain injury. UHL maternity services have had a 30% decrease in perinatal mortality since 2010 with a significant fall in stillbirth rates particularly in the last two years.

Maternity and Neonatal safety collaborative Launched in February 2017 by NHS Improvement, this is a national initiative to provide support for all Maternity services to implement quality improvement; this is to roll out over three years. Leicester Maternity service were placed in wave 3 and commenced the quality improvement journey in March 2019 and now hope to present their project nationally in March 2020. The project was to improve safety and the maternity team looked to improve neonatal outcomes and reducing term admissions to Neonatal units by fetal surveillance and escalation.

Specific Information Requested

Home Birth Service
Alongside the national initiatives Leicester Maternity service launched a new style provision in September 2018, for home births. The rate of home births in LLR had remained around 1.2% for many years and the service was covered by community midwives providing an on call system. During the Trust review of the on call system and lone working, the team decided to case hold all home birth women and provide a dedicated team to cover the service 24/7. The team has worked hard to promote home birth and has delivered 500 babies at home since it began, therefore increasing the rate of home birth so far to 2%. It is evaluated extremely well by the Women.

Maternal Mortality
In November 2019 the MBRRACE-UK Maternal Mortality report-Saving Lives, Improving Mothers Care, was published looking at data for women who died during the period 2015-2017. Nationally there were 209 women died during or up to 6 weeks after pregnancy from causes associated with their pregnancy. Maternal mortality is only given as a national rate due to the total numbers being so small, the rate in the report is 9.2 women per 100,000, nationally. Underlying maternal health, age, ethnicity and deprivation are all known risk factors and all considered by the UHL clinical teams as they talk with mums to be.

Patient Feedback
There are several methods of collecting patient feedback; the national monthly reporting method is Maternity Friends and Family test. There is a national requirement to collect at Least 30% of the women who use our service, the scores for this are reported publically, in 2019, 90%-97% of women would recommend or highly recommend our services.
The CQC collect data annually which is reported as a National Maternity survey and collated and published by the Picker institute, they survey all women who delivered in the month of February each year on a wide range of questions. The 2019 survey is due to be released nationally January 2020. Leicester maternity service had improved in 6 questions and were worse than 2018 in one question.

Locally Women's services also gain patient feedback through 'message to matron'. In January 2018 Healthwatch Leicestershire commissioned a patient and staff experience report 'In Mum's Words' gathering experiences from local women and health care professionals. This was discussed at the LMNS (Local maternity and neonatal system).

Bounty Contract
UHL Maternity services continue to have a contract with an organisation called Bounty who provide packs to women with a variety of free samples and information for mums and babies. The contract is reviewed annually, there is no obligation to do this, however 98.2% of women when asked reported that they like to receive these packs. Bounty also provide a photography service on the wards, this service goes to tender when it is due for renewal. The contracts and meetings with Bounty are held with a senior procurement lead and clinical leads to ensure the information and samples abide with local policy.

Access to Maternity Services
There is no policy in place that women must prove eligibility for maternity care, if they have a positive pregnancy test they can access maternity services by attending their GP's surgery where a midwife is allocated. Over a number of years UHL midwives have tried to encourage women and the surgeries to book the women an appointment with a midwife but traditionally they have an appointment with a GP first and then book in with a midwife. This can cause delay as the national recommendation is to book for maternity care before 10 weeks. Having changed in the past 2 years from 12 weeks. This data is monitored on the local maternity dashboard, currently around 75% of women book before 10 weeks and 92% before 12 weeks.

Finally, as Councillor colleagues will know we are about to consult with the public on plans to invest circa £108m in a new state of the art maternity hospital at the Royal and stand-alone midwifery unit at the General. As well as providing purpose built modern facilities for women, their babies and their families, the co-location of maternity services will also solve some of the long standing staffing issues that have been exacerbated by trying to run a modern maternity service from 3 sites without enough midwives, obstetricians and neonatologists.

Elaine Broughton, Head of Midwifery, University Hospitals of Leicester NHS Trust.

Appendix C

The role and form of a single strategic commissioner for an Integrated Care System in Leicester, Leicestershire and Rutland

December 2019

A partnership between:

- East Leicestershire and Rutland Clinical Commissioning Group
- Leicester City Clinical Commissioning Group
- West Leicestershire Clinical Commissioning Group

Introduction and executive summary 01

The NHS Long Term Plan aims to establish a health service fit for the future. Its ambition is to give everyone the best start in life, deliver world-class care for major health problems such as cancer and heart disease, and help people age well.

The plan, published by the Government in January 2019, identifies local Integrated Care Systems (ICS) as the way forward. These build upon existing Sustainability and Transformation Partnership footprints to bring together NHS organisations in collaboration with local authorities and others such as the voluntary and community sector, to take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.

As part of these arrangements there will be one strategic commissioning voice for each ICS, typically in the form of a single clinical commissioning group (CCG). It is expected that an ICS will be in place in Leicester, Leicestershire and Rutland (LLR) by April 2021.

The three CCGs in LLR currently have responsibility for commissioning the majority of health services for the local population. We are working with our partners to determine what an ICS looks like in LLR and a key part of this is considering how best to form a single strategic commissioner locally.

No decisions on the future form of a single strategic commissioner have yet been made but, having undertaken an initial assessment of the options, we do have a current preference to work towards the creation of a new single CCG for LLR.

We believe this is likely to be the most effective solution to help us deliver improved care and outcomes for patients across our whole area, allow for targeted resource allocation to tackle health need and inequalities, and enable the system to become financially sustainable.

This is because the system as it is currently configured naturally means that the majority of our financial resources tend to land with our acute hospitals, with an emphasis on supporting people to recover when they become unwell.

Changing the way that the system works through the creation of an ICS and the coming together of the three existing CCGs as one new strategic commissioning organisation gives us the greatest opportunity to redirect resources to others services – such as general practice and community services.

This will allow a greater focus on preventing ill health and managing long-term health conditions proactively to keep people well and out of hospital wherever possible.

Fundamentally the development of an Integrated Care System - which would operate at the three levels of system (LLR), place (existing upper tier local authorities) and neighbourhood (emerging Primary Care Network geographies) – is very different to the way in which the local NHS has worked over the last two decades.

At its heart the new system represents a move away from the competition between NHS providers, which has prevailed over the last two decades. Whilst these arrangements have helped the NHS make good progress against some key challenges such as excessive waiting times, they have often led to patients being caught between organisations and their priorities, with patients' care or experience suffering as a result.

In this context the role of the strategic commissioner will be significantly different to that of existing CCGs. No longer will the focus be on specifying the way in which services are delivered in a particular area, or procuring and monitoring individual contracts.

Instead the focus will be on taking a whole-system view of the requirements of the patient population based on known needs and health inequalities, and setting clear expected outcome improvements for those groups. It will also be responsible for allocating resources to providers, who will operate collaboratively at existing upper tier local authority levels, and in partnership with statutory Health and Wellbeing Boards, to decide upon the best approaches to delivering those desired outcomes, based on a detailed local knowledge of their populations.

The strategic commissioner will be accountable for the money we receive from Government and how we spend it, whilst monitoring delivery of outcomes across the whole system so as to ensure that our investment is making the intended difference. It will also be responsible for engaging with populations and involving them in decisions about local services and the care they receive. These are all things that we believe can be best achieved by working at scale with one organisation rather than multiple, while also enabling us to deliver operational savings that can be reinvested back into frontline services.

It is believed that working in this new way is most likely to provide the opportunity to make the most of every pound available to us. Whilst we expect spend to increase in every part of the system over the coming years, working as one single CCG would enable us to rigorously prioritise how we allocate our discretionary spend in a way that has not been possible before and has the potential to be genuinely transformative.

In doing so it would allow us to create a new type of commissioning organisation that has this commitment to addressing health inequalities and unwanted variation inscribed at its heart through its constitution, as well as being writ large into the organisation's mission, its vision for the future, and the values by which it operates.

The vision for an ICS in LLR is still under development, with plans evolving and being shaped by our current partnership arrangements under Better Care Together.

This document therefore sets out our current thinking about the LLR ICS and the benefits and opportunities presented by developing a single strategic commissioning organisation. We recognise that it does not contain all of the answers at this stage. However, it provides partners and stakeholders with an opportunity to share thoughts on the future of NHS commissioning arrangements in Leicester, Leicestershire and Rutland. These will be used to shape and finalise our proposals in advance of formal consultation on the matter during 2020.

"We are working with our partners to determine what an ICS looks like in LLR and a key part of this is considering how best to form a single strategic commissioner locally."

The proposal

02

Why do we need to change?

The NHS and our partners face significant challenges in meeting rising demand from a growing, ageing population, with increases in the number of people with complex and long-term conditions. We are also faced with increasing costs of services and challenges in effective collaborative working, when trying to manage finances without simply moving the problem around the system. These issues have put the health and care system in LLR under extreme pressure. It is clear that our current hospital-based model of care cannot meet this rising demand effectively or efficiently. This can be seen in the:

- **Health and wellbeing of local people** - early death rates in some conditions, differences in life expectancies, smoking and obesity rates, and the mixed availability of healthcare close to home.

- **Quality of care** - hospitals and community healthcare providers are struggling to keep up with demand and, as a result, the quality of care suffers. For example, waits for cancer treatment, ambulances, A&E and mental health care are too long.

- **Finance and funding** - increasing costs are exacerbated by inefficient buildings, difficulties in recruiting and retaining staff and friction between NHS organisations and local authorities. In addition, current ways of working stifle a collaborative approach to managing health and care funding. This forces the system to manage budgets on an organisation rather than system basis, culminating in commissioners and providers 'shifting' financial problems around the system rather than tackling and controlling them to deliver financial balance as a whole system.

If we do not take further action now to extend our service transformation plans, then services will decline and our service models, financial plans, workforce plans, buildings and technology will not be able to sustain services adequately for the future.

Locally we have been on a journey to tackle these issues for some time, driven by our LLR Sustainability and Transformation Partnership - Better Care Together.

The NHS Long Term Plan, published in January 2019, provides further impetus through the requirement to develop a local Integrated Care System. This emphasises the need to break down artificial barriers that have been built up between NHS organisations over many years and increasingly focus on networks of NHS and other care providers working together to proactively manage the health of the populations they serve.

These arrangements will build on existing partnership plans to deliver the changes needed locally to achieve better health, care and outcomes for local people.

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What is an integrated care system?

An integrated care system is a way of working collaboratively between a range of health and care organisations to help improve people's health and deliver local health services. In and of itself an ICS is not about creating a new organisation or organisations. Instead it is an enhanced set of partnership arrangements that allow the NHS and others to work together and share budgets, staff and resources, where appropriate, in order to best meet people's needs.

It will do this in conjunction with local authorities and others, such as the voluntary and community sector, to understand populations and their health in detail and deliver holistic services that wrap around the needs of the patient.

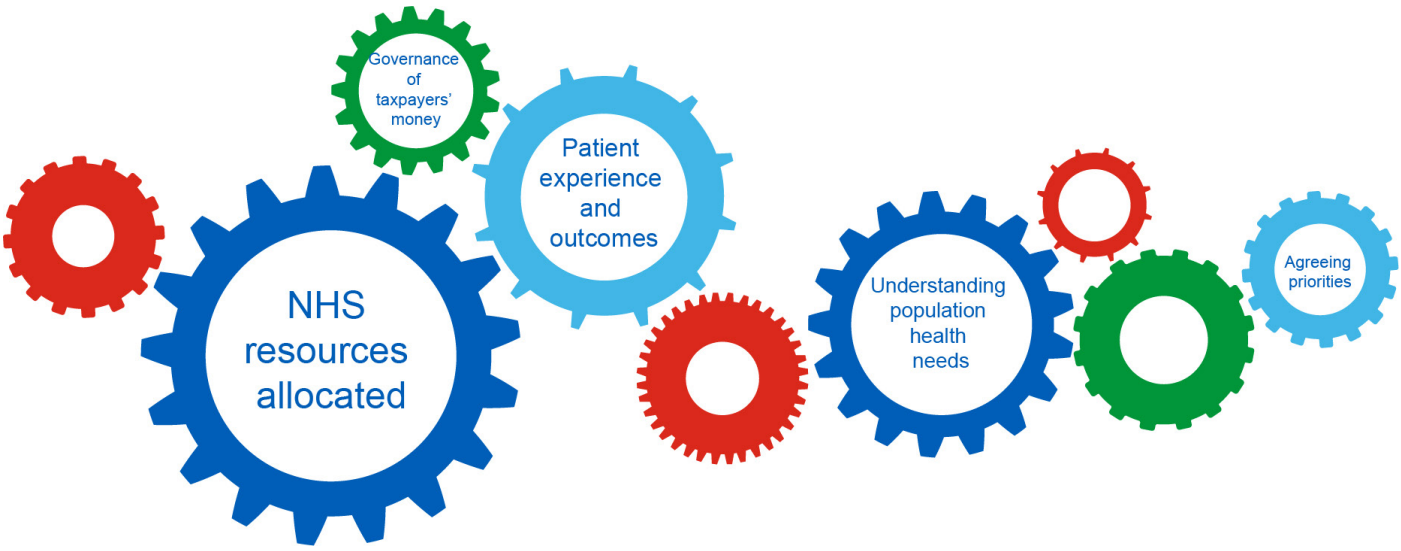
An integrated care system operates at three levels:

System [All of LLR]	A single strategic commissioner will be created to commission health and care services for the whole of LLR, ensuring agreed outcomes are delivered across the patch and within budget. Currently each of the three clinical commissioning groups (CCGs) may be involved this process
Place [Leicester City, Leicestershire & Rutland councils]	Care alliances will bring together hospitals, councils, public health and primary care to develop a complete understanding of local needs within each local authority area. Alliances will design care pathways in response to those needs to deliver better experience and outcomes, with more focus on long-term or multiple conditions
Neighbourhood [Serving 30k-50k people]	Primary care networks will develop multi-disciplinary teams to deliver more services as close to where a patient lives or works as possible, and at a time that is convenient to them. They will draw on the community, voluntary and independent sector, as well as councils to assist with housing and other services

What does this look like in LLR?

The proposals for an ICS in LLR have been developed over recent months and with involvement from NHS organisations, local authorities and representatives from local Healthwatch organisations. Their foundations lie in the learning and experience from our partnership working over a much longer period and from considering best practice elsewhere. Importantly, we have also used insights from members of the public and patients gathered under the Better Care Together programme to help shape our proposals.

System



The overall footprint for our local ICS is Leicester, Leicestershire and Rutland (LLR), which mirrors our current Sustainability and Transformation Partnership – Better Care Together. For NHS organisations it will become the level at which they will be jointly held to account. There will be collective responsibility across NHS organisational boundaries for financial delivery, via an NHS system control total for LLR, and operational performance.

The system footprint will be used as the basis on which national NHS resources will be increasingly allocated and accessed for each ICS, including allocations for NHS capital and technology funding.

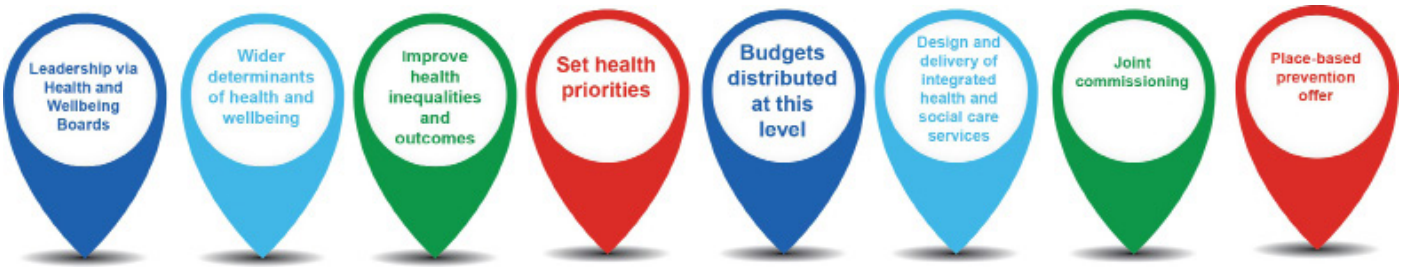
This is also the level at which strategic commissioning within the NHS will operate. In strategic commissioning the focus is on agreeing priorities, focussing on patient experience and outcomes, understanding health needs of the whole population and ensuring overarching governance of tax-payers money.

This move towards developing a single set of strategic commissioning arrangements marks a significant change to the current role and form of the CCGs. It shifts from the traditional model of commissioning as recognised and understood for the last 20 years to one with a greater focus on making shared decisions with providers on how to best use resources, design services and improve population health.

Working together with our partners, at system level, the strategic commissioner will:

- Be accountable to NHS England and NHS Improvement for the overall performance of the NHS in LLR
- Analyse and understand population health and care needs across LLR's one million-plus population, and set and measure outcomes at the LLR system level that addresses known health inequalities and unwanted variation
- Lead the response to the NHS Long Term Plan in LLR
- Lead the overall strategic direction for the Better Care Together programme
- Understand where to allocate NHS resources to 'places' or the care alliance(s) in line with need identified, for example as a result of heath inequalities
- Support local NHS providers to form a local NHS care alliance(s), and in due course commission certain services via the NHS care alliance(s)
- Take ownership and demonstrate leadership in addressing local system challenges.

Place – upper tier local authority boundaries (Leicester City Council, Leicestershire County Council, Rutland County Council)



At this level NHS providers will work with upper tier local authorities and other partners to:

- Be active partners in leadership at place level, in particular via local authority-led Health and Wellbeing Boards in LLR
- Collaborate with local authorities and other partners on the wider determinants for health and wellbeing, so that the health and wellbeing needs of local populations, including population specific health inequalities, are understood and addressed, and place-based outcomes are improved
- Ensure that the LLR-wide Better Care Together strategy, outcomes and priorities meet with expectations and priorities in each LLR place
- Design and deliver integrated health and care services within the place including the Better Care Fund services
- Develop and implement the place-based prevention offer
- Undertake joint commissioning across NHS and local authority organisations, using pooled budgets where applicable.

For NHS organisations this will also be the level at which budgets are likely to be set and distributed by the NHS strategic commissioner and at which population outcome requirements will need to be delivered.

At a place level, NHS organisations will work with upper tier local authorities and other NHS partners to improve health and wellbeing outcomes for their specific populations. Where

appropriate, they will also integrate the delivery and commissioning of health and care. Critical at this level will be the interface with the Health and Wellbeing Board, which will drive forward the localised delivery of improvements within the overall context of the Joint Health and Wellbeing Strategy for that area.

A key component of this level of the ICS will be care alliance(s), which will bring together hospitals, community services and primary care networks to deliver the care needed for local populations, based on assessments of local need determined and directed by Health and Wellbeing Boards, supported by public health insight, at local authority level. Social care may also choose to be part of the care alliance(s) should it so wish.

Care Alliance(s)

Within LLR we have two main local NHS providers - University Hospitals of Leicester NHS Trust, which provides acute hospital-based care, and Leicestershire Partnership NHS Trust, which provides community, mental health and learning disability services. These are supported by around 120 general practices, which are at the frontline of health provision and are usually the first point of contact for patients.

At a regional level we have two main providers in East Midlands Ambulance Service, our emergency transport provider, and DHU Health Care, a provider of primary, out-of-hours and urgent care services. The newly formed primary care networks are also provider organisations.

Although there has been a tradition to date, through our Better Care Together programme, to plan and redesign services across partners, provision has been focused on individual organisations. We believe that in order to meet our challenges a new approach is needed and more collaboration between providers is required.

To deliver this we will develop an NHS care alliance(s) across LLR. Work is ongoing to develop this, but it is likely to have a core membership of our main local NHS providers including our primary care networks. Other NHS providers, including those outside of LLR but who provide services to our patients, will need to consider whether they formally become part of the arrangement or want to be partners collaborating where it makes sense to do so. Local authorities and other providers such as the voluntary sector are likely to be organisations with which the care alliance(s) will work collaboratively to deliver some services, particularly at place and neighbourhood level. Diagrams showing how this would work are shown on page 9.

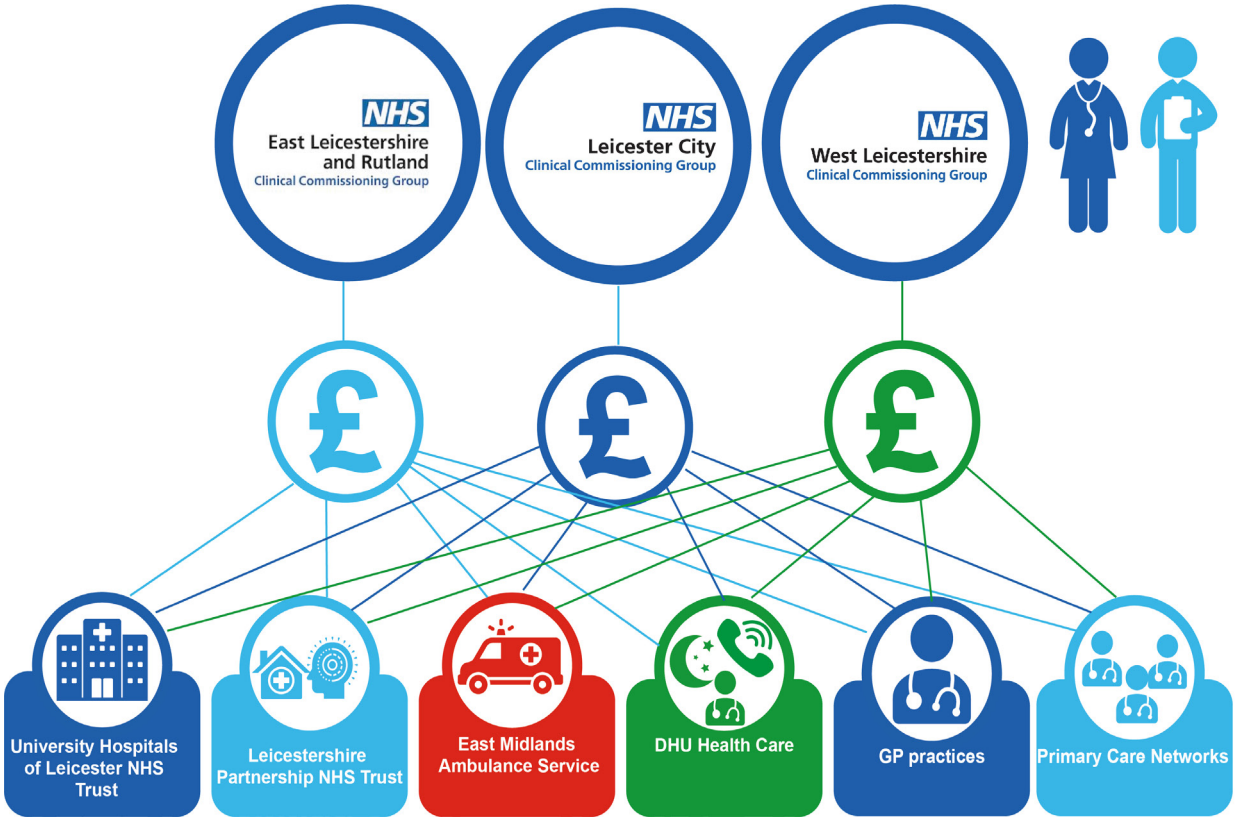
The final crucial component of care alliance(s) and the ICS, will be the primary care networks across LLR.

Neighbourhood – primary care networks

Neighbourhoods are the cornerstone of integrated care across LLR. They are based on 25 groups of GP practices, known as Primary Care Networks (PCNs). These networks, which were established on 1 July 2019, will be the focal point for delivery at the place level - working closely with social care and many other agencies to coordinate and manage care close to home for populations of 30-50,000 patients.

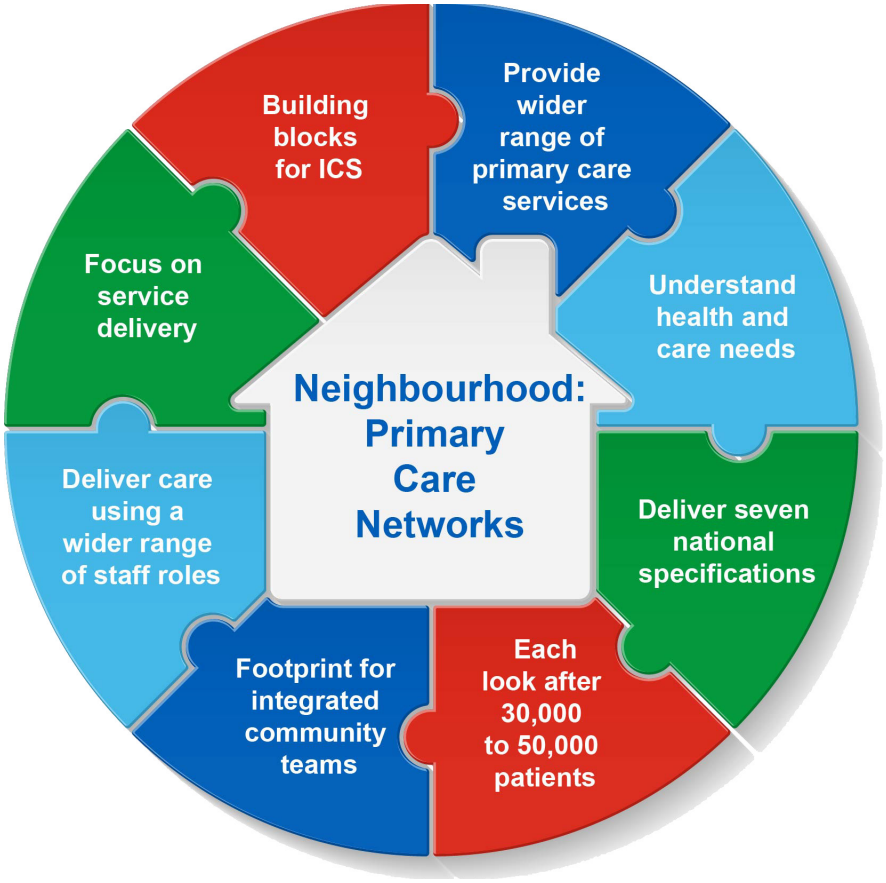
PCNs will be expected to provide a wider range of primary care services to patients, involving a wider set of staff roles than might be feasible in individual practices. They will also be the footprint around which integrated community-based teams will develop. Community and mental health services will be expected to configure their services around PCN boundaries as far as is practicably possible.

Current contracting arrangements:



Contracting under a care alliance:

Primary Care Networks will primarily be focused on service delivery, rather than on the planning and funding of services. This responsibility will remain with commissioners at a system level, supported by local authorities and the Health and Wellbeing Boards where a more localised approach is needed.



However, PCNs are expected to be the building blocks around which integrated care systems are built. The ambition is that they will be the mechanism by which primary care representation is made stronger in integrated care systems, with the clinical directors from each network being the link between general practice and the wider system.

A core role of PCNs will be to deliver against seven core national asks, which are set out as a series of service specifications.

Five will start by April 2020. These include: providing structured medication reviews for patients, delivering enhanced health in care homes, putting in place anticipatory care plans which help patients to make informed decisions about how and where they want to be treated and supported in the future, personalised care to support patients to have choice and control over the way their current care is delivered, and supporting early cancer diagnosis.

Two others will start by 2021. These include cardiovascular disease case finding and locally agreed action to tackle health inequalities (for which the Health and Wellbeing Board will take the lead role).

In summary, PCNs will:

- Understand their specific neighbourhood population health and care needs
- Deliver effective and consistent core general practice services, working collaboratively where it makes sense to do so
- Deliver enhanced primary care services either as individual practices or across a primary care network that enables patients to receive care closer to home - this may include some outpatient and diagnostics
- Design and deliver integrated health and care services with a range of partners (including social care and the NHS care alliance(s)) to meet the needs of the population
- Develop a fully functioning integrated team or network of primary and community care staff, aligned with social care and other community-based services, to support citizens with the most complex needs to stay as independent, and as close to home, for as long as possible.

What do we want to achieve through an ICS?

Ultimately we want better health, care and outcomes along with reduced health inequalities for the people of Leicester, Leicestershire and Rutland.

As part of an integrated care system, we believe there will be greater clarity of vision and purpose, and the speed of decision making and service transformation across the NHS in LLR should improve. It will also help to improve the quality and performance of the services provided, as well as the experiences of patients.

With the NHS moving away from the existing commissioner vs provider arrangements, we also believe the ICS will enable better collaboration and integration between NHS partners, and with other agencies in LLR where appropriate.

It will enable us to focus not only on outcomes associated with improved health and care service delivery, but also those outcomes that are concerned with the wider determinants of population health and wellbeing. The ICS will have a number of positive implications for population health outcomes. The diagram below outlines the benefits that an ICS will bring for our population, how this will be achieved and how our population will notice the difference.

An ICS will ensure that all partners collaborate to improve health outcomes for the entire population and utilise our available resources to tackle health inequalities. It will remove traditional organisational barriers and ensure all partners work collaboratively to deliver excellent patient care.

As a result, our patients will benefit from:

- More integrated joined up care
- New services to support improved health outcomes
- Improved access to services
- Improved joint working across health and local authorities to tackle the wider determinants of health and wellbeing
- Improved quality of care.

What is clear from our work so far is that these benefits and outcomes can only be achieved by taking a unified partnership approach, both in terms of how care is co-ordinated and delivered, and how it is commissioned. This is why the role of the single strategic commissioner will be vital in the ultimate success of an ICS in LLR.

Developing a new single strategic commissioning function for Leicester, Leicestershire and Rutland

What is a CCG and what do they do?

Clinical Commissioning Groups do not provide health services. Instead they are responsible for planning and commissioning health care services for their local area with resources delegated to them by NHS England. They are accountable to NHS England, and Parliament, for how they use these resources and the results they achieve.

Commissioning is about getting the best possible health outcomes for the local population. This involves assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, community health providers and GPs among others.

CCGs must constantly respond and adapt to changing local circumstances. They are responsible for the health of the entire population, and measured by how much they improve outcomes for patients.

Our current arrangements and the challenges they present

The three local CCGs – Leicester City, West Leicestershire and East Leicestershire and Rutland – were formed in April 2013 taking over responsibility from former Primary Care Trusts (PCTs) for planning, paying for, and monitoring local health services. These were new organisations combining the expertise of local family doctors with NHS managers, putting local doctors and nurses at the heart of deciding which health services to provide and where and how they would be provided.

Each CCG is led by a Governing Body. All general practices in a CCG area are members of that CCG and have clinical representatives elected to their respective governing bodies. The CCG

membership retains the authority to set the strategy and direction for the organisation and to hold their governing body to account.

CCGs are responsible for commissioning services including:

- Planned hospital care
- Rehabilitative care
- Urgent and emergency care (including out-of-hours)
- Most community health services
- Mental health and learning disability services.

The CCGs also have delegated authority from NHS England for commissioning general practice primary care services.

The three CCGs in Leicester, Leicestershire and Rutland have a history of successful partnership working. The organisations have worked together to commission many services since their inception in 2013. This particularly included collaborative commissioning of contracts for our main providers – University Hospitals of Leicester NHS Trust and Leicestershire Partnership NHS Trust. These arrangements were supported by hosted teams, whereby groups of staff were employed by one of our CCGs but worked across and on behalf of all three.

However, while our CCGs have performed well against national indicators – all three were rated as 'Good' in the national Improvement and Assessment Framework for CCGs in 2018/19 – there have remained a number of significant issues.

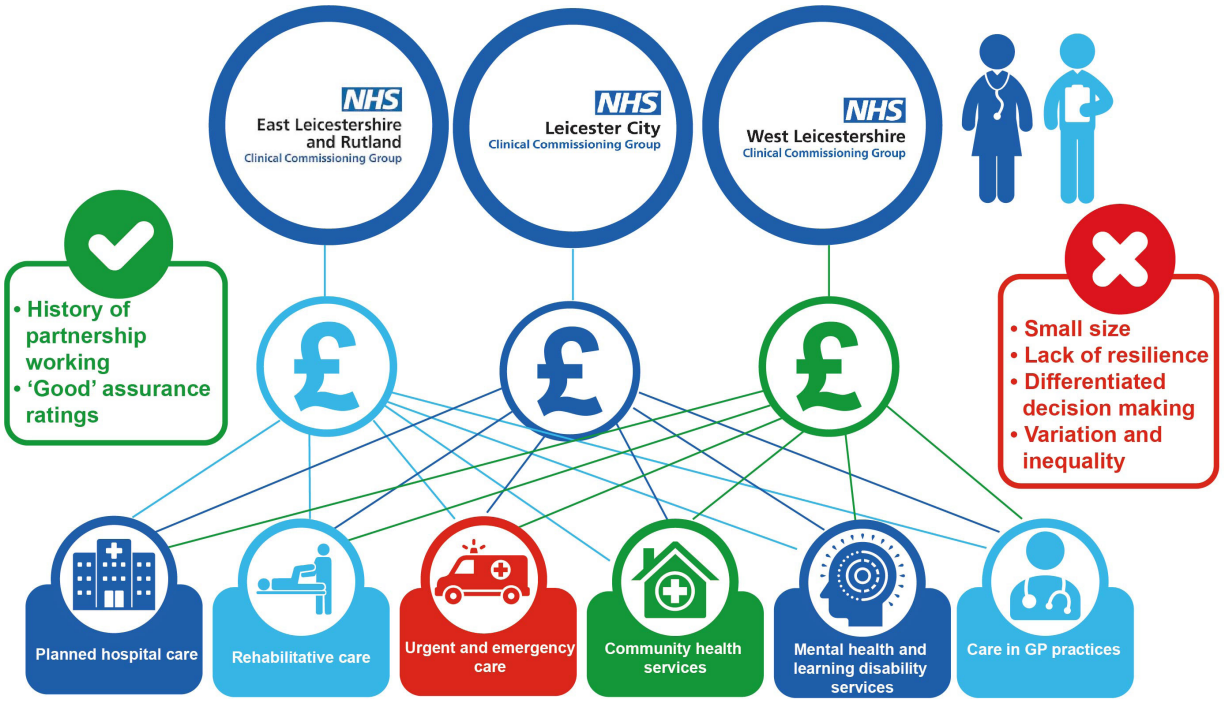
For example, the relatively small sizes of the existing CCGs mean that they can lack resilience, while progress has all-too-often been stifled by less than ideal joined-up working. This is evidenced by times when differentiated decision making by the three governing bodies has led to increased variation and inequality for patients across Leicester, Leicestershire and Rutland, rather than reduce it.

Indeed, current arrangements are confusing for patients and particularly our partners. Patients often do not understand who they should be talking to about issues affecting their care. Within LLR we have one acute provider and one major mental health and community services provider. However, under existing arrangements these organisations have often been frustrated and confused by different and sometimes competing priorities of the three existing CCGs.

Individual CCGs also means individual financial allocations. While this may be perceived by some to be a positive, spending on services across the three CCGs is variable and is often driven by the historic variation in funding per head of population. This means that our CCGs are in different financial positions.

While up until now organisations have only been held to account for delivery of their own financial performance, there is increasingly a move towards holding all NHS partners – both commissioners and providers – to account for delivery as a whole system. This means it will no longer be enough for individual organisations to take steps to manage their own financial performance to the detriment of others within the system.

Meanwhile there is still considerable duplication and sometimes triplication between organisations and there are limitations to what we can do collectively in our current form, with some statutory functions unable to be delegated.



Progress towards a single strategic commissioner

The three CCGs are currently considering the future form of the commissioning organisations, in light of the development of an LLR ICS and the need to ensure a single strategic commissioning voice.

In December 2018 we collectively took the decision to appoint a single accountable officer and management team to oversee the running of the three organisations. The new joint accountable officer has begun and work is ongoing to appoint a single team of executive directors. This is likely to be completed during early 2020.

From October 2019 enhanced joint governance arrangements have begun to be put in place across the three CCGs. These will enable more consistent and streamlined decision-making, but they still have limitations. This is because there are some functions that cannot be delegated.

We are now approaching a point where we need to finalise future organisational form to determine how strategic commissioning will be delivered within the context of the LLR ICS. Listening to our stakeholders is a crucial part of this process and we are keen to hear views on our proposals.

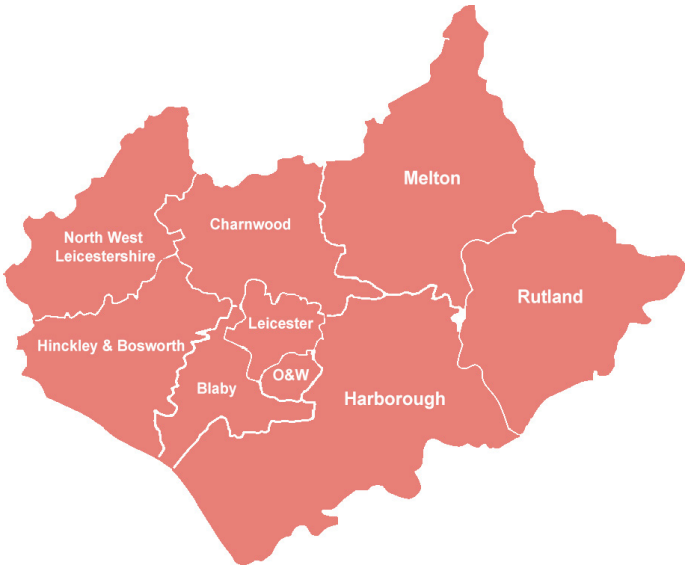
The options which have been considered for a single strategic commissioner include:

We have considered a number of key factors in appraising these options. These include:

- the ability of the option to improve health outcomes for patients, preserve and improve relationships and facilitate effective working
- give long term resilience, stability and permanence
- improve financial position and provide economies of scale
- reduce duplication and provide value for money
- maintain political oversight, improved reporting and pooling of clinical expertise.

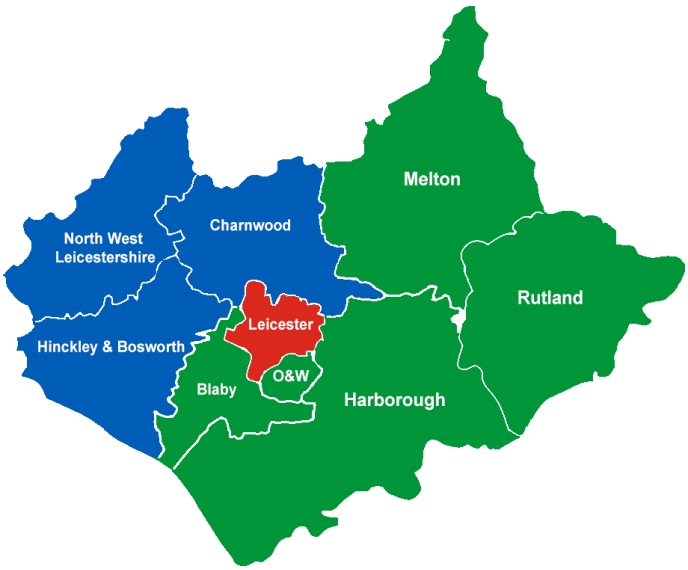
Geographical areas covered by the four options

One new CCG

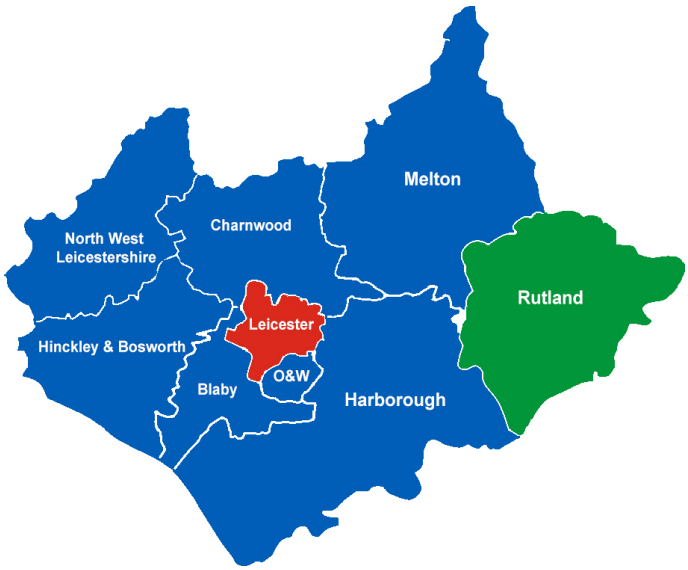


Two CCGs within a federation

Three existing CCGs within a federation



Three CCGs within a federation



Options for a single strategic commissioner in LLR

The options in more detail

	Summary of key advantages	Summary of key disadvantages
 Creation of a new single CCG for LLR, creating a unified commissioning approach and set of leadership arrangements	• Improved consistency of working, creating a single LLR approach • provides opportunity to align resources internally based on agreed priorities and population health need • allows more effective partnership work within the STP footprint, including with NHS England/Improvement, on areas outside of CCGs' current scope e.g. specialised commissioning • more sustainable and substantially reduces duplication as there would be one, rather than two or three, statutory bodies • best chance to address the financial position in LLR • single legal entity for providers and local authorities to engage with, providing a strong commissioner voice • single set of reporting and policy approaches would bring consistency for the people of the city and counties • clinical skills and expertise would be available throughout the area, including specialisms • opportunities will exist for maintained focus on local authority place level through the development of care alliance(s) and capitated place level budgets • ability to move collective resource to area of need	• move to a more consistent way of working across LLR, which could lead to a perceived loss of localism and/or focus on local 'place' • potential for arrangements to be seen as being more 'distant' from local authorities and member practices • loss of financial allocations at an individual CCG level, and potential reduction in associated flexibility to allocate resources accordingly

	Summary of key advantages	Summary of key disadvantages
 Retain the current CCG for Leicester City and create a new CCG for Leicestershire and Rutland. These two CCGs would operate as a federation with a joint management team and some shared governance and decision making	• working to existing local authority scrutiny and health and wellbeing board arrangements, thereby remaining responsive to local demographics and health needs • could reduce some duplication and provide some additional capacity and economies of scale • improved reporting and pooling of clinical expertise in Leicestershire and Rutland would potentially bring advantages for consistency of services in those parts of the STP area	• one of the CCGs could withdraw from the federation at any time - lacks long term resilience • limited advantage for system financial sustainability • does not address immediate financial challenges that we face as system • Potential remains for different decisions to be made that fails to address health inequalities and need • puts individual CCGs into competition with one another for national funding streams
 Retain the current CCGs. The three CCGs would operate as a federation with a joint management team and some shared governance and decision making	• builds upon what we already have • benefit of established structures • protects organisational and place based memory that exists within each of the three CCGs • preserves current relationships, particularly with local authorities, and maintains local patient voice	• one of the CCGs could withdraw from a federation at any time - lacks long-term resilience • possibility of differentiated decision making that further compounds existing health inequalities and unwarranted variation across the system as a whole. • risk that there may not be a genuinely unified strategic commissioning voice that speaks authoritatively and credibly on behalf of the system • puts individual CCGs into competition with one another for national funding streams • limited impact in terms of reducing overheads and management costs across the three CCGs. • existing levels of duplication would not necessarily be addressed to any great extent • does not address underlying financial issues across the three CCGs

	Summary of key advantages	Summary of key disadvantages
 Retain the current CCG for Leicester City and create two new CCGs; one for Leicestershire and one for Rutland. The three CCGs would operate as a federation with a joint management team and some shared governance and decision making This option has already been discounted on the basis that it is undeliverable	• would provide co-terminosity with existing local authority scrutiny and health and wellbeing board arrangements, providing very specific knowledge of local place • potentially improve political oversight since it matches local authority boundaries	• would not provide any additional economies of scale over and above current arrangements and could lead to further fragmentation and service variation • in turn could lead to an exacerbation of existing health inequalities • any one of the CCGs could withdraw from the federation at any time, meaning that the arrangements may lack longevity and resilience • considerable work would be required to set up two completely new CCGs and, given resource and capacity constraints, this may be a significant distraction • unlikely that this option would facilitate more collaborative or effective working at an STP level, nor would it address any concerns raised by providers and partners in relation to weaknesses within current arrangements • does not address underlying financial issues across the three CCGs • unlikely to be supported by NHS England on the basis that a CCG for Rutland would not have the critical mass of patient population to be sustainable in the medium to longer term

Our preferred option – a new single LLR CCG

Taking into account the findings of our options appraisal, we believe a single CCG is most likely to put us in the strongest position to deliver the desired improvements now and in the future.

No decisions have yet been made and the views of our stakeholders will be key in determining our final proposals. These will also be subject to formal consultation before we decide on the future form of a single strategic commissioner in LLR.

Benefits and opportunities of a new single CCG

We believe that a single strategic commissioner in the form of one CCG would have a number of benefits and opportunities for patients, member practices, partners and other stakeholders.

The most significant and compelling, in our view, is that the coming together of the three existing CCGs as one new strategic commissioning organisation - alongside the development of an ICS - provides us with the greatest opportunity to genuinely change our health and care system for the benefit of our patients.

It would allow us to begin a transformative journey that addresses the historic imbalance between in-hospital and out-of-hospital care. We would do this by working as one, in partnership with our providers, to redirect resources to support care provided by GPs and community services that focus on proactively managing the health of patients to keep them well and reduce expensive and unnecessary hospital visits and stays wherever possible.

In summary, the benefits we expect to realise as a result of coming together as one strategic commissioning organisation are:

Better healthcare and outcomes	**Align with health and care partners across the system in order to address health inequalities and ensure consistency of services where appropriate.**
Better use of resources	Redirect clinical time and resources that can be invested in to tackling system-wide health priorities.
Stronger, more consistent commissioning voice and leadership	Provide a stronger clinical voice in strategic decisions about health and care services for Leicester, Leicestershire and Rutland.
Greater support for transformation and innovation	Scale-up the most successful local clinical innovations to rapidly share best practice across a wider area.

We believe a single strategic commissioner in the form of one CCG would have a number of benefits and opportunities for our stakeholders. In summary, these include:

Patients

Benefits for Patients	
✓	Focus on agreed priorities and reducing health inequalities will improve health outcomes for those patients often overlooked or seldom heard
✓	A single commissioning organisation would bring a consistent approach to commissioning policies across LLR, ensuring that they are equitable for all patients within our area
✓	A single LLR CCG would end fragmentation of current commissioning arrangements, reducing the confusion and frustration caused by having multiple CCGs
✓	Would support the move towards becoming an Integrated Care System, which in the long term will help us focus on transformational change and delivering improved outcomes
✓	Provides enhanced opportunity to tackle health inequalities by providing flexibility to target discretionary spend from the collective budget towards those areas with the greatest needs
✓	Enables greater focus on improving service performance through increased capacity and flexibility to target our combined financial resources appropriately
✓	Would allow CCGs to invest more in front line services due to savings achieved in back office functions.

Member practices and other clinicians

Benefits for member practices and other clinicans	
✓	Enable greater sharing of best practiceand learning across PCNs in LLR
✓	More consistent commissioning approach will reduce variation in clinical practice and services
✓	Clinical time can be directed to transformational change – getting greatest gain from the limited clinical resources available to us across the three existing CCGs
✓	It would be easier to scale up the most successful clinical innovations to rapidly share best practice across LLR
✓	Provides a strong, more coherent clinical voice in strategic decisions about health and care, which will help to reduce duplication, and improve performance and outcomes for patients
✓	Easier to integrate with secondary care through an LLR clinical network.

Staff

Benefits for Staff	
✓	Removing organisational boundaries will allow us to create a shared talent pool, giving staff the opportunity to develop and use their skills in more challenging ways
✓	Staff would have greater capacity to support partners, through the Care Alliance(s), to deliver transformational change as duplication of roles would be removed
✓	Likely to improve retention and career progression as a result of a larger organisation with more opportunities for development
✓	Reduced duplication of work and associated frustration
✓	Greater consistency in standards and expectations.

Local authorities

Benefits for Local Authorities	
✓	Provides a single, strong and consistent commissioning vision and voice to partners, which will help to reduce duplication, and improve performance and outcomes for patients
✓	Staff would have greater capacity to support partners, through the Care Alliance(s), to deliver transformational change as duplication of roles would be removed from the system
✓	Through minimising structural barriers that exist between organisations there would be a removal of competing priorities of individual organisations and allow development of aligned objectives which will support both the system and patients
✓	The increased size and singular voice of the commissioning organisation will enable more strategic working and alignment with local and regional partners to develop and transform services
✓	Streamlining and simplification of decision making would mean shorter, more responsive processes and lead to quicker implementation of transformation and improvements.

Financial

Financial Benefits	
✓	One commissioning budget across LLR means increased flexibility to focus resources to need and sectors
✓	Economies of scale by having one instead of three organisations to run, enabling resources saved to be redirected to the front line
✓	Removal of duplication and triplication
✓	Reduces complexity of system wide financial planning and control
✓	Enables more efficient use of assets and resources
✓	Creates a stronger voice within any resource discussion and decisions taking place at a regional and/or national level
✓	More likely to achieve required reduction in CCG management and administration costs.

Developing a new single CCG for LLR

Developing a new single CCG for Leicester, Leicestershire and Rutland gives us the opportunity to create a new kind of organisation that builds upon what is good about our current arrangements while also addressing those things that have often limited progress.

The exact composition of a new Governing Body is still to be determined. However, it is expected that GP members will continue to be elected to the board to represent the views of constituent member practices within a particular place. It is also possible that at least one officer, and possibly an independent director (Independent Lay Member), will be nominally aligned to place to support the development and maintenance of relationships at that level.

However, it is important to recognise that all directors – whether managerial, clinical or independent – will be appointed to the Governing Body to act in the best interests of all 1.1million patients that the new organisation would serve.

As such, all members, regardless of background or interest, will have a collective corporate responsibility and accountability for the success of the organisation and delivery of its statutory responsibilities.

The work of any new Governing Body will be guided by its vision and values, which it will need to collectively develop and agree. This will provide the opportunity to incorporate a firm commitment to identifying and addressing health inequalities into the fabric of the new CCG in a way that is commensurate with the requirements of the NHS Long Term Plan. Governance arrangements will also need to be developed that reflect and protect this commitment.

Financial planning principles of a new single CCG

The need to act on health inequalities and unmet need is a core requirement of the NHS Long Term Plan, which sets out a requirement for strategic commissioning organisations and NHS providers to collectively have a concerted and systemic approach to reducing inequalities.

To support this, local areas have received five-year funding allocations that use a more accurate assessment of health inequalities and unmet need.

Local areas are also required to set out agreed specific, measurable goals for closing health inequalities over the next 5-10 years, including those relating to deprivation - which tends to be one of the greatest drivers of health inequalities within LLR. Working together as one organisation will allow us to take a holistic view of deprivation and unmet need across the whole of our area, with priorities and criteria for investment developed to adequately reflect this.

There is a firm commitment that any new single CCG for LLR would baseline current investment as it is currently understood by both place (e.g., Leicester, Leicestershire and Rutland) and programme. In this way there would be a clear unambiguous picture of existing non-discretionary spend, which represents a starting point for future investment.

As part of our developing financial strategy we would also set out what our long-term investment plan looks like, building in anticipated levels of financial growth over the course of the next four years. This will allow us to demonstrate expected percentage increases, which will be monitored by the Governing Body. It is expected that every part of the system will grow, although differentially in some areas based on need and health inequality.

As part of this arrangement any new single CCG would make investments jointly with local authority partners where beneficial to do so, whilst it would also make investments (and savings) in line with the shape of the LLR strategic plan. This means that there would be a clear focus on mental health, community services, and primary care networks.

As part of the new system it would be essential that the new CCG monitors both how resources are committed and how health inequalities are being improved/changed.

Planning and prioritisation

As a system we have already identified our strategic priorities for the next five years, these being the things that will help us to deliver a step change to local services and health and wellbeing during that period and beyond.

A central tenet of this approach is population health management. This will target prevention, intervention and care for those most likely to benefit. As part of this there is a clear commitment to creating detailed population profiles at place and neighbourhood level for patients in LLR– driven by public health understanding and data – that incorporates risk stratification, social care, and information on the wider determinants of health.

At a strategic level this data and insight will be used to inform the priorities and outcomes required across the system, and influence how discretionary funding may be targeted differentially at a place level to achieve these ambitions. This will be complex, but we are committed to ensuring that we are clear as a system as to what the health inequality improvements we are striving for in Leicester, Leicestershire and Rutland look like.

Critical to this will be working with public health and local authority colleagues to define in a quantifiable way what the health inequalities and contributory factors are within each place – supported by robust data and intelligence. This work is beginning, though it is still in the relatively early stages.

It is clear that we need to identify the right outcomes if we are to ensure investment is targeted to the right areas. However, it is recognised that many of the determinants of health inequalities are most likely to be impacted positively through focus on economic and social issues rather than through a focus purely on health service delivery. This includes educational attainment, employment opportunity, housing, transport, recreation, air quality, and regulations regarding food, alcohol and tobacco.

As a result it is essential that any new CCG works hand in hand – both now and in the future – with the local authority at place level, through statutory Health and Wellbeing Boards, to develop a clear understanding of the causes of health inequalities, and develop priorities that are relevant and appropriate for our places within Leicester, Leicestershire and Rutland.

Timescales and next steps

The existing CCGs and their partners need to work quickly to ensure an ICS is in place by April 2021 in line with national requirements. It is our anticipation that any new arrangements for commissioning will need to be put in place in advance of this. We also want to ensure that we make the best decisions for the future in LLR and that we are configured in the best way possible to support the development of our local ICS.

Through this pre-consultation engagement process, we would like to hear your views on our proposals for a single strategic commissioner in the context of an integrated care system and specifically:

- whether there are things that are important to you that you don't feel we have considered
- the benefits and disbenefits of the proposals from your point of view
- what you think are the most significant issues that will affect successful implementation of a single commissioning organisation
- what you think works well in the current commissioning/provider structure and what you would like to be retained in the future
- what frustrates you about the current commissioning/provider structure and what would you like to see addressed in the future
- your thoughts on how to ensure a single strategic commissioner can be responsive to patients, practices, providers and local authorities

We will use your feedback to shape our plans before undertaking wider consultation. You can let us know your views online, by visiting www.surveymonkey.co.uk/r/SSCICS2019

Glossary

Term	Description
Better Care Together	The partnership of local health and social care organisations working together to improve care.
Care Alliance	Health and social care providers working together to deliver health care in the best way.
Care Plan	A plan that describes the care a person should receive, their medication and what to do if their condition gets worse. It is developed after an assessment of a person's health and wellbeing needs.
Clinical Commissioning Group	Plans and buys most health services for a local population.
Commissioning	Planning, agreeing, buying and monitoring healthcare provision in order to meet the needs of patients.
Constitution	A formal document that describes how an organisation will operate.
Federation	A group of organisations that have joined together to form a larger organisation.
Health and Wellbeing Boards (HWBs)	A statutory forum where political, clinical, professional and community leaders from health and care organisations come together to improve the health and wellbeing of their local population and reduce health inequalities.
Health Inequalities	The unjust and avoidable differences in people's health across the population and between specific population groups.
Healthwatch	An organisation set up by Government to represent the views of users of health and social care services and members of the public.
Holistic Services	Services that treat the whole person, taking into account mental and social factors, rather than just the symptoms of a disease.
Integrated Care Systems or Pathways	Health and social care organisations working together in a local area to provide good quality care for patients. It consists of a strategic commissioner (plan and buy services), a care alliance (organisations that provide care) and primary care networks (groups of GP practices).
Joint Health and Wellbeing Strategy	A document produced by Health and Wellbeing Boards that describes how the health and wellbeing of the local population will be improved.

Term	Description
LLR	Leicester, Leicestershire and Rutland.
Local Authority	Local Government – for example Leicester City Council, Leicestershire County Council, Rutland Borough Council.
Local Authority Scrutiny	Also known as the Health Overview and Scrutiny Committee. It is a meeting of local councillors who review the plans of health organisations to ensure they are fit for purpose and represent the needs of local people.
Medication Review	An examination of a person's medicines by a health professional, such as a GP or a pharmacist, to check they are still working for the patient and are still needed.
NHS Long Term Plan	The NHS Long Term Plan is a ten year plan that describes how health care will be provided and improved. It aims to give everyone the best start in life; deliver world-class care for major health problems, such as cancer and heart disease, and help people age well.
Pathway	The process that patients follow through the NHS to receive treatment for a condition.
Primary Care Network	Groups of GP practices working together with other health and social care professionals, such as nurses, dietitians and pharmacists, to provide excellent health care for patients.
Primary Care Network boundaries	The areas covered by the practices in a Primary Care Network.
Provider	Organisation delivering health care services. For example, a hospital, GP practice, local authority (social care) or community organisation.
Service Specifications	Describes in detail the care that a service will deliver.
Single Control Total	Financial targets to be met by NHS organisations.
Strategic Commissioner	One single organisation, or a group of organisations working together, to plan and buy healthcare for the local area. In this case, for Leicester, Leicestershire and Rutland.
System	The collective group of health and social care organisations that provide care for local people.
Sustainability and Transformation Partnership	The partnership of local health and social care organisations working together to improve care.
Voluntary Sector	Organisations whose primary purpose is to create social impact rather than profit. It is often called the third sector.

A partnership between:

- East Leicestershire and Rutland Clinical Commissioning Group
- Leicester City Clinical Commissioning Group
- West Leicestershire Clinical Commissioning Group

Appendix D

Local Plan & Health Journey

For consideration by: Health & Wellbeing Scrutiny Commission

Date: 30 January 2020

Lead director: Ivan Browne

Useful information

- Ward(s) All
- Report author: Sandie Harwood, Programme Manager: Healthy Places
- Author contact details: sandie.harwood@leicester.gov.uk

1. Purpose of report

This report aims to inform the Health and Wellbeing Scrutiny Commission of health-related input to the Local Plan and the relationship built between the Public Health and Planning departments, over the past years.

- To evidence the relationship developed between Public Health and Planning departments in recent years.
- To provide details of specific health input to the Local Plan and associated policy.

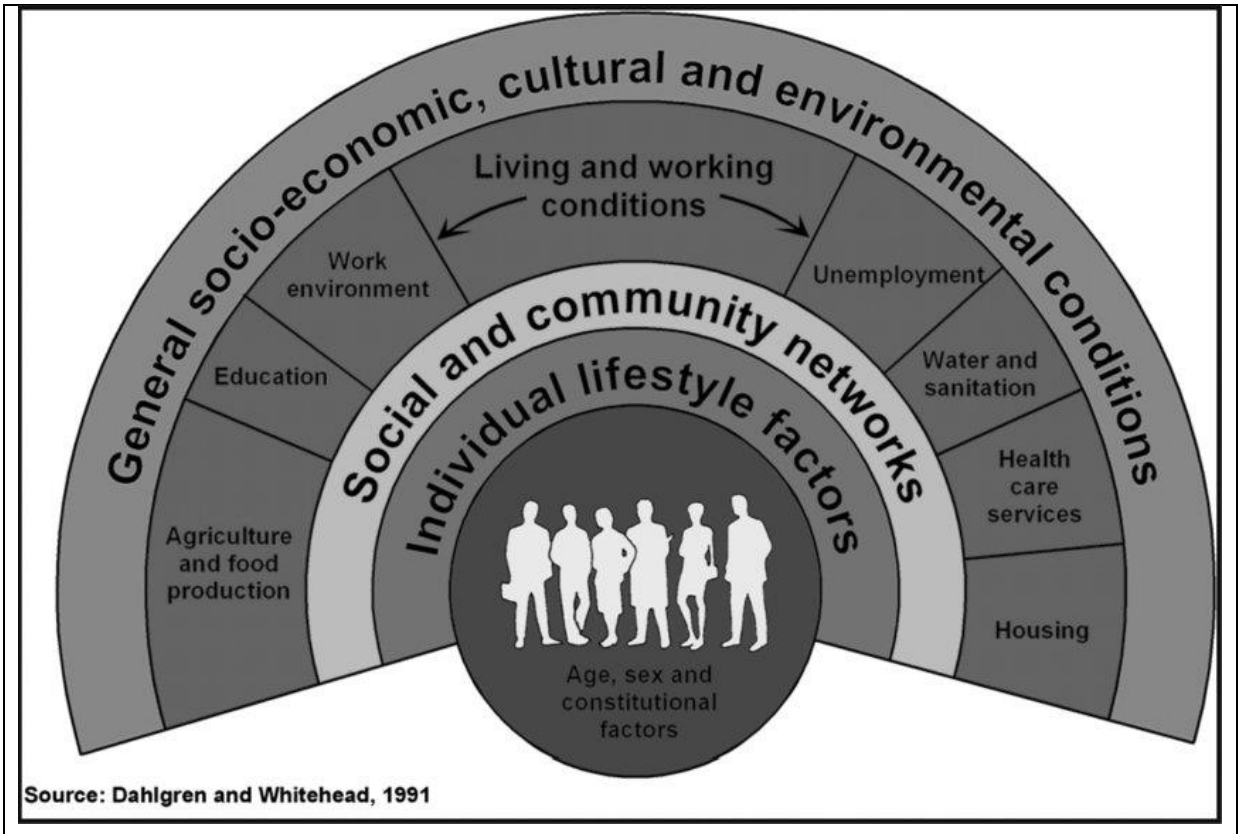
2. Report Summary *(to highlight key info /issues)*

2.1 Introduction and background

2.1.1 The Local Plan is the primary land use plan for the City. It runs for a period of 15 years. In 2013, Public Health transitioned from the NHS to the Local Authority, under the Health & Social Care Act 2020. As part of this transition, the Local Authority gained a duty to promote the health of its population[i].

2.1.2 In 2017, Public Health was restructured, and the Healthy Places team was established to link to, and influence sections of the Council and other statutory agencies, to support delivery of those factors with greatest impact on health and wellbeing, typically known as the wider determinants of health[1]. These include the social and community networks and the wider socio-economic, cultural and environmental conditions in which people live, work and take recreation and are widely considered to be primary drivers of health inequalities. These are shown in the diagram on p3.

[1] The wider determinants of health are societal and environmental factors that influence and impact on health and wellbeing. Examples are education, income, employment, housing, transport, noise and air pollution, town planning, etc. Variations in experience of these factors make for the majority of health inequalities, with resulting, detrimental impact on population health outcomes.



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2.1.3 At its core, the wider determinants of health agenda seeks to collectively tackle the diverse range of social, economic and environmental factors which impact on people's health. The scale of this challenge means it must be approached from multiple fronts and influencing the Local Plan to support positive health and wellbeing outcomes is one element of this.

2.1.4 Both the National Planning Policy Framework[ii] and the Department of Communities and Local Government *Health and Wellbeing Planning Practice Guidance* (HWPPG)[iii], emphasise the importance of collaboration between the Planning system and Health to improve the health and wellbeing of local populations.

2.1.5 Leicester's Joint Health and Wellbeing Strategy 2019-2024[iv] recognises the critical interplay between general socio-economic, cultural and environmental factors and health and wellbeing, with one of its five overarching themes being wider environment-oriented. Some of the shaping of the built and natural environment comes via Planning policy and practice.

2.2 Overview and examples of local collaboration between Public Health and Planning on the Local Plan

2.2.1 Public Health has been involved in the development of the Local Plan work since the devising of options in 2014, with the bulk of work between the two departments occurring since 2017, when Public Health developed an extensive response to the 2nd Stage Local Plan Public Consultation (Emerging Options). This response:

- Incorporated evidence of health impacts of the built environment, green and blue space, urban design and housing;
- Made an overarching recommendation outlining the cross-cutting nature of health and wellbeing, with most sections of the Local Plan offering the potential to positively impact on the health of the local population;

- Offered secondary recommendations, around the consideration of a set of national Active Design Principles, broadening the requirement for Health Impact Assessments, and seeking to increase the available space for health generating activities such as food growing within [each] local community;
- Offered two endorsements around enacting the requirements of the AQAP and proposals for controls on the proliferation of gambling shops, pawnbrokers and pay day loan shops.

2.2.2 Planning policy is deemed by public health to be one of the more effective levers to drive long-term, far-reaching health improvement in society and tangible examples of this have been the local implementation of pedestrianisation within the city centre area and efforts made to develop infrastructure to encourage active travel.

2.2.3 The degree to which our Planning colleagues have understood our recommendations and intentions is manifest in a draft of the Local Plan, in which the Health and Wellbeing section (renamed from 'Public Health and Sports' as per the Consultation response, to emphasise that health is everybody's business) has been consciously moved to the front of the document, thereby subtly demonstrating its greater priority. The prevalence of the terms 'health' and 'wellbeing' also increased considerably in the most recent draft and represents a notable reprioritisation of health and wellbeing in the primary land use policy for this City.

2.2.4 Public Health considers this to be as a result of an increasing understanding on both sides of how each can cooperate to achieve physical, emotional, mental and quality of life improvements for the people of Leicester.

2.2.5 <u>Potential, health-specific, Hot Food Takeaways (HFTs) Development Management Policy (DMP)</u>

2.2.5.1 Public Health and Planning have thoroughly explored and debated the potential value of a health-specific, Hot Food Takeaways (HFTs) Policy in the draft Local Plan.

2.2.5.2 A dedicated paper exploring HFTs Policy was produced in early 2018 to help planners around decisions on the potential inclusion of a policy with the Local Plan. It included a literature review, intelligence gleaned conversations from colleagues in other Councils that had incorporated such policies, and interrogation of local data received from the Planning Department, listing A5 planning applications in last 5-6 years and liaison with our environmental health department. A5 is a Planning use class for HFTs, with those premises used specifically 'for the sale of hot food for consumption off the premises.'[v]

2.2.5.3 This showed that the bulk of new A5 permissions had been granted prior to this time period. The findings generally concluded that the adoption of this policy would provide a limited health impact because:

- A policy would only apply to applications for new hot food takeaways. It could <u>not</u> be used to retrospectively address hot food takeaways already operational or with planning consent;
- Mapping the location of hot food takeaways alongside the prevalence of local childhood and adult obesity in the City had not shown a clear association between their siting and higher prevalence of these health-impacting issues in the City;

- The geography of the City means that a HFTs Policy would mostly affect small and micro-businesses, which may have a lesser impact on childhood obesity than larger fast food outlets and may also unduly penalise independent businesses;
- There could be a significant adverse economic impact for certain areas of the city;
- The food delivery landscape is radically changing the way people can access takeaways. Companies like Uber and Deliveroo now deliver from a wide array of existing food businesses, making the physical location of the business less of a factor in accessing high calorific food then in the past. People no longer need leave their own home to get a takeaway.

2.2.5.4 There is a localised evidence threshold that needs to be achieved to receive approval for a health-specific HFTs policy. Some other areas have struggled to meet this. To help quantify the potential local impact, a draft briefing of evidence was developed in mid-2019 with steer from Planning colleagues and constructed around the Milton Keynes HFTs policy pack. The findings supported that local implementation of a restrictive policy around secondary schools would only have negligible, if any positive impact on health and wellbeing.

2.2.5.5 A local trawl of HFTs related Planning applications in the 6 years to 2018 suggested that only 0.1%-0.3% of new food establishments in the City would have been subject to a health-related HFTs Policy in each of the preceding years.

2.2.5.6 While other areas have adopted HFTs policies, effective, obesity-reducing Planning action extends much beyond such policies, including further supporting and enabling food growing, active travel and recreational activity, as the Public Health submission to the 2nd Stage Local Plan Public Consultation recommended.

2.2.5.7 Whilst no decision has been taken on the inclusion of a Hot Food Takeaways Policy in the Local Plan, there has been a recognition that there should be a focus on a whole systems approach to the obesity challenge, with an emphasis on other projects falling out of the Food Plan and the Children, Young People and Families Healthy Weight Strategy, as a potentially more effective approach than relying on controlling only one small aspect of the obesogenic environment. This approach is yet to be fully developed but has been endorsed in principle in discussions with partners such as Leicester Changing Diabetes.

2.2.6 Interim Corporate Guidance - Achieving Well Designed Homes: Residential Space Standards, Amenities and Facilities (August 2019)

2.2.6.1 This Guidance was developed by the Planning Department in response to 'concerns…about the amount of residential development that has been completed recently in Leicester which includes small units (i.e. below the Nationally Described Space Standards- NDSS), with unsatisfactory levels of residential amenity and the consequential health and social impacts on both individuals and on the character of parts of the city'. It also 'encourages developers to use the NDSS in proposals, and through application of this Guidance the Council will receive NDSS compliant developments positively'.

2.2.6.2 Public Health was involved in the development of this guidance, not least because it provides a public statement of the council's objectives and support for the

principle of introducing the NDSS, including a template to measure how applications respond to these standards. The guidance also provides some assistance to planning officers in negotiations on planning applications to improve the quality of residential accommodation through emphasising how existing policies will be applied to improve accommodation standards. As such, the guidance could contribute to the safeguarding of the health and wellbeing of the population and address socio-economic-related health inequalities. The Public Health contribution was twofold. It developed:

- A Public Health section briefly talking to the negative health impacts of limited and poorly designed residential space, amenities and facilities and the positive health and wellbeing gains from a built and natural environment that is sensitive to the needs of the population;
- An appendix introducing Health Impact Assessments (HIA), and an example of a Rapid HIA in relation to Housing Quality and Design.

2.2.7 Work to support the *Leicester & Leicestershire Strategic Growth Plan*

2.2.7.1 Public Health has worked with Planning to support the development of the *Leicester & Leicestershire Strategic Growth Plan.*

2.3 In development / ongoing

2.3.1 Discussions are ensuing around the potential for a Public Health-led Health Impact Assessment, working closely with Planning colleagues, as part of the forthcoming Local Plan Public Consultation. The Local Plan will be out for public consultation in the spring and another consultation is also planned for later in the year. There is further scope to continue to work with Planning colleagues to refine the scope of health and wellbeing the Plan.

2.4 Conclusion

2.4.1 While collaboration between Planning and Public Health can render some health and wellbeing improvements, it takes a lot of evidence and time to prepare a Local Plan and get it adopted at an independent examination so that we can start implementing those policies and see the result in new development.

2.4.2 This means, that despite the very best efforts of both professions, work to leverage the Planning system can only achieve so much. This makes it more imperative to consider work around the Local Plan as simply one tranche of wider determinants work, rather than an end in itself.

3. Recommendations

3.1 Scrutiny members are asked to:

- Note the relationship built between the Public Health and Planning
- Note wide-ranging health input to Local Plan and associated policy.

4. Financial, Legal and other implications

Financial implications

There are no direct financial implications arising from this report.

Rohit Rughani, Principal Accountant, Ext. 37 4003

Legal implications

No legal comments from a commercial perspective. This may require input from my [legal] planning colleagues.

Mannah Begum, Principal Solicitor (Commercial & Procurement), Ext. 37 1423

As the report is for noting there are no direct legal planning implications at this time.

Jane Cotton, Planning and Highways Lawyer, Legal Services, Ext. 37 0325

Climate Change and Carbon Reduction implications

There are no significant climate change implications directly associated with this report.

Aidan Davis, Sustainability Officer, Ext 37 2284

Equalities implications

When making decisions, the Council must comply with the Public Sector Equality Duty (PSED) (Equality Act 2010) by paying due regard, when carrying out their functions, to the need to eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act, to advance equality of opportunity and foster good relations between people who share a 'protected characteristic' and those who do not.

In doing so, the council must consider the possible impact on those who are likely to be affected by the recommendation and their protected characteristics.

Protected Characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

Whilst there are no direct equality implications arising from this report, the areas of work cited in the report between Public Health and Planning should lead to improved outcomes for people from across a number of protected characteristics and should help towards advancing equality of opportunity and fostering good relations, such as the adoption of the Nationally Described Space Standards (NDSS) by having housing designed to support people to live independently, safely and well.

Sukhi Biring, Equalities Officer, 454 4175

5. Supporting information / appendices

6. Is this a private report (If so, please indicated the reasons and state why it is not in the public interest to be dealt with publicly)?

No

7. Is this a "key decision"?

No

References

[i] Department of Health. 2012. The New Public Health Role of Local Authorities. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213009/Public-health-role-of-local-authorities-factsheet.pdf

[ii] National Planning Framework. February 2019. Available at: https://www.gov.uk/government/publications/national-planning-policy-framework--2

[iii] Department of Communities and Local Government. 2014-2017. Health and Wellbeing Planning Policy Guidance. https://www.gov.uk/guidance/health-and-wellbeing

[iii] Leicester City Council. 2019. The Joi8nt Health and Wellbeing Strategy 2019-2024 https://www.leicester.gov.uk/media/185984/joint-health-and-wellbeing-strategy-2019-2024.pdf

[v] Planning Portal. Use Classes. https://www.planningportal.co.uk/info/200130/common_projects/9/change_of_use

Footnote References

European Centre for Health Policy (1999) *Health Impact Assessment: Main concepts and suggested approach (Gothenburg Consensus),* Brussels: European Centre for Health Policy.

Elliott E, Harrop E, and Williams GH (2010) Contesting the science: public health knowledge and action in controversial land-use developments, in P. Bennett, K Calman, S Curtis and D Fischbacher-Smith (eds) *Risk Communication and Public Health (second edition),* Oxford: Oxford University Press

Leicester City Council

Council **Date: Draft for 19th February 2020**

General Fund Revenue Budget 2020/21 to 2021/22

Report of the Director of Finance

1. **Purpose**

1.1 The purpose of this report is to ask the Council to consider the City Mayor's proposed budget for 2020/21 to 2021/22.

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

1.3 This draft budget has been prepared in advance of the finance settlement for 2020/21 (which has been delayed by the General Election, and the date is not yet known) and the final report will be updated to include any new information received.

2. **Summary**

2.1 Since 2010, the Council has faced the most severe period of spending cuts we have ever experienced. We know from reports of the Institute of Fiscal Studies and our own analysis that government cuts have disproportionately hit the most deprived authorities (such as Leicester).

2.2 The budget for this year is made more difficult because we do not know the level of funding available beyond 2020/21.

2.3 Since last year, the Government has made announcements about the "end of austerity" in the public finances. While there has been some additional spending announced for next year, it should be noted that this does not reverse the significant cuts since 2010, and that pressures continue in demand-led services in Children's and Adults' social care.

2.4 Since 2014/15, the Council's approach to achieving these substantial budget reductions has been based on the following approach:-

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

(b) Building up reserves, in order to "buy time" to avoid crisis cuts and to manage the Spending Review Programme effectively. We have termed this the "managed reserves strategy".

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

2.6 This approach has served us well. Budgets for the period 2013/14 to 2015/16 contributed over £40m to reserves, which have been used to support budgets since 2016/17 and postpone the maximum impact of government cuts. This has been extended by regular reviews of reserves and other one-off monies available. Because of this approach, the Council has sufficient reserves available to balance the budget in 2020/21, and will have some remaining for subsequent years.

2.7 Funding levels beyond 2020/21 are particularly uncertain, with the planned move to 75% rates retention, the Government's planned funding review, and the risk of a return to centrally-imposed cuts to funding overall (see paragraphs 8.5 - 8.8). There are also significant unknowns around future funding for social care services.

2.8 To mitigate these risks, further savings from the spending review process are being used to extend the managed reserves strategy as far as possible. However, it seems inevitable that medium term budgets cannot be balanced without additional significant cuts.

2.9 As a consequence, the following approach has been adopted:-

(a) The budget for 2020/21 has been balanced using reserves, and can be adopted as the Council's budget for that year;

(b) Savings from the previous rounds of spending reviews are still being sought. These will seek to minimise the call on reserves in the remainder of 2019/20 and in 2020/21, and therefore to make additional amounts available to mitigate cuts in future years. Since February 2019, savings totalling £2.7m per year have been achieved and built into budget forecasts.

2.10 **What this means is that, in substance, the budget proposed is a one year budget. Projections of spending and income have been made beyond 2020/21, but they are uncertain and volatile.**

2.11 In common with other authorities nationally, we continue to face growth in social care costs, and it is not impossible that these services will consume an ever greater proportion of the budget (squeezing out the traditional services provided to the whole community).

Government intentions for social care funding beyond 2020/21 are not known; a planned Green Paper has not materialised, and it will be some time before any new proposals have an impact on the Council's financial position.

2.12 It should also be noted that there are some significant risks in the budget. These are described in paragraph 12, and to help mitigate these, a contingency of £1m has been included in the 2020/21 budget.

2.13 The budget provides for a council tax increase of 4% in 2019/20, which is the maximum available to us without a referendum. 2% of this 4% is for the "social care precept" – the Government has permitted social care authorities to increase tax by more than the 2% available to other authorities, in order to help meet social care pressures. In practice, increasing our tax by an additional 2% will only meet a small proportion of the extra costs we are incurring.

2.14 In the exercise of its functions, the City Council (or City Mayor) must have due regard to the Council's duty to eliminate discrimination, to advance equality of opportunity for protected groups and to foster good relations between protected groups and others. The budget is, in effect, a snap-shot of the Council's current commitments and decisions taken during the course of 2019/20. There are no proposals for decisions on specific courses of action that could have an impact on different groups of people. Therefore, there are no proposals to carry out an equality impact assessment on the budget itself, apart from the proposed council tax increase (this is further explained in paragraph 11 and the legal implications at paragraph 15). Where required, the City Mayor has considered the equalities implications of decisions when they have been taken and will continue to do so for future spending review decisions.

3. Recommendations

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

(a) approve the budget strategy described in this report, and the formal budget resolution for 2020/21 which will be circulated separately;

(b) note comments received on the draft budget from scrutiny committees, trade unions and other partners *(to be added for final budget report)*;

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

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

(e) note my view that reserves will be adequate during 2020/21, and that estimates used to prepare the budget are robust;

(f) note the equality implications arising from the proposed tax increase, as described in paragraph 11 and Appendix Three;

(h) emphasise the need for outstanding spending reviews to be delivered on time, after appropriate scrutiny;

(i) agree that finance procedure rules applicable to trading organisations (4.9 to 4.14) shall not apply.

4. Budget Overview

4.1 The table below summarises the proposed budget for 2020/21, and the forecast position for 2021/22:

	2020/21 £m	2021/22 £m
Service budget ceilings	278.3	274.3
Corporate Budgets		
Capital Financing	6.3	6.5
Miscellaneous Corporate Budgets	(2.3)	(2.1)
Corporate Contingency	1.0	
Education Funding Reform	1.0	1.0
Future Provisions		
Inflation		6.3
Planning Provision		3.0
Total forecast spending	**284.3**	**289.0**
Rates Retention		
Business rates income	64.6	
Top-up payment	47.4	
Revenue Support Grant	28.9	
Subtotal: rates retention	140.9	143.2
Less assumed future cuts		(3.0)
Council Tax	121.1	124.4
Collection Fund surplus	1.7	
Social Care grants	10.0	10.0
New Homes Bonus	5.0	4.0
Total forecast resources	**278.7**	**278.6**
Underlying gap in resources	**5.6**	**10.3**
Proposed funding from reserves:	(5.6)	
Gap in resources	**NIL**	

4.2 The proposed budget for 2020/21 has an underlying budget gap of £5.6m, which represents a £3.3m decrease from the forecast in February 2019. The main changes to the budget position are summarised in the table below:

	2020/21 changes £m
Spending Reviews approved	2.4
Growth in local tax base (council tax & business rates)	2.4
Social care pressures (in excess of additional government resources)	(4.8)
Pay inflation	(2.7)
Reduced level of cuts to general funding	2.5
Collection fund surplus (one-off)	1.7
Other changes	1.9
Net decrease in budget gap since February 2019	**3.3**

4.3 The net decrease in the table above conceals significant additional pressures in social care services and pay costs. For 2020/21, the pressure on the budget is mitigated by increased government grant and a one-off surplus on rates and Council Tax income in the Collection Fund; but cost pressures are expected to continue to grow in future years.

4.4 The budget for 2021/22 is presented in broad terms only, and is particularly volatile. The current business rates retention scheme is due to be replaced from April 2021; we do not yet know the format of the new scheme, and the table above assumes that these changes are broadly neutral for the Council's finances. The position could be significantly worse than this: there are particular risks around social care cost pressures, the Government's review of local government funding formula, and/or a return to overall funding cuts for the sector. Under this scenario, the gap for 2021/22 could be as much as £40m.

5. Construction of the Budget and Council Tax

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

(a) The level of council tax;

(b) The limits on the amount the City Mayor is entitled to spend on any service ("budget ceilings"; the proposed budget ceilings are shown at Appendix One)

5.2 In line with Finance Procedure Rules, Council must also approve the scheme of virement that controls subsequent changes to these ceilings. The proposed scheme is shown at Appendix Two.

5.3 The City Council's proposed Band D tax for 2020/21 is £1,641.23, an increase of just under 4% compared to 2019/20.

5.4 The tax levied by the City Council constitutes only part of the tax Leicester citizens have to pay (albeit the major part – around 84% in 2019/20). Separate taxes are raised by the Police & Crime Commissioner and the Combined Fire Authority. These are added to the Council's tax, to constitute the total tax charged.

5.5 The actual amounts people will be paying in 2020/21, however, depend upon the valuation band their property is in and their entitlement to any discounts, exemptions or benefit. Almost 80% of properties in the city are in band A or band B, so the tax will be lower than the Band D figure quoted above.

5.6 The Police and Crime Commissioner and Combined Fire Authority will set their precepts in February 2020. The formal resolution will set out the precepts issued for 2020/21, together with the total tax payable in the city.

6. Departmental Budget Ceilings

6.1 Budget ceilings for each service have been calculated as follows:

(a) The starting point is last year's budget, subject to any changes made since then which are permitted by the constitution (e.g. virement), and excluding one-off additions identified in the 2019/20 budget;

(b) Decisions taken by the Executive in respect of spending reviews, where the savings take effect in 2020/21, have been deducted from the ceilings;

(c) An allowance for non-pay inflation has been added to the budgets for independent sector adult care (2%), foster care (2%) and the waste PFI contract (RPI, in line with contract terms). Apart from these areas, no allowance has been made for non-pay inflation.

6.2 In contrast to previous years, the budget ceilings shown at Appendix One do *not* include any allowance for pay inflation. At the time of writing, the local government pay scales for 2020/21 had not been determined, and therefore a provision (equivalent to a pay award averaging around 2.5% across all pay grades) is being held centrally to meet the cost. This will be distributed to departmental budget ceilings when the details of the pay award are known.

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

City Development & Neighbourhoods

6.4 The department provides a wide range of statutory and non-statutory services which contribute to the wellbeing and civic life of the city.

6.5 The department's costs are not subject to the same levels of volatility as social care services, and pressures tend to be more easy to predict in advance. Nonetheless, the impact of austerity means the department (whilst expecting to live within its resources in 2019/20) may struggle to do so in 2020/21. Key pressures are:-

(a) Reduction in capital project work undertaken by the Estates and Building Services (EBS) division, and consequent loss of fee income. This pressure amounts to some £1m per annum;

(b) Pressures on budgets for property maintenance, which have recently been centralised as part of an earlier spending review (the Technical Services Review). The department is struggling to provide an appropriate level of service to meet assessed needs and a shortfall of some £0.6m has been identified;

(c) Lower income from Neighbourhood Services, particularly from sources such as DVD and CD rental, which for a time performed well but there is now little demand.

6.6 In total budget pressures of up to £2m per year are anticipated.

6.7 The department continues to contribute to the spending review programme, and has achieved £2.5m as part of the new Spending Review 4 Programme, with work ongoing to deliver further savings.

<u>Adult Social Care</u>

6.9 Adult Social Care services nationally are facing severe cost pressures. This is now recognised by the Government, although long-term solutions have been continually deferred (we still await proposals in the form of a green paper).

6.10 Consequently, the Government has been providing additional resources on a year by year basis, at inadequate levels, with no guarantee that these will be increased (or indeed maintained) in future years. Total social care grant (to deal with pressures in both adults' and children's social care) now stands at £10m. For practical purposes, the budget assumes that this level of funding forms a base from which future Government decisions on funding will be made (i.e. it is unrealistic to assume that it will not continue in some form although there are no guarantees). Additionally, Better Care Fund monies paid directly to the department now amount to some £28.5m per year.

6.11 The Adult Social Care Department has managed its budget well in recent years. This is a consequence of additional funding which has been provided in council budgets, and measures to contain costs (including staffing reductions of 20% and tight controls ensuring the service can only be accessed by people who are statutorily entitled). It is expected that the department will live within its resources in 2019/20.

6.12 In 2020/21 and beyond, the department continues to face significant demand led pressures:-

(a) The growth in need of our existing service users resulting in additional support being added to their existing package of care. This is expected to increase at 5.5% per annum.

(b) Growth in service user numbers is expected to grow overall at 0.5% per annum. Growth in older service user numbers is being contained currently, but we are seeing more significant growth in working age adults with mental health conditions and learning disabilities.

(c) The cost of meeting need is rising by more than inflation, due to the impact of continuing increases in the National Living Wage (NLW) which drives care costs. The Government's intention is that the NLW will rise to £10.50 by 2025 (or two thirds of median wages at that time): this implies an increase of some 5% per annum during the intervening period.

6.13 The proposed budget provides an additional £3.1m per year to the departmental budget, in addition to support from the Better Care Fund.

6.14 It is expected that the cost of providing statutory packages of support will increase by around £15m per year, each year, beyond 2020/21, of which two thirds is due to need and one third to wage pressures. At present we have no indication of what funding might be made available by the Government (nor indeed whether social care will continue to be paid for in the same way as currently). The corporate budget strategy is predicated on two options, one being that the Government will provide sufficient funding to meet increased need in 2021/22, and one that they will provide less than the full cost.

6.15 The department continues to provide support to the Spending Review 4 Programme, which is meeting the Council's overall budget savings targets. To date, £2.6m has been achieved as part of this programme and proposals are being developed to achieve a further £0.8m.

Children's Services

6.16 In common with authorities across the country, increasing demand for social care services is putting considerable pressure on the budget of the department (and of the Council). Anecdotally, more authorities seem to be reporting children's social care as the major source of their budget pressure than adult care. Recently, Blackpool council has reported that the children's social care service is overspending by £9m in 2019/20, and Liverpool has projected a £33m increase in its 20/21 budget gap arising from children's social care.

6.17 Whilst the department expects to live within its resources in 2019/20 (having received an injection of £11m in the 2019 budget on a one-off basis) it is now clear that the pressures on the system will persist. These include:-

(a) Social care placement costs. Pressures reported last year continue, and whilst placement numbers seem to have stabilised (but not reduced) we are seeing more

teenagers with severe behavioural issues entering the system requiring high level support. This is despite the interventions of the new multisystemic therapy and functional family therapy teams, who have between them diverted 95 children from care in the first half of 2019/20;

(b) Pressures in respect of transport costs for looked after children and SEN pupils. These pressures may be reduced following a review and consultation of the local transport offer.

6.18 Whilst the director is achieving savings to reduce the overall burden on the general fund, the budget provides a further £11m on an on-going basis from 2020/21 (and an additional £3m on a one-off basis in 2020/21 to buy time for more fundamental review).

6.19 Measures taken, or expected to be taken, to control costs include:-

(a) Continued operation of the therapeutic intervention teams (which were partially funded by one-off business rates pilot income in 2019/20). These teams are now working with over 200 children per year;

(b) Seeking to increase the number of internal foster carers and reduce the use of external agencies;

(c) Careful review of all external residential and semi-independent placements;

(d) Savings from internal administration budgets;

(e) Reductions in the cost of the Connexions and Education Welfare Services.

<u>Health & Wellbeing</u>

6.20 The Health and Wellbeing Division consists of core public health services, together with sports and leisure provision. It is partly funded from Public Health Grant and partly from the general fund. Public Health Grant has been falling in recent years, but will be maintained at current levels in 2020/21. The department expects to manage within its budget.

6.21 The future of Public Health Grant beyond 2020/21 is unclear – it is anticipated that it will be consolidated into the new 75% business rates retention scheme (assuming this is implemented). This, however, remains uncertain as it is subject to agreement between the Ministry of Housing, Communities and Local Government; and the Department of Health – the latter may wish to impose requirements on how former Public Health Grant is spent in the future. We have no indication of the equivalent amount of grant we will receive in 2021/22.

6. 22 The department continues to contribute to the spending review programme, and has plans in place to achieve the remaining Spending Review 4 target for the department.

Corporate Resources & Support

6.23 The department primarily provides back office support services, but also some public facing services such as benefits and collection of council tax. It has made considerable savings in recent years in order to contribute to the Council's savings targets. It has nonetheless achieved a balanced budget each year.

6.24 The department is absorbing pressures within its overall budget envelope (including additional legal work associated with growing childcare caseloads, falling housing benefit administration grant and managing the change to Universal Credit). The department expects to live within budget in 2019/20 and 2020/21.

6.25 The department has achieved £2.4m towards the Council's Spending Review 4 Programme, and anticipates saving a further £0.9m principally through staffing reviews.

7. Corporately Held Budgets and Provisions

7.1 In addition to the service budget ceilings, some budgets are held corporately. These are described below.

7.2 The budget for **capital financing** represents the cost of interest and debt repayment on past years' capital spending. This budget is not controlled to a cash ceiling, and is managed by the Director of Finance. Costs which fall to be met by this budget are driven by the Council's treasury management strategy, which will also be approved by Council in February, and are affected by decisions made by the Director of Finance in implementation of this policy.

7.3 A one-off **corporate contingency** of £1m has been created in 2019/20 to manage significant pressures that arise during the year. This is particularly appropriate given the scale of reductions departments are having to make.

7.4 As set out in previous reports, **education funding reforms** have reduced the amount available to support centrally-managed services for schools and pupils, and for higher-needs pupils. These changes have a knock-on impact to general fund budgets. A provision has been made accordingly. (As well as the corporately held budget, some funding is now included in the departmental budget).

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

7.6 For 2021/22, amounts have also been included for future cost increases. These are indicative amounts – the budget for this year will be set in February 2021. A planning provision of £3m has also been included, to meet any future unavoidable cost pressures.

8. Resources

Business Rates Retention Scheme

8.1 Since 2013, local government has retained 50% of the business rates collected locally, with the other 50% being paid to central government. In Leicester, 1% is paid to the fire authority, and 49% has been retained by the Council. This is known as the "Business Rate Retention Scheme".

8.2 In recognition of the fact that different authorities' ability to raise rates does not correspond to needs, there are additional elements of the business rates retention scheme:

(a) a **top-up to local business rates**, paid to authorities with lower taxbases relative to needs (such as Leicester) and funded by authorities with greater numbers of higher-rated businesses.

(b) **Revenue Support Grant** (RSG), which has declined sharply in recent years as it is the main route for the government to deliver cuts in local government funding (and the methodology for doing this has disproportionately disadvantaged deprived authorities).

8.3 At the time of writing, allocations of the top-up and RSG payments have not been announced. The draft budget for 2020/21 is based on forecasts from the information announced by the government at the Spending Round, which broadly equates to an inflationary increase on all elements of the scheme for one year only.

8.4 Our estimates of rates income take into account the amount of income we believe we will lose as a consequence of successful appeals. A significant number of appeals against the 2017 revaluation have not yet been decided, and appeals have been a source of volatility since business rates retention was introduced. Despite Government attempts to reduce this volatility, this is likely to continue as there are still a large number of outstanding appeals from earlier years (and any successful appeals will be backdated, potentially for several years). Valuations and appeals are not within the Council's control.

8.5 No figures have been made available for local government funding beyond 2020/21, either nationally or locally. While there have been moves in recent months to relax austerity in public spending, there are also significant pressures on the public finances and spending commitments (including schools, the NHS and police) will need to be funded. It should not be assumed that there will be no further cuts to funding for "unprotected" departments, including local government.

8.6 Significant reforms to the funding system are planned from April 2021 (delayed from 2021), including increasing the proportion of rates retained locally to 75%. In itself, the change should be financially neutral, as other funding elements will be reduced to offset the additional retained rates. There may also be reforms to the system to cushion the impact of appeals.

8.7 There is likely to be a more substantial effect on the Council's finances from the "fair funding review" planned for the same date, which will redistribute resources between councils. At the time of writing, it is unclear what the impact will be on individual authorities. We should benefit from the new formula fully reflecting the differences in council taxbase between different areas of the country; however, there are other pressures on the funding available, including intensive lobbying from some authorities over perceived extra costs in rural areas.

8.8 For planning purposes, the budget figures for 2021/22 assume additional real-terms cuts of £3 million per year. This represents a significantly slower rate of cuts than we have seen in the period from 2013 to 2020. If the fair funding review and overall funding position are less favourable, these cuts could be significantly higher.

Council Tax

8.9 Council tax income is estimated at £121.2m in 2020/21, based on a tax increase of just below 4% (the maximum allowed without a referendum). For planning purposes, a tax increase of 2% has been assumed in 2021/22.

8.10 The proposed tax increase in 2020/21 includes the additional "social care levy" allowed since 2016/17, and designed to help social care authorities mitigate the growing costs of social care; the Government will expect us to demonstrate that the money is being used for this purpose.

8.11 Council tax income includes the additional revenue raised from the Empty Homes Premium, which doubles the charge for a property left empty for more than two years. Following the Council decision in November 2018, an additional rate will be introduced from April 2020 so properties left empty for more than five years pay a higher rate. It is assumed in this report that the additional income from this higher rate will be minimal, as the higher charge increases the probability that properties will be brought back into use.

Other grants

8.12 The Government also controls a range of other grants. The majority of these are not shown in the table at paragraph 4.1, as they are treated as income to departments (departmental budgets are consequently lower than they would have been). Those held corporately are described below:

a) **New Homes Bonus (NHB)**. This is a grant which roughly matches the council tax payable on new homes, and homes which have ceased to be empty on a long

term basis. The future of NHB is in doubt, and it may be rolled into the new business rates retention scheme from 2021/22. The projection for 2021/22 assumes that any replacement for NHB will reduce over time.

b) Additional funding to support **Social Care** has been made available each year since 2017/18, although this has been as a series of one-off allocations rather than a stable funding stream. For 2020/21, the total funding nationally will be £1.65 billion (a £1 billion increase from 2019/20). Our estimated share of this is over £10 million; for comparison, this budget proposes increases to Adults' and Children's budgets totalling over £17 million in 2020/21.

Collection Fund surplus / deficit

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

8.14 The Council has an estimated **council tax collection fund surplus** of £0.8m, after allowing for shares paid to the police and fire authorities. This has arisen because of growth in the number of homes liable to pay tax (which has been greater than was assumed when the budget was set) and a reduction in the costs of the council tax support scheme, linked to improvements in the local economy.

8.15 The Council has an estimated **business rates collection fund surplus** of £0.9m. This is largely due to a reduction in the forecast cost of appeals, following updated information from external advisers.

9. Managed Reserves Strategy

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

9.2 The Council has agreed to maintain a minimum balance of £15m of reserves. The Council also has a number of earmarked reserves, which are further discussed in section 10 below.

9.3 In 2013, the Council approved the adoption of a managed reserves strategy. This involved contributing money to reserves in the early years of the strategy, and drawing down reserves in later years. This policy has bought time to more fully consider how to make the substantial cuts which are necessary.

9.4 The managed reserves strategy is being extended by using in-year savings arising from spending reviews, and future reviews should enable a further extension of the strategy. Given the forecast funding gaps from 2021/22 onwards, and the level of uncertainty around future funding, it is essential that these reviews are implemented promptly to ensure that managed reserves are available to mitigate the medium-term funding risks.

9.5 As at the end of the 2018/19 financial year, some £35m was available to support future budgets, a significant increase on the forecast when the 2019/20 budget was set. This increase is the result of savings in corporate budgets (as reported in the 2018/19 outturn) and a review of the accounting treatment of grant funding from previous years.

9.6 This report only covers the Council's General Fund budget. The schools budget (which is separately funded via Dedicated Schools Grant) is also under significant cost pressure with increasing costs on the High Needs Block, which provides support to pupils with special needs and disabilities. Proposals to manage these costs will be brought forward in due course; however, this may involve the use of General Fund reserves in the short term, which would reduce the amount available for budgets beyond 2020/21. [It should also be noted that the Department for Education is currently consulting on proposals which, if they go ahead, will prevent General Fund reserves being used to support DSG pressures].

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

	£m
Brought forward 1st April 2019	33.6
Use planned in budget	(1.9)
Additional savings in-year	1.7
Forecast carry forward 1st April 2020	**33.4**
Required in 2020/21	(5.6)
Uncommitted balance	**27.8**

10. Earmarked Reserves

10.1 In addition to the general reserves, the Council also holds earmarked reserves which are set aside for specific purposes. These include ring-fenced funds which are held by the Council but for which we have obligations to other partners or organisations; departmental reserves, which are held for specific services; and corporate reserves, which are held for purposes applicable to the organisation as a whole.

10.2 Earmarked reserves are kept under review, and amounts which are no longer needed for their original purpose can be released for other uses, including the managed reserves strategy. At the time of preparing the draft budget, this review process is ongoing.

11. Budget and Equalities

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

11.2 In accordance with section 149 of the Equality Act 2010, the Council must "have due regard", when making decisions, to the need to meet the following aims of our Public Sector Equality Duty :-

(a) eliminate unlawful discrimination;

(b) advance equality of opportunity between those who share a protected characteristic and those who do not;

(c) foster good relations between those who share a protected characteristic and those who do not.

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

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

11.5 This report seeks approval to the proposed budget strategy. The report sets out financial ceilings for each service which act as maxima above which the City Mayor cannot spend (subject to his power of virement). However, decisions on services to be provided within the budget ceilings are taken by managers or the City Mayor separately from the decision regarding the budget strategy. Where appropriate, an individual Equalities Impact Assessment for these changes will be undertaken when these decisions are developed.

11.6 While this report does not contain details of specific service proposals, it does recommend a proposed council tax increase for the city's residents. The City Council's proposed tax for 2020/21 is £1,614.23, an increase of just below 4% compared to 2019/20. As the recommended increase could have an impact on those required to pay it, an assessment has been carried out to inform decision makers of the potential equalities implications. This analysis is provided at Appendix Three.

12. Risk Assessment and Adequacy of Estimates

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

12.2 In the current climate, it is inevitable that the budget carries significant risk. In my view, although very difficult, the budget for 2020/21 is achievable subject to the risks and issues described below.

12.3 The most significant risks in the 2020/21 budget arise from:

(a) Social care spending pressures, specifically the risks of further growth in the cost of care packages and inability to contain the costs of looked after children;

(b) Ensuring spending reviews which have already been approved, but not yet implemented, deliver the required savings;

(c) Achievability of estimated rates income (although technically any shortfall will appear as a collection fund deficit in the 2020/21 budget), and particularly the extent of successful appeals against the 2017 revaluations. There is a further risk relating to a national legal challenge on NHS properties claiming charitable relief, where an appeal is likely. If successful, this would result in a major transfer of resources away from local authorities across the country;

(d) Increases in pay costs, over and above the 2.5% average pay award included in the proposed budget.

12.4 For 2021/22 and beyond, the budget projections are particularly uncertain. Risks to a balanced budget in these years include:-

(a) Non-achievement, or delayed achievement, of the remaining spending review savings; and/or further budget pressures within service departments meaning that any savings achieved cannot be used to reduce the overall budget gap;

(b) Loss of future resources. The funding landscape after 2020/21 is largely unknown, with the move to 75% business rates retention and the planned needs review (which could result in a gain or loss to the Council). Despite the Government's announcements of "the end of austerity", the risk of further cuts to funding from 2021/22 remains significant;

(c) Longer-term reforms to social care funding and expectations on local authorities, and the need to manage ongoing demographic pressures;

(d) Government policy includes above-inflation increases to the National Living Wage. This will put additional pressure on contract costs (particularly for independent sector care packages in Adults' Social Care).

12.5 A further risk is economic downturn, nationally or locally. This could result in new cuts to grant; falling business rate income; and increased cost of council tax reductions for taxpayers on low incomes. It could also lead to a growing need for council services and an increase in bad debts. The effect of Brexit remains to be seen.

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

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

(b) A one-off corporate contingency of £1m is included in the budget for 2020/21;

(c) A planning contingency is included in the budget from 2021/22 onwards (£3m per annum);

(d) Spending Review savings are being implemented as soon as possible, and the resulting savings "banked" to support future budgets.

12.7 Subject to the above comments, I believe the Council's general and earmarked reserves to be adequate. I also believe estimates made in preparing the budget are robust. (Whilst no inflation is provided for the generality of running costs in 2020/21, some exceptions are made, and it is believed that services will be able to manage without an allocation).

13. Consultation on the Draft Budget

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

(a) The Council's scrutiny function;
(b) Key partners and other representatives of communities of interest;
(c) Business community representatives (a statutory consultee);
(d) The Council's trade unions.

13.2 Comments will be incorporated into the final version of this report.

14. Financial Implications

14.1 This report is exclusively concerned with financial issues.

14.2 Section 106 of the Local Government Finance Act 1992 makes it a criminal offence for any member with arrears of council tax which have been outstanding for two months or more to attend any meeting at which a decision affecting the budget is to be made unless the member concerned declares the arrears at the outset of the meeting and that as a result s/he will not be voting. The member can, however, still speak. The rules are more circumscribed for the City Mayor and Executive. Any executive member who has arrears outstanding for 2 months or more cannot take part at all.

15. Legal Implications (Kamal Adatia, City Barrister)

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

15.2 At the budget-setting stage, Council is estimating, not determining, what will happen as a means to the end of setting the budget and therefore the council tax. Setting a budget is not the same as deciding what expenditure will be incurred. The Local Government Finance Act,

1992, requires an authority, through the full Council, to calculate the aggregate of various estimated amounts, in order to find the shortfall to which its council tax base has to be applied. The Council can allocate greater or fewer funds than are requested by the Mayor in his proposed budget.

15.3 As well as detailing the recommended council tax increase for 2020/21, the report also complies with the following statutory requirements:-

(a) Robustness of the estimates made for the purposes of the calculations;
(b) Adequacy of reserves;
(c) The requirement to set a balanced budget.

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

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

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

17. **Report Authors**

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Appendix One

Budget ceilings

	Adjusted 19/20 budget £000s	Spending Reviews approved £000s	Non-pay inflation £000s	Other changes £000s	2020/21 budget ceiling £000s
1. City Development & Neighbourhoods					
1.1 Neighbourhood & Environmental Services					
Divisional Management	**358.8**	0.0			**358.8**
Regulatory Services	**3,025.0**	(55.0)			**2,970.0**
Waste Management	**17,323.9**	0.0	458.0		**17,781.9**
Parks & Open Spaces	**3,731.9**	0.0			**3,731.9**
Neighbourhood Services	**5,410.0**	(255.0)			**5,155.0**
Standards & Development	**1,611.6**	0.0			**1,611.6**
Divisional sub-total	**31,461.2**	**(310.0)**	**458.0**	**0.0**	**31,609.2**
1.2 Tourism, Culture & Inward Investment					
Arts & Museums	**4,168.1**	(78.0)			**4,090.1**
De Montfort Hall	**540.4**	0.0			**540.4**
City Centre	**175.9**	0.0			**175.9**
Place Marketing Organisation	**375.3**	0.0			**375.3**
Economic Development	**89.1**	0.0			**89.1**
Markets	**(296.8)**	(80.0)			**(376.8)**
Adult Skills	**(870.4)**	0.0			**(870.4)**
Divisional Management	**208.5**	0.0			**208.5**
Divisional sub-total	**4,390.1**	**(158.0)**	**0.0**	**0.0**	**4,232.1**
1.3 Planning, Development & Transportation					
Transport Strategy	**10,024.0**	(150.0)			**9,874.0**
Highways	**4,018.3**	(100.0)			**3,918.3**
Planning	**974.4**	0.0			**974.4**
Divisional Management	**207.9**	0.0			**207.9**
Divisional sub-total	**15,224.6**	**(250.0)**	**0.0**	**0.0**	**14,974.6**
1.4 Estates & Building Services	**4,330.1**	(150.0)	0.0	0.0	**4,180.1**
1.5 Housing Services	**2,860.7**	0.0	0.0	0.0	**2,860.7**
1.6 Departmental Overheads					
School Organisation & Admissions	**454.3**	0.0			**454.3**
Overheads	**566.6**	50.0			**616.6**
Divisional sub-total	**1,020.9**	**50.0**	**0.0**	**0.0**	**1,070.9**
DEPARTMENTAL TOTAL	**59,287.6**	**(818.0)**	**458.0**	**0.0**	**58,927.6**

Appendix One

Budget ceilings

	Adjusted 19/20 budget £000s	Spending Reviews approved £000s	Non-pay inflation £000s	Other changes £000s	2020/21 budget ceiling £000s
2.Adults					
2.1 Adult Social Care & Safeguarding					
Other Management & support	**656.9**	0.0			**656.9**
Safeguarding	**172.4**	0.0			**172.4**
Preventative Services	**6,418.1**	0.0			**6,418.1**
Independent Sector Care Package Costs	**95,843.0**	(70.0)	2,035.7	12,393.0	**110,201.7**
Care Management (Localities)	**6,677.8**	0.0			**6,677.8**
Divisional sub-total	**109,768.2**	**(70.0)**	**2,035.7**	**12,393.0**	**124,126.9**
2.2 Adult Social Care & Commissioning					
Enablement & Day Care	**2,972.2**	0.0			**2,972.2**
Care Management (LD & AMH)	**4,945.1**	0.0			**4,945.1**
Preventative Services	**2,062.1**	0.0			**2,062.1**
Contracts,Commissioning & Other Support	**4,814.0**	0.0			**4,814.0**
Substance Misuse	**5,559.7**	0.0			**5,559.7**
Departmental	**(21,512.3)**	0.0		(9,308.0)	**(30,820.3)**
Divisional sub-total	**(1,159.2)**	**0.0**	**0.0**	**(9,308.0)**	**(10,467.2)**
DEPARTMENTAL TOTAL	**108,609.0**	**(70.0)**	**2,035.7**	**3,085.0**	**113,659.7**
3. Education & Children's Services					
3.1 Strategic Commissioning & Business Support	**1,039.4**	0.0	0.0	0.0	**1,039.4**
3.2 Learning Quality & Performance					
Raising Achievement	**308.3**	0.0			**308.3**
Learning & Inclusion	**1,926.3**	0.0			**1,926.3**
Special Education Needs and Disabilities	**8,316.6**	0.0			**8,316.6**
Divisional sub-total	**10,551.2**	**0.0**	**0.0**	**0.0**	**10,551.2**
3.3 Children, Young People and Families					
Children In Need	**11,185.7**	0.0			**11,185.7**
Looked After Children	**38,772.0**	0.0	188.3		**38,960.3**
Safeguarding & QA	**2,620.2**	0.0			**2,620.2**
Early Help Targeted Services	**5,251.1**	0.0			**5,251.1**
Early Help Specialist Services	**2,334.5**	0.0			**2,334.5**
Divisional sub-total	**60,163.5**	**0.0**	**188.3**	**0.0**	**60,351.8**
3.4 Departmental Resources	**(8,766.8)**	0.0		14,000.0	**5,233.2**
DEPARTMENTAL TOTAL	**62,987.3**	**0.0**	**188.3**	**14,000.0**	**77,175.6**

Appendix One

Budget ceilings

	Adjusted 19/20 budget £000s	Spending Reviews approved £000s	Non-pay inflation £000s	Other changes £000s	2020/21 budget ceiling £000s
4. Health & Wellbeing					
4.1 Health and Wellbeing					
Adults' Services	**4,250.6**	0.0			**4,250.6**
Children's 0-19 Services	**8,967.5**	0.0			**8,967.5**
Lifestyle Services	**1,259.2**	(45.0)			**1,214.2**
Staffing, Infrastructure & Other	**1,359.0**	0.0			**1,359.0**
Sports Services	**2,794.3**	(300.0)			**2,494.3**
DEPARTMENTAL TOTAL	**18,630.6**	**(345.0)**	**0.0**	**0.0**	**18,285.6**
5. Corporate Resources Department					
5.1 Delivery, Communications & Political Governance	**5,659.5**	0.0			**5,659.5**
5.2 Financial Services					
Financial Support	**4,773.1**	0.0			**4,773.1**
Revenues & Benefits	**6,315.1**	0.0			**6,315.1**
Divisional sub-total	**11,088.2**	**0.0**	**0.0**	**0.0**	**11,088.2**
5.3 Human Resources	**3,857.6**	0.0			**3,857.6**
5.4 Information Services	**9,254.0**	(132.0)			**9,122.0**
5.5 Legal Services	**2,674.4**	0.0			**2,674.4**
DEPARTMENTAL TOTAL	**32,533.7**	**(132.0)**	**0.0**	**0.0**	**32,401.7**
TOTAL -Service Budget Ceilings	**282,048.2**	**(1,365.0)**	**2,682.0**	**17,085.0**	**300,450.2**
***less* public health grant**	**(26,103.0)**			(496.0)	**(26,599.0)**
NET TOTAL	**255,945.2**	**(1,365.0)**	**2,682.0**	**16,589.0**	**273,851.2**

Appendix Two

Scheme of Virement

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

Budget Ceilings

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

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

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

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

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

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

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

Corporate Budgets

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

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

   (b) the Director of Finance may allocate the provision for the 2020/21 pay award;

   (c) the City Mayor may determine the use of the corporate contingency;

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

Earmarked Reserves

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

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

    (a) a budget ceiling, if the purposes of the reserve are within the scope of the service budget;

    (b) a carry forward reserve, subject to the usual requirement for a business case.

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

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

Appendix Three

Equality Impact Assessment

1. **Purpose**

1.1 The purpose of this appendix is to present the equalities impact of the proposed 3.99% council tax increase. This is the maximum increase that the Government will allow us without a referendum.

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

2.1 As at September 2019, there are 128,112 properties liable for Council Tax in the city (excluding those registered as exempt, such as student households).

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

2.3 Council tax relief for pensioner households follows different rules. Low-income pensioners are eligible for up to 100% relief.

3. **How are they affected?**

3.1 The table below sets out the financial impact of the proposed council tax increase on different properties, before any discounts or reliefs are applied. It shows the weekly increase in each band, and the minimum weekly increase for those in receipt of a reduction under the CTSS for working-age households.

3.2 For band B properties (almost 80% of the city's properties are in bands A or B), the proposed annual increase in council tax is £48.27; the minimum annual increase for households eligible under the CTSS would be £9.65 (for a working-age household, and excluding the impact of any other discounts).

Band	No. of Properties	Weekly increase	Minimum Weekly Increase under CTSS
A-	287	£0.66	£0.13
A	76,201	£0.79	£0.16
B	25,466	£0.93	£0.19
C	14,580	£1.06	£0.32
D	6,131	£1.19	£0.45
E	3,326	£1.45	£0.71
F	1,499	£1.72	£0.98

G	589	£1.98	£1.24
H	33	£2.38	£1.64
Total	**128,112**		

Notes: "A-" properties refer to band A properties receiving an extra reduction for Disabled Relief. Households may be entitled to other discounts on their council tax bill, which are not shown in the table above.

3.3 In most cases, the change in council tax (£0.93/week for a band B property with no discounts) is a small proportion of disposable income, and a small contributor to any squeeze on household budgets. A Council Tax increase would be applicable to all properties - the increase would not target any one protected group, rather it would be an increase that is applied across the board. However, it is recognised that this may have a more significant impact among households with a low disposable income.

3.4 Some households reliant on social security benefits are likely to be adversely affected due to the cumulative impact of further implementation of the Government's welfare reforms, in particular the rollout of Universal Credit full service which was implemented in Leicester in June 2018.

3.5 The ASDA income tracker for August 2019[1] shows relatively strong growth in disposable incomes over the past year, reflecting low unemployment, real-terms wage growth, and falling inflation rates. However, this is not evenly spread, with the lowest-income fifth of households seeing a 2.6% *fall* in discretionary spending power over the year.

3.6 Research by the Joseph Rowntree Foundation (JRF) has identified certain groups who are particularly likely to be on a low income[2] and may therefore see a disproportionate effect from a small (in absolute terms) increase in council tax. These include lone parents, single-earner couples and larger families (with 3 or more children).

3.7 The JRF report also highlights ongoing inflationary pressures on the household budgets of low-income groups. While overall CPI inflation has fallen recently, there have been higher increases in the costs of domestic fuel and public transport, which have a disproportionate effect on many low-income households. Increasing childcare costs, which are not fully met by tax credits or Universal Credit, are also identified as a particular pressure.

4. Alternative options

4.1 Within the current financial context, the alternative options of a lower (or no) increase would inevitably require even greater cuts to services. It is not possible to say where these cuts

[1] The ASDA income tracker is an indicator of the economic prosperity of 'middle Britain', taking into account income, tax and all basic expenditure. ASDA's customer base matches the UK demographic more closely than that of other supermarkets.

[2] *A Minimum Income Standard for the United Kingdom in 2019,* JRF, July 2019. The JRF report is based around a different measure of "low income" to the ASDA income tracker, based on the ability to afford an assessed minimum living standard.

would fall; however, certain protected groups (e.g. older people; families with children; and people with disabilities) could face disproportionate impacts from reductions to services.

5. Mitigating actions

5.1 For residents likely to experience short term financial crises as a result of the cumulative impacts of the above risks, the Council has a range of mitigating actions as described in the report. These include: funding through Discretionary Housing Payments; the council's work with voluntary and community sector organisations to provide food to local people where it is required – through the council's or partners' food banks; through schemes which support people getting into work (and include cost reducing initiatives that address high transport costs such as providing recycled bicycles); and through support to social welfare advice services. The Council is also running a welfare benefits take-up campaign, to raise awareness of entitlements and boost incomes among vulnerable groups.

6. What protected characteristics are affected?

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

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

Analysis of impact based on protected characteristic

Protected characteristic	Impact of proposal:	Risk of negative impact:	Mitigating actions:
Age	Older people are least affected by a potential increase in council tax. Older people (pension age & older) have been relatively protected from the impacts of the recession & welfare cuts, as they receive protection from inflation in the uprating of state pensions. Low-income pensioners also have more generous (up to 100%) council tax relief. However, in the current financial climate, a lower council tax increase would require even greater cuts to services. While it is not possible to say where these cuts would fall exactly, there are potential negative impacts for this group as older people are the primary service users of Adult Social Care. Working age people bear the brunt of the impacts of welfare reform reductions – particularly those with children. Whilst an increasing proportion of working age residents are in work, national research indicates that those on low wages are failing to get the anticipated uplift of the National Living Wage.	Working age households and families with children – incomes squeezed through low wages and reducing levels of benefit income.	Access to council discretionary funds for individual financial crises; access to council and partner support for food; and advice on managing household budgets.
Disability	Disability benefits have been reduced over time as thresholds for support have increased. The tax increase could have an impact on such household incomes. However, in the current financial climate, a lower council tax increase would require even greater cuts to services. While it is not possible to	Further erode quality of life being experienced by disabled people as their household incomes are squeezed further as a	Disability benefits are disregarded in the assessment of need for CTSS purposes. Access to council discretionary funds for individual financial crises; access to council and

	say where these cuts would fall exactly, there are potential negative impacts for this group as disabled people are more likely to be service users of Adult Social Care.	result of reduced benefits.	partner support for food; and advice on better managing budgets.
Gender Reassignment	No disproportionate impact is attributable specifically to this characteristic.		
Pregnancy and Maternity	Maternity benefits have not been frozen and therefore kept in line with inflation. However, other social security benefits have been frozen, but without disproportionate impact arising for this specific protected characteristic.		
Race	Those with white backgrounds are disproportionately on low incomes (indices of multiple deprivation) and in receipt of social security benefits. Some BME people are also low income and on benefits. Nationally, one-earner couples have seen particular falls in real income and are disproportionately of Asian background – which suggests an increasing impact on this group.	Household income being further squeezed through low wages and reducing levels of benefit income.	Access to council discretionary funds for individual financial crises, access to council and partner support for food and advice on managing household budgets. Where required, interpretation and translation will be provided in line with the Council's policy to remove barriers to accessing the support identified.
Religion or Belief	No disproportionate impact is attributable specifically to this characteristic.		

Sex	Disproportionate impact on women who tend to manage household budgets and are responsible for childcare costs. Women are disproportionately lone parents. Analysis has identified lone parents as a group particularly likely to lose income from welfare reforms.	Incomes squeezed through low wages and reducing levels of benefit income. Increased risk for women as they are more likely to be lone parents.	If in receipt of Universal Credit or tax credits, a significant proportion of childcare costs are met by these sources. Access to council discretionary funds for individual financial crises, access to council and partner support for food and advice on managing household budgets.
Sexual Orientation	No disproportionate impact is attributable specifically to this characteristic.		

Appendix Four

Consultation Responses

[To be added once consultation is complete]

Appendix F

Leicester's Food Plan 2020-25

For consideration by: Health & Wellbeing Scrutiny Commission

Date: 30 January 2020

Lead director: Ivan Browne

Ward(s) affected: All
Report author: Etain McDermott, Public Health Programme Manager
Author contact details: etain.mcdermott@leicester.gov.uk; 0116 454 2377

1.0 Purpose of Briefing

1.1 To provide a summary as to the development of the Food Plan 2020 - 2025 and other associated initiatives.
1.2 To highlight achievements related to the previous food plan.
1.3 To update the Commission on future priorities and next steps in relation to the Food Plan 2020 - 2025.

2.0 Recommendations

2.1 This briefing note is for information only

3.0 Background

3.1 Leicester's 1st Food Plan was launched in April 2014 and marked the start of a long term programme to make Leicester 'a healthy and sustainable food city': a place where the production, distribution, purchase and use of food supports better health, stronger communities and a successful economy – while protecting the environment and conserving natural resources.

3.2 The 2014 – 2016 Food Plan aimed to see more community food projects in place across the city, more land under food production, increases in cookery skills courses, a growing food economy and new food-related enterprises thriving.

3.3 A programme of work has been underway to develop Leicester's 2nd Food Plan. Recent focus has been to reflect on the success of the previous plan, develop new priorities based on consultation with key stakeholders that reflect the current picture in relation to food across Leicester City and to re-invigorate partnerships to effectively update and implement the new food plan from 2020 onwards.

3.4 The Food Plan is multi-faceted and aims to bring together health, environment sustainability and economic development into a single plan with relevant commitments and ambitions.

3.5 The draft plan is currently in the design phase with an anticipated launch date of March 2020.

4.0 History of Leicester's Food Plan

Leicester's 1st food plan was launched in 2014 with its associated actions and ambitions remaining a priority across a number of Council Departments. There is as much focus as ever on food, particularly the importance of access to good food for all, reducing food poverty, tacking environmental issues and increasing sustainable practice within the food sector.

The impact of poor nutrition and limited access to good food increases health inequalities across the city, leading to negative impacts on diet related ill health amongst the most disadvantaged. The Food Plan therefore remains a Public Health priority.

Below is a summary of food related activity since the launch of the 2014 Food Plan.

4.1 2014

- Leicester became a founding member of the Sustainable Food Cities Network
- Food Partnership established
- Development of healthy and sustainable food policies
- Food strategy developed and action plan implemented
- Food Plan Charter developed
- Food Plan Board established led by the Deputy Mayor
- Recruitment of a Food Plan Project Manager

4.2 2015

- Commissioning of Food and Nutrition Programmes:
    - Food for Life - developing healthy food culture in schools
    - Food Growing Support Programme - bespoke support to communities to develop skills and resilience in food growing
- Launch of Get Growing Grant Scheme
- Leicester Nutrition and Dietetic Service working in early years settings to develop policy and practice around food and nutrition
- Networking Event for Food Plan stakeholders
- First Holiday Food Programme delivered
- Development and delivery of emergency food provision and links into surplus food for food banks (FareShare East Midlands)
- Emergence of Community Food Projects such as The Real Junk Food project
- Food Hall Established in the Market Place
- The Allotment Strategy 2015-2020 launched

4.3 2016

- Food Poverty Conference
- Emergency Food Partnership established
- Development of Food Poverty Strategy
- Food Growing Events held in the community
- Implementation of the peer support breastfeeding programme

4.4 2017

- Food Poverty Event organised by Action Homeless on behalf of the emergency food partnership
- Development and co-ordination of the holiday food programme 2017-2020
- Approval for Phase 2 of Leicester's Food Plan:
    - To re-instate the food plan board
    - To link the food plan formally to the sustainability board to maximise the opportunities for co-ordination
- Launch of Good Food East Midlands (Public Health England)
- Feeding Leicester partnership established

4.5 2018

- Multi-agency Food Plan Event held to establish future food plan priorities
- Lead Member approved Leicester to become a Feeding Britain Pilot
- Recommissioning of Food Growing and Food for Life Programmes 2018-

2021

- Development of Food Plan Board to take forward food, health and sustainability strategically across the city:
    - **Food and Drink Sector**
        - LLEP, Economic Development, Environment Team, Food and Drink Forum
        - Public Health led work to address health in food businesses as part of Health in all Policies
        - Partnership work with Leicestershire County Council and the Food and Drinks Forum to identify opportunities to work with Food and Drink Sector
    - **Food Poverty**
        - Building food security - community food growing for low income families, improving cooking skills
        - Protecting people from hunger – auto-registration for free school meals, boosting uptake of healthy start vouchers, improving council tax debt collection practices, holiday food provision and breakfast clubs
        - Low cost food for vulnerable groups – social supermarkets, community cafes, mobile shops, access to white goods and furniture
        - Supporting people in crisis – implementation of 'food bank plus' to provide advice and support alongside food; drop-in kitchens; emergency cash payments or vouchers; fuel banks
- Social Value Charter Launched
- Liz Kendall MP agreed to Chair Feeding Leicester steering group
- Children, Young People and Families Healthy Weight strategy launched with implementation of the '1000 tweaks' social media campaign
- Leicester's 3rd Holiday Food Programme implemented
- Pilot Exchange visit to bring Feeding Britain pilot areas together to share learning and experiences of alternative food bank models, including voucher free food banks, community led food hubs and social supermarkets
- Funding bid for Department for Education Holiday Activity and Food Grant Fund

4.6 2019

- Hosted Feeding Britain Trustee and MP Visit
- 2nd Food Plan Consultation Event
- Holiday Food Programme - long term plan developed to ensure sustainability and secure further funding
- Food Plan Board agree 2nd plan ambitions
- LCC Catering achieve Food Served Here Silver Award
- Partnership work with Business Experts FoodSync to organise a workshop with East Midlands Chamber, Food and Drink Forum, LLEP and local universities to support businesses to link with the sustainable food agenda
- Final draft of Food Plan and Action Plan developed

5 Leicester's Food Plan 2014 – 2016 achievements:

5.1 Supporting Healthier Food Choices

- The development of a healthy weight strategy for children and young people which aims to halt the rise in children presenting as overweight or obese in

Year 6 by 2023

- The implementation of the '1000 tweaks' social media campaign to encourage individuals, families, organisations and businesses to make small changes to help children and young people to eat good food and enjoy physical activity
- Support to schools to increase positive healthy eating behaviours, knowledge about nutrition and increased cooking and growing skills
- Support to early years settings to provide healthy, balanced meals and snacks for under 5's and their families through "Eat Better, Start Better". To date over 100 settings have engaged in the programme and 39 settings have achieved the 'Good Nutrition for Under 5's' award
- Improved support to breastfeeding mums so that by 6-8 weeks, 58% of mums are still breastfeeding. This is significantly higher than the national average
- In 2015, Leicestershire Partnership Trust achieved level 3 of UNICEF Baby Friendly Initiative and in 2018 University Hospitals of Leicester achieved level 2
- Improved food standards for Leicester City Council school dinners serving fresher, healthy, ethical food using some local and organic ingredients though the Silver Food for Life Served Here accreditation award
- Development of holiday food programme through collaborative partnership working and influencing national policy providing over 32,000 meals and reaching up to 1,900 children in 2019

5.2 Tackling Food Poverty

- Leicester as a Feeding Britain Pilot site (Feeding Leicester) developing joined up, longer-term approaches to tacking food poverty
- Development of an Emergency Food Partnership to support food aid projects including increased access to surplus food, funding to purchase white goods and development of advice offers in four food banks
- Emergency food provision in the city for those in crisis via the City Councils customer services, delivered by the Action Homeless Stop Shop

5.3 Supporting Food Growing

- The community food growing support programme provides funding to community groups to develop food growing skills and knowledge. Over 60 community groups and 70 schools in the city have been supported.
- Leicester City Council maintains 45 allotment sites holding more than 3,000 plots, there are currently 22 allotment societies who have voluntary stewards providing day to day management and support to allotment holders
- Development of "Grow your Own Grub" project with schools, 12 schools in 2019 grew a meal in a wheelbarrow and designed a recipe as part of a competition supported by The Conservation Volunteers (TCV) and Leicester City Council

5.4 Supporting the Food and Drink Sector and Reducing Waste

- Comprehensive support to food and drinks businesses managed by Leicester City Council has secured £3.1million of funding from European Regional Development Fund (ERDF) to deliver the 'Collaborate' project - a comprehensive three-year business support programme across Leicester and Leicestershire running from 2017 to 2019
- A "Meet the Producer" event was held linking local catering businesses with

local suppliers. The aim of which was to reduce food miles, support local food growing and encourage re-distribution of surplus food to reduce food waste

- FareShare East Midlands distributes tonnes of surplus food annually, reducing food waste and creating good links with local supermarkets such as Tesco, Co-op East Midlands.

6 Ambitions of Leicester's Food Plan 2020 onwards;

6.1 To enable the Food Plan to achieve its vision, a number of ambitions have been developed. These ambitions focus on the whole food system, recognising how health, social, economic and environmental factors are interconnected.

Ambitions		**Outcomes**
1	**Supporting Healthier & Sustainable Food Choices**	Improved food knowledge and skills Increased access to nutritional and sustainable food Making healthier choices an easy choice
2	**Tackling food poverty**	Improved access to good food for all Reducing the impact of deprivation on diet
3	**Building community food knowledge, skills and resources**	Connected communities sharing skills and knowledge about food growing and cooking and celebrating the diversity of food
4	**Promoting a vibrant and diverse sustainable food economy**	Improved health and sustainable food offer Food businesses generating quality employment. Responding to consumer demand to increase the availability of healthy and sustainable food
5	**Transforming catering and food procurement**	Encourage Public organisations and businesses to provide food that improves the health and wellbeing of communities, the environment and local food and farming economy's Embedding health and sustainability into current procurement practice; influencing local organisations to prioritise health and environmental sustainability within their buying power, including minimising waste and carbon use
6	**Reducing waste and the ecological footprint of the food system**	Encourage and support the adoption of sustainable diets to improve health and environment Reduce energy use in food production Reduced use of plastics across the food system

7. Governance

The Food Plan has been developed in partnership with a number of key stakeholders including environmental sustainability, economic regeneration, tourism, culture and inward investment and revenues and benefits. With key stakeholders contributing to relevant sections, actions and ambitions.

The draft plan has had on-going oversight from the Chair of the Food Plan Board and has been presented to the Board for comment on a number of occasions;

December 2018
June 2019
December 2019

The plan has been approved by the Board to move into the design phase with an anticipated launch date of March 2020.

8. Next Steps

To get approval for publication and launch of Leicester's Food Plan 2020-2025.

6. Financial, legal and other implications

6.1 Financial implications

There are no direct financial implications arising from this report.

Rohit Rughani, Principal Accountant, Ext. 37 4003

6.2 Legal implications

There is mention within the report of securing ERDF funding to deliver projects to support the food and drink sector and reducing waste. Any funding conditions will need to be complied with and cascaded down appropriately.
In respect of all other projects arising from the delivery of the Food Plan, legal advice should be sought as maybe required.

Mannah Begum, Principal Solicitor, Contracts and Commercial Team, Ext 1423

6.3 Climate Change and Carbon Reduction implications

The production, consumption and disposal of food is a significant source of carbon emissions from a variety of sources. Following the council's declaration of a climate emergency in 2019 addressing consumption related carbon emissions in the city is important to efforts to achieve carbon neutrality in Leicester.

Many of the actions within the food plan have had and will continue to have a positive impact on these emissions. This includes work to support and encourage food growing, reducing food waste and energy use in food production, and promoting and increasing provision of sustainable food options.

Aidan Davis, Sustainability Officer, Ext 37 2284

6.4 Equalities Implications

An ECA has not been completed

6.5 Other Implications

None

7. Background information and other papers:

None

Health and Wellbeing Scrutiny Commission

Work Programme 2019 – 2020

Meeting Date	Topic	Actions arising	Progress
4th Jul 19	1. Merlyn Vaz Health and Social Care Centre 2. Primary Care Networks 3. NHS Long Term Plan 4. Public Health Overview		
29th Aug 19	1. Primary Care Strategy 2. Community Health Services Redesign 3. Leicestershire Partnership NHS Trust		
10th Oct 19	1. LCC Update on Manifesto Commitments 2. UHL new developments following funding announcement 3. CCG report on LLR Urgent & Emergency Care Transformation Plan 2019/20 4. Hospital Close and Jarrom Street re: future plans and health workers accommodation		
5th Dec 19	1. 0-19 Children's Offer 2. All-age Mental Health Transformation Programme 3. Strategic Outline Case for the Rebuild of the Bradgate Unit 4. Public Health Contribution to Minimum Space Standards 5. Prescribing Update		

Appendix G

Meeting Date	Topic	Actions arising	Progress
30th Jan 20	1. Maternity Services 2. CCG Configuration Options 3. Public Health input to Local Plan 4. Leicester's Food Plan 5. Draft General Fund Revenue Budget 2020/21		
2nd Apr 20	1. Strategic Business Case for the Rebuild of the Bradgate Unit 2. Local Plan for Leicester – Proposals 3. Childhood Obesity 4. Manifesto Commitments relating to Health 5. Access to Leisure Services		

Forward Plan Items

Topic	Detail	Proposed Date
Young People's Council's Mental Heath Report	Discussions to be had with the YPC about the best way to bring this to scrutiny.	
NHS local plan for Leicester - proposals	To arrange members briefing tbc	January 2020
Council's Local Plan	Commission to be updated on progress re: key areas relating to health scrutiny	
JOINT SCRUTINY WORK	10th September 2019 – Joint Scrutiny of 'Better Care Fund (BCF) Annual Report' including work with NHS and Over 85s. Health scrutiny members invited to attend Adult Social Care Scrutiny Commission meeting.	