**CABINET**

TUESDAY, 15 NOVEMBER 2016

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP - Councillor Keith Glazier (Chair)
Councillors Nick Bennett, Bill Bentley, Chris Dowling, David Elkin (Vice Chair), Carl Maynard, Rupert Simmons and Sylvia Tidy

A G E N D A

1 Minutes of the meetings held on 11 and 18 October 2016 *(Pages 3 - 6)*

2 Apologies for absence

3 Disclosures of interests

Disclosures by all members present of personal interests in matters on the agenda, the nature of any interest and whether the member regards the interest as prejudicial under the terms of the Code of Conduct.

4 Urgent items

Notification of items which the Chair considers to be urgent and proposes to take at the appropriate part of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgent.

5 East Sussex Better Together Accountable Care Model *(Pages 7 - 34)*
Report by Director of Adult Social Care and Health

6 East Sussex Broadband: next steps *(Pages 35 - 36)*
Report by Director of Communities, Economy and Transport

7 Treasury Management Stewardship Report 2015/16 and mid year report 2016/17 *(Pages 37 - 56)*
Report by Chief Operating Officer

8 Any other items considered urgent by the Chair

9 To agree which items are to be reported to the County Council

PHILIP BAKER
Assistant Chief Executive
County Hall, St Anne's Crescent
LEWES BN7 1UE 7 November 2016

Contact Andy Cottell, 01273 481955,
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Agenda Item 1

**CABINET**

MINUTES of a meeting of the Cabinet held on 11 October 2016 at Council Chamber, County Hall, Lewes

PRESENT Councillors Keith Glazier (Chair)
Councillors Nick Bennett, Bill Bentley, Chris Dowling, David Elkin (Vice Chair), Carl Maynard, Rupert Simmons and Sylvia Tidy

Members spoke on the items indicated

| | |
|---|---|
| Councillor Blanch | – item 5 (minute 32) |
| Councillor Clark | – item 5 (minute 32) |
| Councillor Field | – item 5 (minute 32) |
| Councillor Forward | – item 6 (minute 33) |
| Councillor Keeley | – item 6 (minute 33) |
| Councillor O'Keeffe | – item 6 (minute 33) |
| Councillor Pursglove | – item 5 (minute 32) |
| Councillor Tutt | – items 5 and 6 (minutes 32 and 33) |
| Councillor Ungar | – item 5 (minute 32) |
| Councillor Webb | – item 5 (minutes 32) |

30 MINUTES OF THE MEETING HELD ON 20 SEPTEMBER 2016

30.1 The minutes of the meeting held on 20 September 2016 were agreed as a correct record

31 REPORTS

31.1 Copies of the reports referred to below are included in the minute book

32 RECONCILING POLICY, PERFORMANCE AND RESOURCES (RPPR)

32.1 The Cabinet considered a report by the Chief Executive together with additional information regarding the Government's multi year settlement.

32.2 It was RESOLVED to:

1) note the updated Medium Term Financial Plan (MTFP) including the changes to the forecast funding gap for 2017/19 and pressures (Appendix 1 of the report) which indicate a projected shortfall against previous plans of £4.9m for 2017/18 (£7.5m for 2018/19) and detail a number of additional financial risks;

2) note that plans are being developed for savings totalling £23.8m in 2017/18 (£17.3m previously included in the MTFP plus £6.5m additional) which remains within our agreed planning range of £70-90m;

3) ask Chief Officers to continue to work on savings plans based on the areas of search identified in Appendix 2 of the report;

4) note the Scrutiny Committees' initial comments on areas of search set out in Appendix 3 of the report; and

5) recommend that County Council express a view on whether to accept the Government's four year funding offer as the minimum funding level the Council could expect to receive and approve the efficiency plan set out in Appendix 4 of the report

Reason

32.3 To note the latest update of the Medium-Term Financial Plan and further information on the areas of search being progressed by officers as savings for 2017/18 and 2018/19.

## 33 PROPOSED CLOSURE OF PELLS CE PRIMARY SCHOOL, LEWES

33.1 The Cabinet considered a report by the Director of Children's Services

33.2 It was RESOLVED – to approve the closure of Pells CE Primary School, Lewes with effect from 31 August 2017

Reason

33.3 The representation period following publication of the statutory notices brought only one response to the proposal to close Pells CE Primary School, Lewes. The response does not bring forward any new information or evidence to suggest the recommendation for closure should be reconsidered. The Cabinet remains concerned about this very vulnerable school in terms of its long term sustainability on the grounds of its capacity to secure and maintain improvements in standards and in the context of declining popularity and financial viability. The Cabinet believes that children will achieve better outcomes if they attend other schools. For the reasons set out in the report and previous reports on this matter, the Cabinet approved the closure of Pells CE Primary School with effect from 31 August 2017.

## 34 ITEMS TO BE REPORTED TO THE COUNTY COUNCIL

34.1 The Cabinet agreed that item 5 be reported to the County Council.
*[Note: The item being reported to the County Council refers to minute number 32]*

**CABINET**

MINUTES of a meeting of the Cabinet held on 18 October 2016 at County Hall, Lewes

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PRESENT Councillors Keith Glazier (Chair)
Councillors Nick Bennett, Bill Bentley, Chris Dowling, David Elkin (Vice Chair), Carl Maynard, Rupert Simmons and Sylvia Tidy

Members spoke on the items indicated

| | |
|---|---|
| Councillor Tutt | – item 4 (minute 35) |
| Councillor Webb | – item 4 (minute 35) |

35 REPORTS

35.1 Copies of the reports referred to below are included in the minute book

36 RECONCILING POLICY, PERFORMANCE AND RESOURCES - GOVERNMENT'S MULTI YEAR SETTLEMENT OFFER

36.1 The Cabinet considered a report by the Chief Executive together with a Resolution of the County Council agreed at its meeting on 18 October 2016.

36.2 The following was moved by Councillor Elkin and seconded:

The Cabinet agrees to (1) accept the Government's multi year settlement offer and to approve the draft efficiency plan set out at Appendix 2 of the report; and (2) make representations to the Government reaffirming the County Council's concerns about the effect of existing cutbacks and future cutbacks in Local Government funding in view of the effect these are having on residents in East Sussex and in particular the most vulnerable

36.3 It was RESOLVED to:

(1) accept the Government's multi year settlement offer and to approve the draft efficiency plan set out at Appendix 2 of the report; and
(2) make representations to the Government reaffirming the County Council's concerns about the effect of existing cutbacks and future cutbacks in Local Government funding in view of the effect these are having on residents in East Sussex and in particular the most vulnerable

Reason

36.4 Having considered the Resolution of the County Council, the Cabinet agreed to accept the multi-year settlement and to approve the efficiency plan. The Cabinet also agreed that representations should be made to the Government regarding the significant financial pressures around Adult Social Care and Children's Services that need to be addressed and that the reductions in Government Funding cannot be achieved through efficiencies alone, but require difficult cuts in services.

37 ITEMS TO BE REPORTED TO THE COUNTY COUNCIL

37.1 The Cabinet agreed that no items should be reported to the County Council

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**Report to:** **Cabinet**

**Date of meeting:** **15 November 2016**

**By:** **Director of Adult Social Care and Health**

**Title:** **East Sussex Better Together Accountable Care Model**

**Purpose:** **To seek Cabinet endorsement of the work to develop a local Accountable Care Model since May 2016, setting out the case and plans to implement a transitional year in 2017/18 as part of the process to moving to a full Accountable Care Model in 2018/19**

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***Recommendations:*** **Cabinet is recommended to agree:**

1. **to continue to progress work to develop a local fully integrated Accountable Care Model across the East Sussex Better Together footprint, as set out in the report, involving a transitional year in 2017/18;**
2. **to receive a further report to Cabinet in July 2017 setting out a business case for the future organisational arrangements to implement a full Accountable Care Model in 2018/19;**
3. **to a transition year of Accountable Care through forming a commissioner provider alliance to manage collectively, with East Sussex Better Together Commissioning Partners, the health and social care system in 2017/2018;**
4. **to delegate authority to the Chief Executive to take any action considered appropriate to give effect to, or in consequence of the above recommendations, including (but not limited to), determining the services included, agreeing and entering into an agreement which will govern the alliance and pooled budget agreements with the East Sussex Better Together partners.**

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## 1 Background

1.1 Cabinet recognised three years ago that the scale of the financial challenge facing the NHS, Adult Social Care, Public Health and Children's Services across the county required a fundamentally different approach to our joint work with Health and other partners. In response the East Sussex Better Together (ESBT) programme was initiated in 2014 to deliver fully integrated health and social care services and a sustainable local health and social care economy for future generations. An ESBT Scrutiny Board has been set up to enable elected Members to consider these transformation plans. The key challenges faced by our local health and social care economy, and the case for change, are set out in Appendix 1 of this report.

1.2 In May 2016 Cabinet agreed the principles and characteristics of a local Accountable Care Model (ACM) and decided to look at developing a detailed business model as the next step. The key design principles and characteristics that were originally agreed are attached for reference in Appendix 2. The work during the 2017/18 transition year presented in this report will deliver this model for implementation in 2018/19.

1.3 The Council has been developing, as part of the Reconciling Policy, Performance and Resources (RPPR) process, an integrated Strategic Investment Plan for the commissioning of health and social care with the ESBT commissioning partners; Eastbourne Hailsham and Seaford Clinical Commissioning Group (EHS CCG) and Hastings and Rother Clinical Commissioning Group (HR CCG). Detailed work on the Strategic Investment Plan was agreed by Cabinet and includes setting up a pooled budget for all ESBT Health and Adult Social Care resources, Public Health provision and elements of Children's Services (at this stage disability services and mental health). The work is being undertaken with partners, including the local NHS providers, senior District and Borough Council housing officers and the Voluntary and Community Sector. The full

proposal will be considered as part of the Council's RPPR process in January 2017. This approach is critical to ensuring we make coherent decisions for the future, making the best use of the collective resources available and to testing aspects of a future ACM during 2017/18.

## 2 Local engagement to develop the Accountable Care Model

2.1 Research and discussions have taken place to shape the development plans for an ACM, and continue to inform our work and the arrangements for the transition year of Accountable Care in 2017/18. This has included:

- A seminar and workshops on the impact of future models on health and social care in East Sussex
- Multi-agency Steering Group discussions between statutory partners
- ESBT Strategic Investment Plan discussions, as part of RPPR, focussing on the activity and capacity changes needed to effect a move to community based prevention and proactive care
- Partnership engagement events, such as Shaping Health and Care.

2.2 County Council Member input has been sought in a range of ways including through the ESBT Scrutiny Board on 4th October, Whole Council Forum on 11th October, and there has also been a presentation and discussions at a Health Overview and Scrutiny Committee (HOSC) seminar on 18th October.

2.3 Work is also taking place with GPs and other primary, community and acute care professionals to agree a shared understanding and high level plan for the system transformation required, based on the five year financial assumptions detailed in our integrated Strategic Investment Plan.

## 3 The East Sussex Accountable Care Model

3.1 There is a clear consensus on the need to build a whole system model of Accountable Care that incorporates primary prevention, primary and community care, social care, mental health, and acute and specialist care. In line with this East Sussex Healthcare NHS Trust and Sussex Partnership NHS Foundation Trust formally joined the ESBT Programme Board in September 2016, enabling a full alliance between commissioners and providers. A summary of the main local considerations for moving to Accountable Care is provided in Appendix 3.

3.2 The new model will involve changing the local system from one of separate organisations to managing the way we pay for and deliver health and social care on an integrated, system-wide basis, based on delivering the outcomes that matter to local people rather than, as currently, based on activity.

3.3 There are different options for establishing an ACM, including a virtual partnership arrangement, partial integration of specified elements of service and full integration. More details about these are provided in Appendix 3. The proposed changes will not change the roles of the County Council and the Clinical Commissioning Groups (CCGs). We will remain the accountable strategic commissioning bodies for health and social care services, exercised through democratic accountability to the Council. The County Council and CCGs will continue to set outcomes and oversee their delivery, as well as ensuring service user voice and choice are maintained.

3.4 The ACM will mean evolving the working arrangements of commissioners and providers and other partners. This will be important to ensure the new integrated delivery vehicle has the freedom to define the detail of the service model and how providers would work together to deliver this, as well as the operating model and partnership arrangements. The freedom would however be dependent on delivery of the outcomes specified by the Council and CCGs.

3.5 In order to encourage more coordinated care between health and care providers, an ACM will have to bring together a range of services that currently sit across a number of different organisations. Local discussions have taken account of the need to develop and agree an organisational form, and also decide how the prospective ACM will relate to GP Practices, other

staff groups, and providers in the independent and voluntary sector, as well as the communities where they provide services. The 2017/18 transition year will allow us the opportunity to test and evaluate the options available to us on organisational form, in addition to undertaking more detailed work on governance and support arrangements. The suggested options to explore include:

- Using NHS legislation to establish a new NHS Trust Board, to include social care and Public Health provision
- Partners on the ESBT Programme Board forming a limited company or limited liability partnership (LLP) e.g. forming a corporate joint venture vehicle to deliver the single contract for the whole population
- Other organisational models such as Community Interest Companies and Mutual Companies.

**4 2017/18 Transition Year**

4.1 It is considered that the most effective way to develop the evidence base further in East Sussex is to have a transition year of Accountable Care through forming a commissioner provider alliance. This would be made explicit through an agreement that sets out the operating arrangements between the ESBT Programme partners and allows us to test and develop:

- The optimum population base for capitation and the devolution of budgets to localities
- The phasing of the introduction of a capitation payment mechanism
- The methodologies for organisational and individual incentives to deliver the outcomes
- What the funding and contracting model should be with primary care, voluntary and community organisations and the independent care sector.

4.2 Local determination on the preferred organisational form would also form a key part of the deliberations in early 2017/18, in order that recommendations can be made to Cabinet in July 2017. The ESBT Scrutiny Board will have an ongoing role in all of these considerations.

4.3 During the transition year all organisational accountabilities remain unchanged, including employer and employee status, with partners joining up funding and activity through the delivery of the Strategic Investment Plan, creating pooled and aligned budgets and an agreement to govern providers and the commissioner and provider alliance. The transition year will also determine how the Council will fulfil its ongoing statutory responsibilities, financial control, and governance requirements. The immediate work on the Strategic Investment Plan and pooled budget that will be implemented in 2017/18 will be addressed through RPPR, including the necessary assurance process for entering into the new budget arrangements. This will require the commissioning of specialist financial and legal advice to mitigate risks arising from these developments.

4.4 The Council will continue to set priorities for the local population and make investment decisions, as well as scrutinising the delivery of health and care services. The agreement will describe how the governance of the health and social care economy will take place through single system leadership, with accountability to the Council, CCG Governing Bodies and Trust Boards, and overarching local whole system leadership and decision-making through the following mechanisms:

- An integrated single budget covering collective health and social care investment
- An integrated Strategic Investment Plan to prioritise investment, to be considered through the RPPR process
- A unified outcomes framework and a single performance management process.

## 5 Risk Management

5.1 It is recognised that, as the Council enters into the new ACM arrangements, it will continue to need to meet its statutory responsibilities, financial control and governance requirements. The partnership will bind organisations together and in these circumstances there are a range of additional risks due to a proposed shared accountability for health and social care. For example, there are significant current and historic financial challenges for NHS providers and the new arrangements will need to ensure that the Council is not disadvantaged as a consequence.

5.2 A major change process of this kind and scale inevitably presents risks. The most significant ones are as follows, together with mitigating actions:

- Loss of democratic accountability and control: in the ACM there is no change to the key roles of the Council, which are to determine expected outcomes, set investment levels, and to scrutinise performance. These roles will be built into the formal agreements underpinning the ACM, including the agreement proposed for the transitional year;
- Failure to discharge statutory responsibilities: the Council will, through the ACM formal agreements, determine expected outcomes, and these will include the discharge of relevant statutory responsibilities. The ACM will require flexibility to determine how best to discharge responsibilities, but the outcomes will be pre-determined by the Council alongside other partners;
- Loss of financial control and/or unintended financial consequences: the pooling agreement for the transitional year and subsequent financial arrangements will need to specify the financial management responsibilities of all partners and the monitoring mechanisms that ensure that the actual expenditure incurred is in line with the SIP (or that prompt corrective action can be taken). Expert advice will be taken to guard against unintended financial consequences such as tax liabilities;
- Limited management capacity: the development of the ACM is a major management challenge for all of the partners involved. It requires focus and substantial officer time to work through the practical arrangements. All partners have recognised this importance and have prioritised the workload. In addition specialist advice and support is being procured to provide additional capacity for the next nine months or so.

5.3 In considering risk management, it is important to recognise that the Council is already exposed to significant risk, as its social care responsibilities are inextricably linked to the wider healthcare economy which is currently managed by various NHS bodies. As already described, the current way of delivering health and social care in the ESBT area is clinically and financially unsustainable, and the Council is already therefore exposed to risks. Radical transformation of how care is organised and delivered is necessary if there are not to be significant cuts to the level of support we provide to residents.

## 6. Conclusion

6.1 As outlined through the Council's RPPR process it is predicted if nothing changes between current and projected demand and available health and social care budgets the anticipated funding gap will be over £200million by 2020/21. We have made strong progress already through our ESBT programme to integrate services and redesign care pathways in line with best practice, however, we also need to transform the way services are organised and provided to bridge the financial gap, which requires full integration to achieve a health and social care economy that is sustainable in the long-term.

6.2 Taking account of learning from elsewhere, and after local deliberation, moving to a fully integrated model of Accountable Care offers the best opportunity to achieve the full benefits of an integrated system. It is equally the case that formal integration on this scale would represent significant risks to all the organisations involved in our health and care system. A transitional year of Accountable Care, under an alliance arrangement, would allow for the collaborative learning and evaluation to take place between the ESBT programme partners and other

stakeholders, to further develop the evidence base locally for increased levels of formal integration and designing the appropriate contractual and funding arrangements to suit local preferences. Over the medium term there will also be a need to have dialogue with national Government in order to achieve our aims and objectives.

6.3 Accountable Care models based on a whole population capitated budget and longer outcomes based contracts are an opportunity to transform commissioning and service provision. Significant amounts of engagement have taken place with local decision-makers and stakeholders to both share the rationale for moving to an ACM and the potential options. Consensus has been reached that a transitional year is the most effective way to further develop the evidence base, allowing collaborative learning to take place across the constituent parts of the local health and care system in keeping with the local circumstances of strong partnership working.

6.4 It is recommended that authority is delegated to the Chief Executive to take the necessary actions to continue work towards developing a local ACM and to implement a commissioner provider alliance for a 17/18. This will include agreeing the services included, and entering into the necessary contractual arrangements, such as those related to pooled and aligned budgets, and an agreement which will govern the alliance.

**KEITH HINKLEY**
**Director of Adult Social Care and Health**

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LOCAL MEMBERS

County Council Members whose electoral divisions are in the EHS CCG and HR CCG areas

BACKGROUND DOCUMENTS

None

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## Appendix 1 – The Case for Change in East Sussex (Accountable Care)

### 1. Summary

This paper outlines why the move to a new model of Accountable Care is needed in East Sussex building on our initial research in August 2014[1]. Over the coming years we will be required to meet the rising demand for health and social care services within an increasingly restricted financial envelope. At the moment we are struggling to meet this new challenge, so we know that something has to change.

### 1.2 Key points

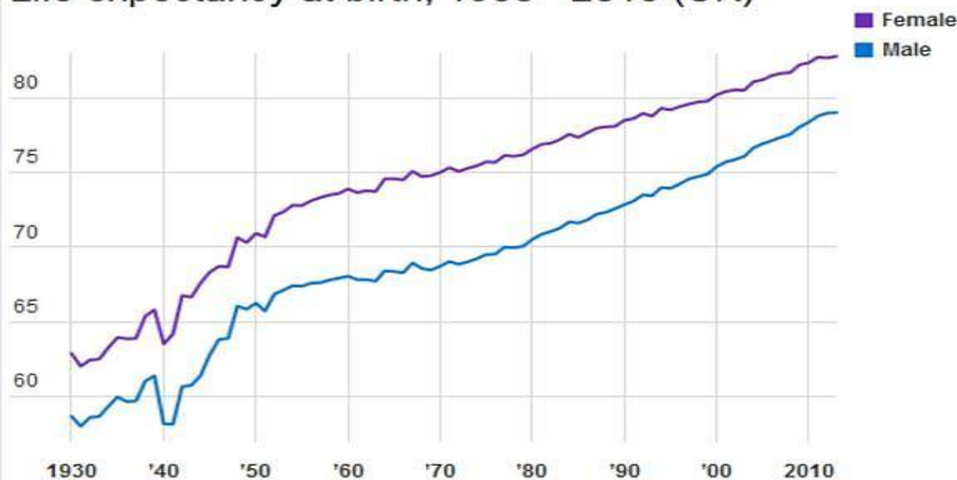
- Across health and social care in England, there is a requirement to provide services that centre on the needs of patients and service users to meet the rising future demand within our financial resources.
- In East Sussex the population is projected to rise steadily by 0.4% each year for the next five years but there will be disproportionate growth in our over-65 population, a group set to grow by 9% between 2015 and 2020.
- While life expectancy has increased and is higher than the national average, disability free life expectancy has not increased in line with this and there are significant health and social inequalities across the county.
- Leaving the system 'as is' is not an option. In financial terms we face an anticipated funding gap of over £200 million by 2020

It is clear that these circumstances require a new model of care to be designed that is fit for purpose in the 21st century to address the challenges we face in East Sussex

### 2. Rising demand and changing needs

2.1 The rapid rise in demand for health and social care is a familiar story for many health and care systems across the world. Populations are growing and people are living longer. There is an increase in chronic conditions, with more and more of us requiring long-term support. As patients and clients of services we also each expect to receive high quality and consistent care, resulting in the best possible outcomes for ourselves and for others.

Figure 1



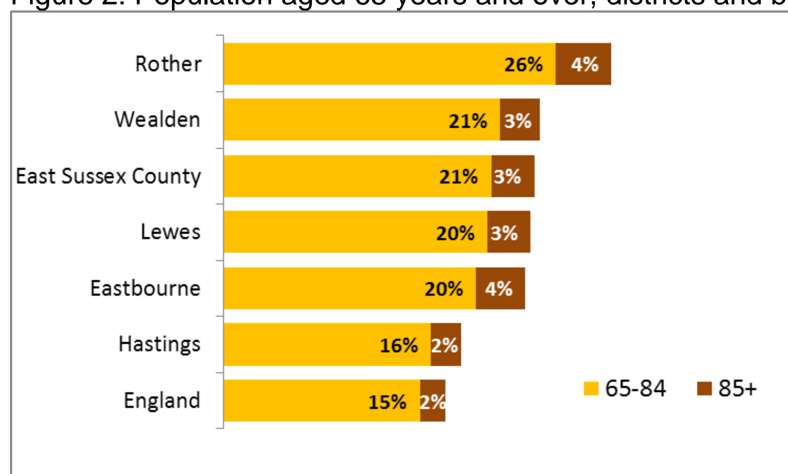

Source Human Mortality Database

[1] 'Moving to Accountable care in East Sussex' (East Sussex Better Together, 2015)

2.2 The NHS and social care services in England are facing unprecedented challenges due to demographic shifts, ever advancing technology and an extended period of financial austerity[2], coupled with an ever-growing expectation as to what services they should deliver. There is consensus nationally that change is required in order to meet these demands. As the recent NHS Five Year Forward View describes there is also growing consensus about the nature of the change required, particularly around the importance of overcoming the current divisions between health and social care, primary and secondary care and mental health and physical health. The Five Year Forward View outlines a number of organisational forms – including multi-specialty community providers (MCPs) and primary and acute care systems (PACS) – through which such services could be delivered on a more integrated basis. These organisational forms share characteristics with Accountable Care models and systems that are emerging elsewhere in the world.

2.3 In East Sussex we are at the forefront of experiencing this pattern of rising demand and pressure on diminishing resources. The East Sussex Joint Strategic Needs Assessment (JSNA) identifies that there is a larger older aged population in East Sussex compared to nationally (figures 1 and 2). More than three out of four lower super output areas (LSOAs) in East Sussex have a greater percent of persons aged 65 years and over compared to the England figure. Whilst the East Sussex population is expected to increase by 0.4% each year the number of older people is expected to increase by 9% between 2015 and 2020. Life expectancy in East Sussex is higher than the national average, but disability free life expectancy at age 65 has not increased in line with this (figure 3), creating unprecedented demand on social care services. There is projected to be a 15% increase in persons with a disability between 2014 and 2027 (figure 4) with an 18% increase in persons with a higher severity disability. There are also inequalities in years of life lost for causes considered amenable to healthcare. Hastings & Rother CCG have rates 1.5 times higher than High Weald Lewes Havens CCG (figure 5).

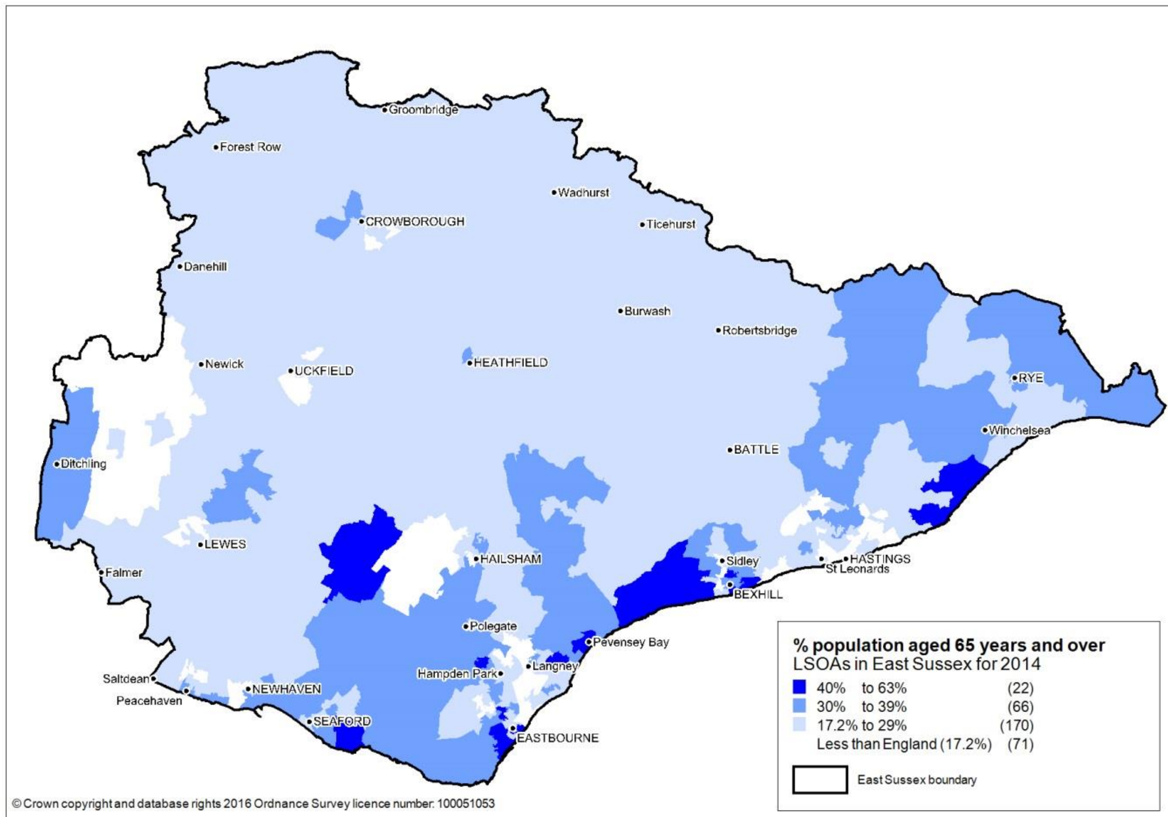
Figure 2: Population aged 65 years and over, districts and boroughs in East Sussex




Source: Mid-2014 resident population estimates, ONS June 2015

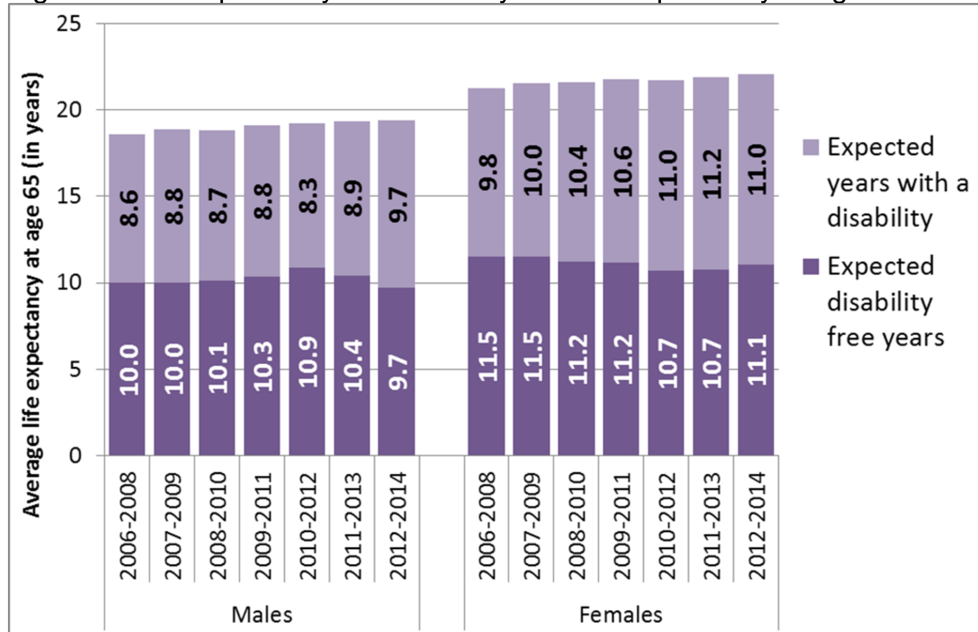
[2] NHS Five Year Forward View (2014)

Figure 3: Population aged 65 years and over by LSOA in East Sussex, 2014




Source: Mid-2014 resident population estimates, ONS November 2015.

Figure 3: Life expectancy and disability free life expectancy at age 65 in East Sussex




Source: ONS March 2016

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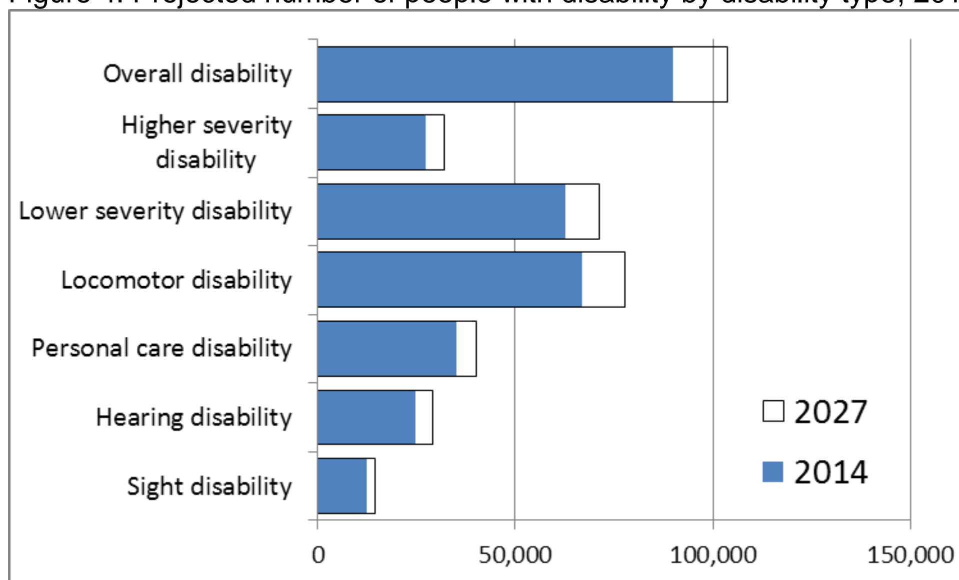
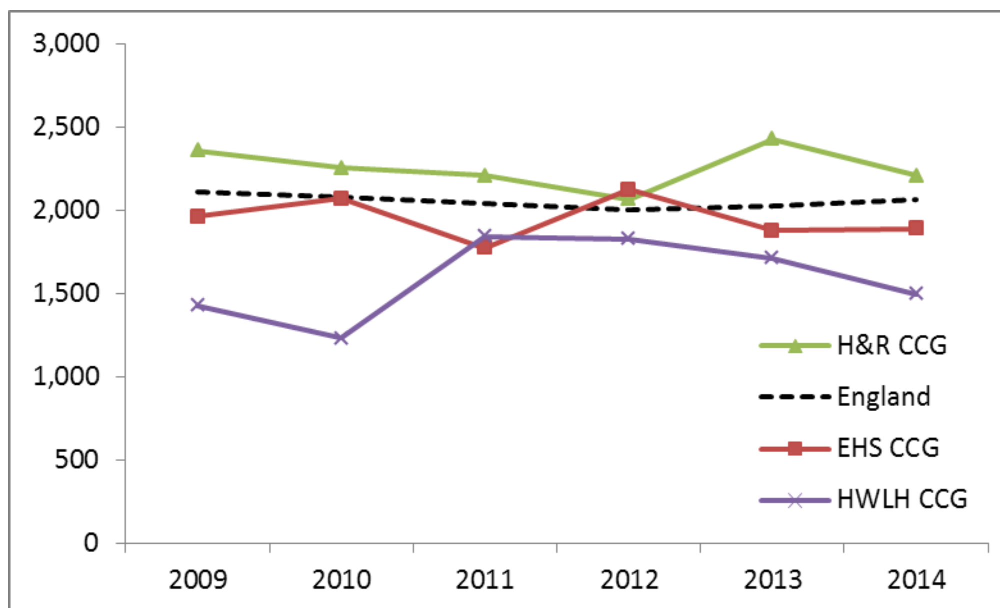
Figure 4: Projected number of people with disability by disability type, 2014-2027




Source: ESCC projections, July 2013

Figure 5: Directly age and sex standardised potential years of life lost (PYLL) from causes considered amenable to healthcare per 100,000 registered patients, CCGs in East Sussex, 2009 to 2014




Note: H&R CCG = Hastings & Rother CCG, EHS=Eastbourne, Hailsham & Seaford CCG, HWLH = High Weald lewes Havens CCG

Source: CCG Outcome Indicator Set, HSCIC, Sept 2015

2.4 With increasing pressure across all services and an anticipated funding gap of over £200 million by 2020[3] if status quo is maintained, as a response we launched East Sussex Better Together (ESBT) in August 2014 - our bold and transformative approach to developing a fully integrated and sustainable health and social care economy in East

[3] Draft ESBT 5 Year Strategic Investment Plan (updated 2016/17 modelling)

Sussex. We aim to achieve this through a 150 week whole system programme designed to invest to the best effect the combined £846 million[4] we spend on health and social care services on behalf of our population.

2.5 Our initial research[5] shows us that, Accountable Care models, whereby a 'whole person' focus crosses traditional health and social care silos, have emerged internationally as the most likely solution to address the 'Triple Aims' of healthcare systems of the future, where integrated approaches should be applied "to simultaneously improve care, improve population health, and reduce costs per capita"[6]

2.6 Through offering a different way of organising the way we arrange, pay for and deliver care, Accountable Care models offer a potential solution to the challenges associated with achieving a high value and integrated health and social care system. This helps to deal with some of the current the perverse incentives that are present in how health and social care is currently commissioned in England, enabling us to:

- Tackle poor system alignment and reducing fragmentation across the system or care pathway by incentivising collaboration between providers to coordinate care, in order to deliver person centred outcomes and eliminating unnecessary treatment or duplication.
- Incentivise community-based preventative service delivery (sometimes called the lowest level of effective care) and population wellness, therefore achieving better outcomes for patients as well as greater cost efficiency.
- Give people a stronger voice in their own care and determining what matters through the process of actively setting outcomes that matter to the local population
- Allow for a better fusion of planning with frontline service delivery to enable a more flexible service response to meet needs more effectively and efficiently, as well as stream lining and simplifying the overall commissioning and contract management function.

2.6 Accountable Care, with the use of whole population capitated budget and payment mechanism, coupled with longer term outcomes based contracts as a way of arranging and paying for health and social care services, is increasingly seen as the model required to drive the changes needed to address these multiple and interdependent issues to make our health and social care services more sustainable for future generations.

## 3 Demographic profile in East Sussex

3.1 There is a rapidly changing demographic picture in East Sussex. Between 2014 and 2027, the population is predicted to grow by 6% with the over 65 group alone growing by 27%. Figure 6 illustrates the disproportionate growth in over 65s between 1981 and 2027, compared to other age groups in our population.

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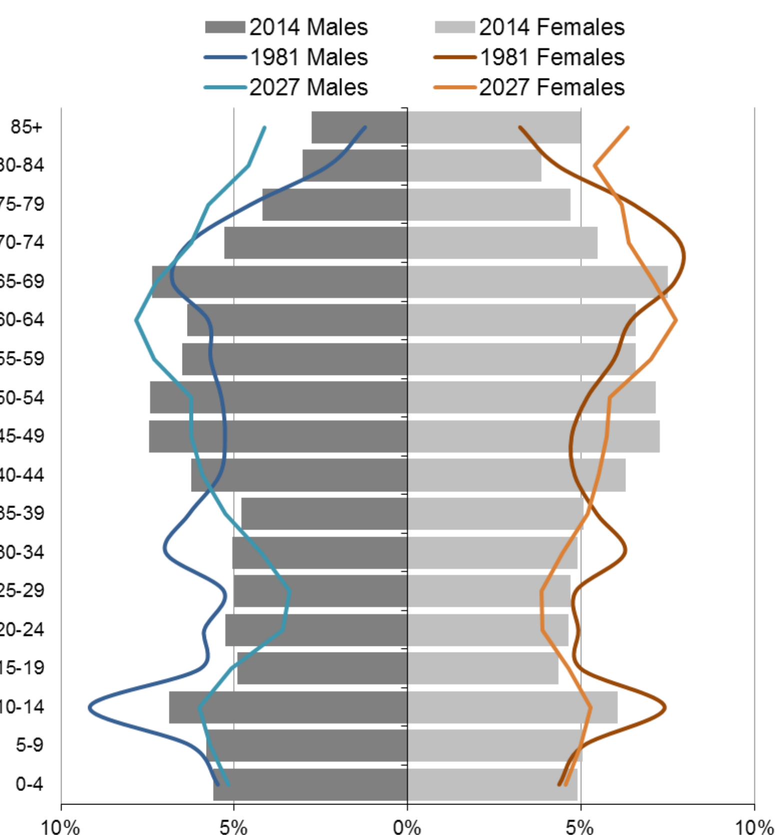
[4] 2016/17 figures

[5] 'Moving to Accountable care in East Sussex' (East Sussex Better Together, 2015)

[6] Institute for Healthcare Improvement – Triple Aim for Populations

Figure 6: Population structure in East Sussex, 1981, 2014 and 2027 projections




Source: ONS population estimates 1981 & 2014, ESCC projections for 2027

Figure 6 illustrates the disproportionate growth in over 65s between 1981 and 2027.

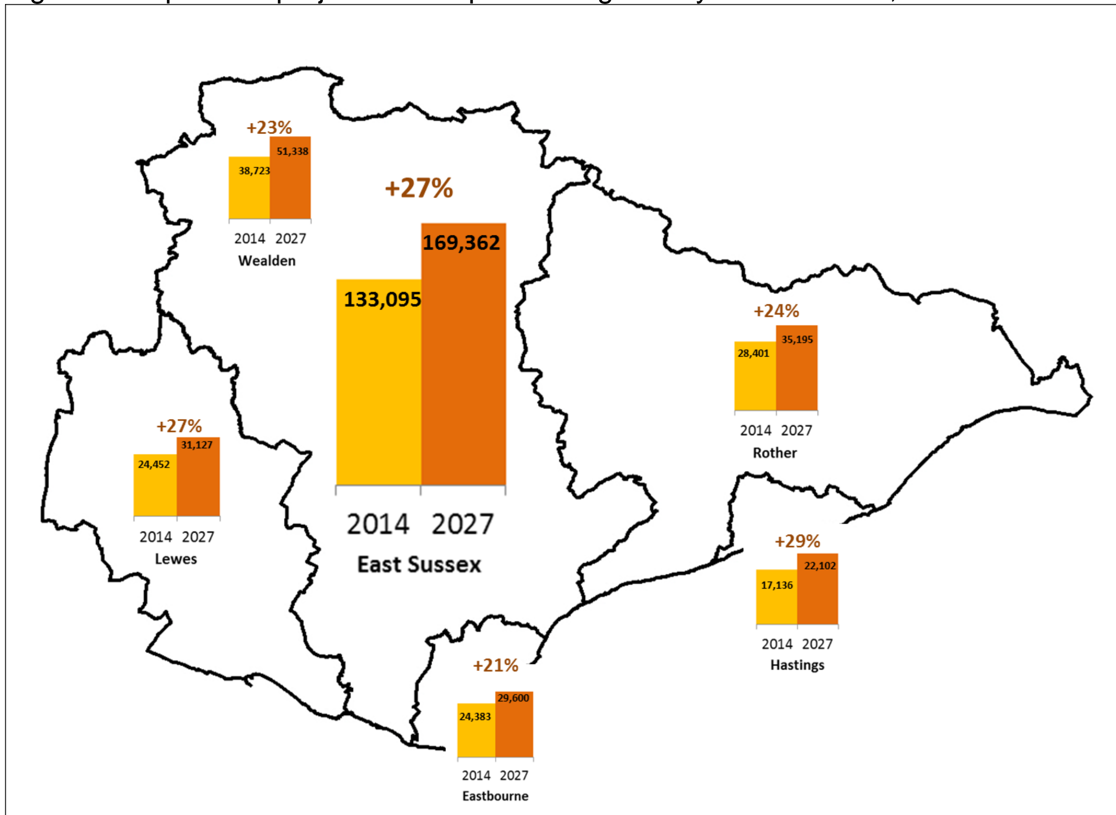
3.2 There are demographic shifts across all age brackets in East Sussex, as table 1 shows. However, across our geography, figures 7 and 8 show just how significant the increase in the proportion of the over 65s and 85s is.

Table 1: East Sussex population projections by age group, 2014-2027

| Age bands | 2014 | 2015 | 2019 | 2023 | 2027 | % change over the period |
|---|---|---|---|---|---|---|
| People aged 0-9 | 57,536 | 58,004 | 58,874 | 58,525 | 57,942 | 1% |
| People aged 10-19 | 59,793 | 57,977 | 55,539 | 58,459 | 59,754 | 0% |
| People aged 20-34 | 79,589 | 78,132 | 74,934 | 69,776 | 66,869 | -16% |
| People aged 35-44 | 60,498 | 59,908 | 59,079 | 61,779 | 62,275 | 3% |
| People aged 45-54 | 79,086 | 79,278 | 77,574 | 70,788 | 68,327 | -14% |
| People aged 55-64 | 70,169 | 70,612 | 77,024 | 83,416 | 85,004 | 21% |
| People aged 65-69 | 40,140 | 40,476 | 35,861 | 37,055 | 40,830 | 2% |
| People aged 70-74 | 29,120 | 30,542 | 38,988 | 35,674 | 35,936 | 23% |
| People aged 75-79 | 24,052 | 24,155 | 26,688 | 35,016 | 34,022 | 41% |
| People aged 80-84 | 18,653 | 18,804 | 20,276 | 21,723 | 28,524 | 53% |
| People aged 85-89 | 12,668 | 12,867 | 13,485 | 14,818 | 16,008 | 26% |
| People aged 90 ad over | 8,462 | 8,680 | 10,131 | 11,884 | 14,042 | 66% |
| **Total** | **539,766** | **539,435** | **548,453** | **558,913** | **569,533** | **6%** |

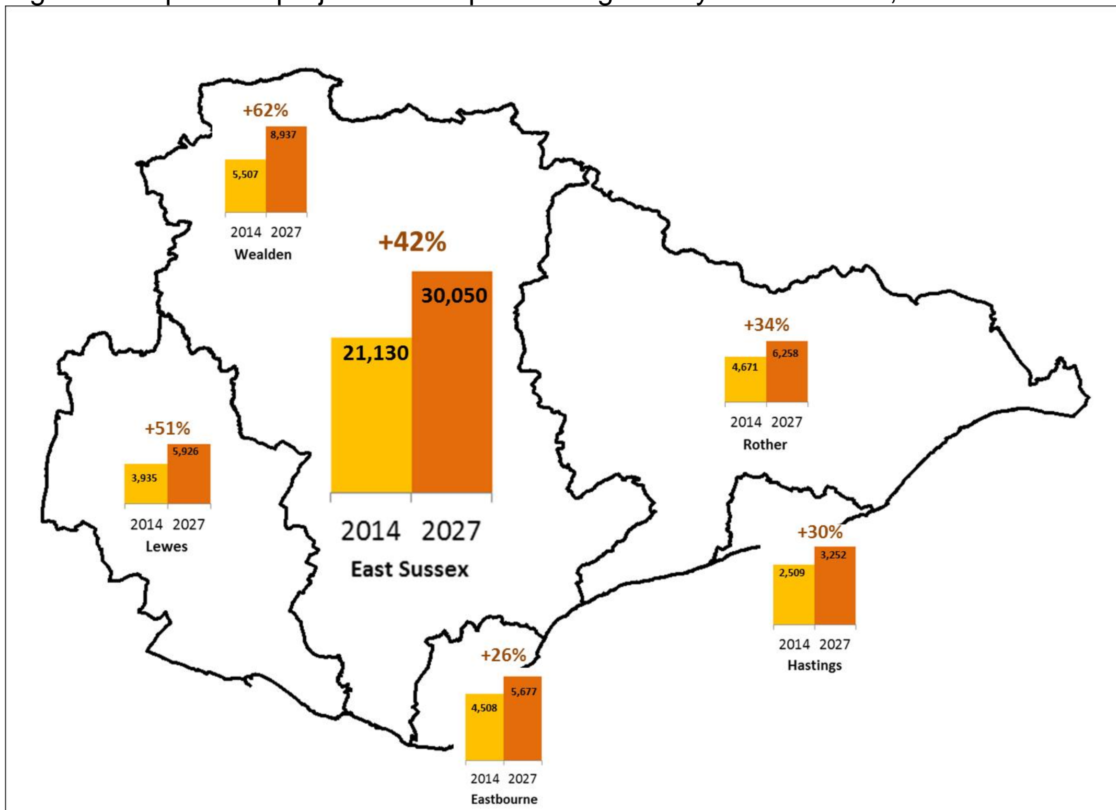
Source: ESCC projections (dwelling led), January 2016

Figure 7: Population projections for persons aged 65 years and over, 2014-2027




Source: ESCC projections (dwelling led), January 2016

Figure 8: Population projections for persons aged 85 years and over, 2014-2027




Source: ESCC projections (dwelling led), January 2016

3.3 However, although people are living longer, healthy life expectancy is not increasing in line with this. The numbers of over 65s with dementia, diabetes and longstanding health conditions caused by stroke in our population is expected to increase. In addition there is evidence that health inequalities are widening[7]. In short more people are living longer with complex needs, requiring extended help and support in non-hospital-based settings in an environment where our funding is constrained.

## 4. Consequences of 'doing nothing'

4.1 Like many parts of the country, demand for health and social care services is growing. If the use of services grew in line with overall changes in the population the system would be unlikely to cope through organic growth alone. This doesn't take into account the fact that services are disproportionately used by older people, our fastest growing population segment, and therefore this has an intensifying effect on the pressure on services caused by natural overall population growth.

4.2 Work by PricewaterhouseCoopers, completed in 2015, to assess the financial implications of a 'do nothing' option concluded that, if left unaddressed, there would be an East Sussex-wide funding gap of approximately £200million by 2018. We have updated this analysis to take into account the current ESBT footprint and project that by 2020 there will be an anticipated funding gap of over £200 million. This includes the costs of activity taking place within the ESBT area or financed by the CCGs outside of ESBT, as well as social care spend.

4.3 The ESBT integrated 5 Year Strategic Investment Plan[8] provides further detail on the areas of activity such as unplanned care (also known as non-elective admissions or NEL) and increased primary and social care, GP prescribing costs, Continuing Health Care and Funded Nursing Care costs, that are currently putting pressure on services leading to the £200million gap. This is currently being presented through the Council and CCGs' budget-setting processes.

## 5 Summary and conclusion

5.1 The significant challenges brought about by the demographic profile of our population in East Sussex and the financial context we are working in (set out in the 5 Year ESBT Strategic Investment Plan), show that in East Sussex shares many characteristics with health and care systems around the country and globally. Over the coming years we will be required to meet the rising demand for health and social care services within an increasingly restricted financial envelope. We can only meet this new challenge by leading and delivering the transformation of health and social care as envisioned by East Sussex Better Together.

5.2 The challenges that shape the context that we are working in and the need for a new model of care include:

- Increased demand and also changes in the nature of demand caused by the changing age structure in our population. In East Sussex we have high numbers of people over 75 years and over 85 years such that, although our population is projected to rise steadily by 0.4% each year for the next five years, there will be disproportionate growth in our over-65 population a group set to grow by 9% between 2015 and 2020. In ten years' time it is estimated the population aged over 65 in East Sussex will increase to around 160,000[9].

[7] East Sussex Joint Strategic Needs Assessment http://www.eastsussexjsna.org.uk/
[8] Draft ESBT 5 Year Strategic Investment Plan (updated 2016/17 modelling)
[9] East Sussex in Figures

- While life expectancy has increased and is higher than the national average, disability free life expectancy has not increased in line with this and there are significant health and social inequalities experienced across the county. In 2012-14 the gap in life expectancy between the most and least deprived Wards in East Sussex was 13.6 years. Circulatory diseases and cancer are the main contributors to the life expectancy gap between the most and the least deprived areas and to people dying prematurely.

- There is an increasing prevalence of long-term conditions (LTC) and in particular a significant older population living with multiple LTCs. In 2011, 20% of people in East Sussex had a long-term health problem or disability and by 2024 this is expected to increase to around 22% of the total population. National figures show that people with Long Term Conditions, such as Diabetes, account for 50% of all GP appointments, 64% of outpatient appointments and 70% of all inpatient bed days and consume 70% of the total health and care spend.
- Increased demand, particularly for urgent care, caused by changes in expectations and patient behaviour.

- Demand is outstripping increased NHS investment and local government budget reductions. Our local acute and community provider, East Sussex Healthcare NHS Trust (ESHT) is carrying a historical deficit of approximately £50 million. East Sussex County Council needs to make savings of between £70 million and £90 million by March 2019 due to funding from Government shrinking. This is on top of £78 million already saved since 2010 and represents around 20% of the Council's total budget. Although in the past the Council has sought to protect Children's and Adult Services this is no longer possible and it is anticipated that £45.1 million will need to be saved from Adults' and Children's Services by March 2019.

- Within East Sussex Better Together we have three organisations that are responsible for commissioning health and care services. Moving to a place-based approach will enable us to fully share the commitment to integration, as well as the leadership, accountability and systems needed to mobilise a collaborative system-wide approach.

- East Sussex Better Together (ESBT) is one of four place-based localities in the Sussex and East Surrey Sustainability and Transformation Plan (STP) footprint. Together with our neighbouring CCGs, Local Authorities and Provider Trusts, we are working to develop an STP which will drive transformation of the patient experience and outcomes, over the longer term, to deliver sustainability. Local place-based approaches, such as ESBT, that deliver integration, prevention, proactive care, self care and self management, as well as wider population health and wellbeing, will form the bedrock of delivering the STP, as these approaches underpin the sustainability of local acute hospital services.

- Disjointed systems of care are failing to deliver the best possible outcomes and return on public investment. National and international evidence is clear that investment in integrated primary, community and social care provides the best outcomes and reduces demand for more costly hospital care and other bed-based care. The current situation however incentivises the use of hospital care through activity and volume based payments.

- The provision, quality and sustainability of hospitals is a high profile issue, and our local Challenged Health Economy analysis (2014) showed that hospital reconfiguration in and of itself won't solve this. As the Wanless Reports[10,11] originally

[10] Securing Our Future Health: Taking a Long-Term View (Derek Wanless, 2002)
[11] Securing Good health for the Whole Population (Derek Wanless, 2004)

stated, simply investing in acute hospital care without addressing the underlying problem of the sustainability of the whole system is not the answer. This includes putting population health at the heart of the care model, as well as ensuring acute, primary, community, mental health and social care investment is in balance so that we can provide high quality care and specialist services when people need them

- Difficulty in recruiting and retaining a skilled workforce across primary, acute, community and social care that can meet the new demands being made is a challenge nationally. In East Sussex we face specific challenges in the east of the county with the sustainability of some General Practice partnerships, and there is ongoing difficulty with recruiting community nurses and care workers in the independent care sector.

5.4 It is predicted if nothing changes between current and projected demand and available health and social care budgets the funding gap will be over £200milion by 2020/21. We have made strong progress already under our East Sussex Better Together (ESBT) programme to integrate services and redesign pathways in line with best practice, however we also need to transform the way services are organised and provided at a deeper level to bridge the financial gap - this means integrating more fundamentally as commissioners and providers to achieve a health and social care economy that is sustainable in the long-term.

5.5 Put simply, doing nothing is not an option. At the time of writing we are now in week 117 of our 150 week ESBT programme with progress made in the first year on key areas of service and pathway redesign to support integrated delivery, such as integrated local health and social care teams, streamlined points of access and urgent care. The programme also aligns key workstreams such as workforce, financial planning, Information Management and Technology (IM&T) and data sharing to enable the necessary changes to back office systems to be made to support the overall transformation to person centred integrated care. The rationale behind ESBT – which is fully recognised and supported by all our inspectors and regulators as critical to sustainability in East Sussex in the long-term - is documented in previous reports and more detail can be found at https://news.eastsussex.gov.uk/east-sussex-better-together.

5.6 The next phase of our programme therefore needs to focus on transforming commissioning and delivery. To ensure that resources are directed where they are of best use and to guarantee sustainability we will need to be ready to begin to implement the transitional plan for testing new approaches to arranging and delivering local health and social care services in shadow form by April 2017.

**Appendix 2 – Key principles and characteristics of an ESBT Accountable Care Model**

| | Key principles and characteristics of a local Accountable Care model |
|---|---|
| 1 | Our evidence-driven, place-based models will firmly embed the first principle for us all of a prevention-led approach across the Sussex and East Surrey STP. The model will have a strong emphasis on population health promotion, prevention, early intervention and self-care and self-management to reduce demand for services and allow care to be delivered increasingly out of hospital and at the lowest level of effective care. |
| 2 | All health and social care services should be in scope – primary, local acute District General Hospital (DGH), community, mental health, social care and public health services for children and adults. Those that are ruled out will be by exception. |
| 3 | 'Whole person' care needs to be supported by a whole population approach rather than segmenting or subdividing the population by conditions or age, and thus although delivery will normally be based around localities with populations of circa 50,000, accessing health and care should support patient choice and be consistently simple for patients regardless of where they access it. |
| 4 | The model will have a positive impact and deliver outcomes that are important to local people – both health outcomes and experiential outcomes. This includes involving local people in designing, commissioning and delivering outcomes. |
| 5 | The outcomes based contract and capitated budget will be sufficiently large to achieve the economies of scale needed to tackle each Place's total funding gap, and establish an ongoing in-year budget balance. |
| 6 | There will be a focus on reducing the costs of commissioning and transacting the business, as well as avoiding the pathway fragmentation that undermines integration and adds in transaction costs through operating parallel models. We will seek to achieve our aims through collaboration in the way that we procure new models. |
| 7 | There will be a strong culture of whole system working on the ground that actively empowers staff to be able to 'do the right thing', putting patients' and clients' needs first within a single health and social are system covering primary, community, local DGH, mental health, social care, public health services, and independent and voluntary services where appropriate. |
| 8 | Our model will align incentives in order to inspire and attract health and social care professionals and offer maximum levels of clinical and staff engagement and leadership, embed system-wide organisational development. |
| 9 | The organisational forms in each Place will require collective leadership and have governance and operational mechanisms that enable learning and development to take place in stages to share and manage risks between commissioners and providers. This will lead to delivery of full Accountable Care models, as per the ambitions of the Five Year Forward View (FYFV), i.e. the fullest possible levels of integration and maximum ability to achieve the long term vision and benefit of a sustainable and affordable health and social care system. |

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**Appendix 3 – Developing the Evidence Base for a Local Accountable Care Model**

**1. Summary**

1.1 This paper summarises and explains why the features of Accountable Care make the provision of quality health and care services affordable and sustainable in the East Sussex Better Together (ESBT) area building on our initial research in August 2014[1], and the further research and local discussions that have taken place since its publication

**1.2 Key points**

Our ESBT whole system programme has provided a firm foundation for designing and implementing whole system care pathways and the integration of health and social care in commissioning and delivery. As good as this service transformation is however, it needs to be delivered by affordable and sustainable providers in East Sussex, in primary, community, mental health and social care as well as hospital-based acute secondary care, as all areas locally are challenged. In order to fully deliver our ESBT vision and realise the benefits of integration and service transformation we need to also transform the architecture of our local system in two ways:

- Integrating strategic planning and commissioning
- Integrating service delivery – establishing a sustainable provider landscape.

**2. Integrated strategic planning and commissioning**

2.1 To ensure that we make fully integrated decisions about the collective use of the available £846 million health and social care funding to deliver the best possible outcomes and return on in investment, there will be a single strategic planning and commissioning process across the Council and the CCGs for investment in health and social care services in 2017/18. This is a significant step forward in planning collectively for our shared resources and reflects the need to make unified decisions about priorities to get best value. It will also be critical to making coherent decisions for the future and to testing aspects of an Accountable Care model in 2017/18. The following key elements will support integrated strategic planning and commissioning:

- An integrated single budget covering collective health and social care investment, including a single control total
- An integrated Strategic Plan to prioritise investment
- A unified Outcomes framework and a single performance management process
- A virtual devolution of budgets to localities

**3. Integrated service delivery – establishing a sustainable provider landscape**

3.1 The key focus for the first phase of the ESBT 150 week programme was redesigning the pathways and services that make up our new care model. To enable us to deliver our ESBT vision of long-term sustainability, we now need to focus on our local provider landscape and put in place the right provider infrastructure to deliver outcomes on a whole system and whole person basis. This needs to happen at a scale required to bridge an anticipated funding gap of approximately £200 million by 2021[2].

[1] 'Moving to Accountable care in East Sussex' (East Sussex Better Together, 2015)
[2] Draft ESBT 5 Year Strategic Investment Plan (updated 2016/17 modelling)

3.2 In the Autumn of 2015 we undertook research into international examples of good practice to establish the characteristics of health and care systems who are successfully meeting the 'triple aims' of health and care systems globally – improved quality, improved population health and reduced costs per capita. That research pointed to provider models known as 'Accountable Care' as being particularly effective at bringing improvements to the quality of care and health outcomes, as well as slowing down the rate of increase in health and care spending. Both Multi-specialty Community Providers (MCPs) and Primary and Acute Care Systems (PACS) are forms of Accountable Care. In ESBT we believe that Accountable Care is the most likely model of care to resolve our issues of provider sustainability across primary, acute, community, mental health and social care, and our choice of model needs to reflect the corresponding breadth of integration.

3.3 This work was backed up by the NHS Five Year Forward View, published in Autumn 2014[3], which strongly encouraged local areas to be innovative in thinking about new models of care outlining some parameters, for example MCPs and PACS which were helpful in guiding our initial thinking. In the context of the Five Year Forward View and the Sussex and East Surrey Sustainability and Transformation Plan, it is recognised that some elements of the transformation to new models of care are also likely to require dialogue with Government departments and the NHS about changes to policy or statutory guidance.

**Why 'Accountable Care' – a working definition**

Accountable Care is a term used to describe a range of health and care delivery systems that have similar features to support delivery. The definition we have adopted locally is:

*A **system** in which a **group of providers** are held jointly **accountable** for achieving a set of **outcomes** for a prospectively defined **population** over a period of time and for an agreed **cost** under a contractual arrangement with a commissioner*

## 4 Common features of Accountable Care systems

4.1 The Kings Fund[4] has identified that although there are several organisational approaches to Accountable Care models, all models share the following common features that transform the delivery of discrete care services into a whole care system that is empowered to proactively manage overall population health and prevention, as well as providing care services, through stronger networks of delivery and accountability:

- Single leadership teams working to aligned objectives.
- Single capitated budget aligned to delivery of specific outcomes – as an alternative payment mechanism to activity based payments, payment by results and block contracting.
- Longer contract lengths for example 5 – 7 and 10 – 15 years.
- A focus on whole population health that translates into 'make or buy' programmes of care and disease management, prevention and wellness.

[3] www.england.nhs.uk/ourwork/futurenhs/

[4] Accountable Care organisations in the US and England, testing, evaluating and learning what works, Kings Fund, March 2014

- Use of shared electronic health records that have the ability to exchange information across providers and teams, and be aggregated to ensure real-time collective business intelligence.
- Greater attention to actively involving, engaging and supporting patients, clients and their families in the setting of outcomes and the management of care.
- Shared risk approach to both delivery and commissioning of services.
- All parties working to a common set of financial and quality measures.

4.2 Having looked at the evidence we have think that a 'PACS' type of model of Accountable Care looks the most appropriate for East Sussex. This would mean that East Sussex Healthcare NHS Trust (ESHT), as our local provider of acute hospital and community services, would be a part of a fully collaborative model with primary care, mental health and social care, enabling us to deliver the scale and impact of the benefits we are seeking to achieve for our population in the following ways:

- Integrating provision of out of hospital health, care and support to deliver prevention, wellbeing and independence and less reliance on high cost services
- Integrating acute and primary care and improving hospital based and primary care services to reduce variation, increase standards and improve productivity
- Providing parity of esteem and approach to mental and physical health
- Integrating effort on the challenges of workforce, IT, estates and quality across these services to deliver more benefit for the system as a whole.

***Primary and Acute Care Systems (PACS)***
*Although there is no rigid definition of PACS models or how they are expected to work in practice, a PACS model "will deliver an expanded version of core general practice, but will go much further (than MCPs) in joining with acute hospitals to create a single provider system" (NHS New Models of Care: update and initial support, July 2015)*

4.3 There is no 'off the shelf' solution however, and as a result of these discussions we asked PricewaterhouseCoopers (PwC) to facilitate four seminars to get a better technical understanding about the governance of Accountable Care models during March to April 2016. These were attended by clinical and executive leaders from across our local health and social care system alongside representatives from the Local Medical Committee and Healthwatch East Sussex. The summary reports from these workshops and the original research paper can be found on the ESBT website at ESBT Website/ Accountable Care

4.4 Having been firmly embedded as partners in the ESBT programme of service and care pathway redesign, as a result of the seminar discussions in May 2016 it was formally agreed that ESHT and Sussex Partnership NHS Foundation Trust (SPFT) would join the ESBT Programme Board to make our approach truly whole system, enabling a full alliance between commissioners and providers of health and social care.

## 5 Why a new model of Accountable Care will help in East Sussex

5.1 The 'Accountable Care' models we have explored focus on delivering local health and social care services based on the outcomes, or results, for patients and service users. Put simply, it means the whole health and care system is geared towards preventing ill

health (keeping people well) and promoting independence and wellbeing, while ensuring we have high quality hospital, care and specialist services when people need them. This approach is already being used successfully in other countries around the world.

5.2 We know that the change in our population structure is driving unprecedented levels of unplanned (non-elective) activity in our acute care hospitals locally - more detail about this can be found in the companion paper to this report 'The Case for Change in East Sussex (Accountable Care)'. We have this in common with many hospitals both in the UK and in other high-income countries, for example KPMG have found that caring for older people with multiple conditions accounts for "more than half of the typical caseloads of hospitals….and more than 70% of occupied bed days" that they work with[5].

5.3 Studies from health and care systems across the world also "show that between 20 – 25 percent of all patients could be cared for in different settings, quite frequently at home"[6]. This means there is a real opportunity to transform to a model which can truly support prevention, early intervention, and proactive care to deliver the lowest level of effective care and support, and where enabling patients, clients and carers to be more in control of their conditions, health, and wellbeing is at the heart of the model.

5.4 We also understand that improving chronic care and that of long term conditions is largely a matter of proactive disease management in a strong and resilient primary and community care setting; this has long been our vision under ESBT (our 6+2 box pathway) and we are putting in place integrated services and pathways to make this a reality. The six boxes describe the services and support required throughout the whole cycle of an individual's care and support – from prevention through to bedded care, mental and physical health, primary and secondary services. Two further boxes are additional areas where we want to improve the quality and affordability of services.

Figure 1 The ESBT 6+2 box framework

5.5 A summary of the improvements we are making under the ESBT 6+2 box framework is as follows

- Streamlined point of access for referrals - Health and Social Care Connect
- Multi-disciplinary proactive care, crisis response and single integrated Health and Social Care Locality Teams
- A new model of urgent and emergency care

[5] In Search of the Perfect Health System: Britnell M(2015)
[6] In Search of the Perfect Health System: Britnell M(2015)

- Primary prevention, self-care and self-management and assistive technology – all designed to put patients, clients and their carers in more control of their condition
- Supporting and growing the contribution and role of wider voluntary and community sector
- Elective (planned) care – making improvements to variations in outcomes and cost across a range of inpatient and outpatient procedures and operations
- Medicines optimization – implementing our strategy to reduce waste in the use of prescribed medication

5.6 These improvements will however only take us so far. We recognise that we need to change some longstanding barriers within our providers to create a system that works better for our clients and patients and is more sustainable in the long run. The central platform of a future Accountable Care operating model includes:

| Transformation | Rationale |
|---|---|
| Create active and engaged patients, clients and carers to be equal partners in their own care | Sustainable health and care and a health-conscious society relies on patients and clients who are active in decisions, and who are empowered and supported to manage their conditions through personalised care, health coaching and patient support groups as well as better use of technologies. Patients who are active and equal partners in their own healthcare have been found to 'consume' between 8 – 21% less care, feel more satisfied and have better outcomes[7] - and this represents enormous potential to be unleashed at scale. This should include approaches at the end of life as well as from the beginning. |
| Putting our staff in control | Our health and care workforce is our greatest asset and there is a chronic workforce shortage while demand for services is growing, whether this primary and acute care physicians and nurses, social workers, therapists and occupational therapists or independent sector care workers and assistants. Low levels of staff autonomy have been found to undermine recruitment and retention and adversely affect patient care[8]. Devolving integrated health and care budgets to local teams will give our staff control over the financial resource they are responsible for using, enabling stronger links to be made with the natural assets in the communities where they are delivering services.<br><br>We need to work together as a local system on workforce motivation and development to broaden the portfolio and skills base of our health and care professionals, and encourage a more flexible and sensible approach to task delegation to make the work more attractive – reducing costly demarcations that don't serve patients' and clients' interests and making attractive opportunities for career development the norm. |
| Full integration at a system-wide level | Whilst the changes we are making under ESBT to integrate care pathways and services will have a positive impact on the quality and overall affordability of our health and social care system, there will remain a funding gap if we don't resolve the issue of provider sustainability. Our research has shown that this can be overcome |

[7] Patients with lower activation associated with higher costs: delivery systems should know their patients' "scores" Health Affairs (2013)

[8] 'Reducing patient mortality in hospitals: the role of human resource management, Journal of Organizational Behaviour (2006)

| | |
|---|---|
| | through moving away from individual care providers towards a fully integrated 'care system', that is large enough to be accountable for the full continuum of care and achieving the 'triple aims' of improving health, quality and affordability[9] - something that it is currently impossible for any single organisation in our provider landscape to achieve. |
| Change the fragmented annual activity-based, fee for service payment model and moving to a single capitated budget payment mechanism, backed up with a longer-term contract | If we leave payment arrangements as they currently are our hospitals have no incentive to reduce the numbers of patients they see and income, as they are paid by activity and volume (fee-for-service) – the numbers of outpatients' appointments, day cases, operations and procedures. Conversely there is also little incentive for an already over-stretched primary care to undertake more work without extra resource.<br><br>Changing the payment mechanism to whole population capitation and a longer-term contract means we will be able to move away from an annual cycle of revenue investment based on activity, and invest in a fundamental shift in the model of care to, chronic disease management, prevention and population health - dynamically shifting resources around the system to support this. |
| Reduce transactions between commissioners and provider | We currently spend time and money transacting the business as separate commissioners and providers. By moving to a more unified and integrated approach to commissioning, and performance managing the outcomes we want to achieve as a single system and sharing the risks to both commissioning and delivery of services, we can both improve the resilience of our commissioning organisations and reduce costs with a smaller commissioning infrastructure. |

5.7 Through our ESBT whole systems programme we have made a strong start to create the conditions we need for this whole system integration and a fundamental shift in the model of care. Moving to an Accountable Care model represents the next step in that journey by establishing an affordable and sustainable provider landscape with the above aspects at the heart of the care model, that is embraced by a new operational and business environment that is fully integrated and incentivised to deliver these objectives.

## 6 Impacts of Accountable care models

6.4 As in many parts of the country, demand for health and social care services is growing, and if the use of services grew in line with overall changes in population, the system would be unlikely to cope through organic growth alone. We also know that services are disproportionately used by older people, who are also our fastest growing population in the County, and that the complexity of care needs is increasing across the care groups we cover. This is more fully documented in the companion piece to this paper - 'The Case for Change in East Sussex (Accountable Care)'.

6.5 The evidence supporting impact of Accountable Care models on reducing cost is not extensive, but where it has been measured, a reduction in running costs of between 17-25% has been achieved. A summary of some of the available international evidence is presented in the table below[10].

[9] 'Achieving Healthcare reform: How physicians can help' New England Journal of Medicine (Fisher E.S. et al (2009)
[10] PricewaterhouseCoopers source: IHP integrated care toolbox

| System | Benefits | Key features of the model |
|---|---|---|
| Veterans Administration (USA) | 20% lower budget than if patients were Medicare funded | Substantially lower drug costs<br>55% fewer bed days than US average |
| Kaiser Permanente (USA) | 19% lower costs than competing providers and health plans | NHS ALOS was 3.5x as high as Kaiser's (2005)<br>ALOS in NHS increases with age – not at Kaiser |
| Geisinger (USA) | 21% lower plan costs (not-for-profit provider) | Over 5 years, reduced bed days for diabetes patients by 43%,<br>health navigators reduced admissions by 20% |
| Gesundes Kintzigtal (Germany) | 17% overall lower health system costs over 4 years | focus on guided self-care<br>Improved healthcare outcomes for the population |
| Valencia Region (Spain) | 25 % lower costs than rest of Spain | Tendered provider care management of entire population to private consortia that are also liable for cost of running hospital<br>Reduced ALOS by 30% |

6.6 It is recognised that even these world-class examples of integrated care organisations do not always consider their journey to 'full integration' as being complete. For example in the Valencia region in Spain, operating in its current form since 2001, primary care has independent contractor status with which the integrated care provider has a delivery relationship. It is also understood that it takes time to reach the levels of whole system organisational working to deliver benefits on this scale. Given the pace and scale of the transformation needed to meet the challenges faced by our local health and social care economy, including an anticipated £200million funding gap in 2020 and significant local workforce challenges, this highlights the need to make a start with a transitional period of collaborative development and learning about Accountable Care in shadow form, starting in April 2017.

## 7 Local dialogue to develop an Accountable Care Model

7.1 There is no 'off the shelf' Accountable care model that will work in East Sussex; it needs to be understood and locally designed in order to work in the specific circumstances and pressures on the ESBT health and social care economy. It is also something new to local organisations and stakeholders, which necessitates an immense amount of dialogue and engagement across a range of stakeholder interests, both to grow understanding and build trust as it heralds a very different form of collaborative working. Research and local discussions have taken place between June - October 2016 to shape the content of the development plans for Accountable Care, and will continue, to consider the basis of the future vision for our local Accountable Care Model and the arrangements for a transition year of Accountable Care in 2017/18. This has been taken forward through:

- A seminar on the impact of future models on health and social care in East Sussex
- Multi-agency Steering Group discussions
- ESBT Accountable Care Strategic Investment Plan discussions as part of RPPR during September and October 2016 focussing on the activity and capacity changes needed to effect a move to community based prevention and proactive care

7.2 Work is also currently taking place with GPs, and other primary, community and acute care professionals to agree a shared understanding and high level plan for the system transformation required to deliver sustainable provision across primary, community, acute, mental health and social care by 2020/21, based on the five year financial assumptions detailed in our Integrated 5 Year Strategic Investment Plan[11]. Discussions about this and the arrangements for the transitional year are taking place in a range of arenas and forums.

7.3 Sessions have also taken place with County Council Members at the ESBT Scrutiny Board on 4th October, Whole Council Forum on 11th October, and there has also been a presentation and discussions at a special Health Overview and Scrutiny Committee (HOSC) session on 18th October. Discussion with the wider stakeholders in the voluntary and community sector and independent care sector have taken place including the October Shaping Health and Care events and this will continue through a range of forums.

7.4 Through discussions a common understanding has been reached that Accountable Care models bring together a new care model (whole person, community based, preventative care) with a new payment, contracting and organisational model (population based capitated budgets and payment mechanisms housed within a longer-term contract). This brings new flexibility to incentivise the shift to preventative and proactive care in the community, and organisations using this model have been able to improve population health and wellbeing, improved quality as well as a reduction in the per capita cost of care, at times to the scale of 17-25% compared to the running costs of equivalent health and care systems that are run on a more traditional and non-integrated basis.

7.5 Further to this, due to the interconnected nature of primary, community, acute, mental health and social care across the ESBT footprint, and the size of the financial challenge we need to address, we are committed to developing an Accountable Care Model that has all of these services in scope, plus elements of specialist care where this is appropriate. This will enable optimum levels of flexibility across our health and care system to effect the following changes, some of which are already being seen in UK Vanguards sponsored by the NHS[12]:

- A focus on prevention and population health management and a recasting of the relationship between local people and their health and care services, connecting people with assets and resources in communities to keep them well as well as using person-level and population data to organise care around people's needs and preferences.
- Providing urgent care that is integrated with primary, community, mental health and social care, reducing the need for emergency or unplanned hospital admissions. Our hospital-based services will only be used to meet appropriate in-patient needs.
- People's ongoing care needs are more coordinated through services in home and community based-settings. This will be delivered through integrated multi-disciplinary local area teams based in communities, and by linking hospital specialists to community and primary based care through greater use of technology to deliver care remotely.
- As far as possible people who have the most complex needs will have care and support delivered in the community, enabling a reduction in the number of hospital beds and inpatient care only for those who need intensive or complex care.

7.6 Strong progress has been made in all of these areas under the ESBT Programme, however, this won't be enough to close the anticipated £200million funding gap to secure an

[11] Draft ESBT 5 Year Strategic Investment Plan (updated 2016/17 modelling)

[12] New Care Models: Integrated Primary and Acute Care Systems, NHS September 2016

affordable and sustainable health and care system in the long term. Moving to Accountable Care will transform the way we do business as a health and social care system and economy in order to fully realise the benefits of service and pathway transformation and integration.

## 8 Contractual model and funding options

8.1 In order to secure the benefits of moving to a fully integrated Accountable Care system there are three main contractual models to consider, which can be summarised as follows[13]:

| Model | Advantages | Disadvantages |
| --- | --- | --- |
| **Virtual arrangement:** commissioners and providers are bound together by an alliance agreement | Establishes a shared vision, ways of working and the role of each provider in the Accountable Care system. Represents a pragmatic step forward with least disruption especially if GPs have already come together to operate at scale | Overlays rather than replaces traditional commissioning contracts, adding an extra layer to an already complex set of arrangements and can be weak in terms of deploying resources flexibly |
| **Partially integrated:** a contract is let for the vast majority of health and care services with a single budget | The contract can include social care and services delivered by the voluntary and independent care sector. It could also include aspects of local enhanced primary care services in the contract and by agreement QOF and directed enhanced services. | A procurement process would need to be undertaken to identify a contract holder potentially resulting in collaborative working relationships being undermined. The contract holder would have to integrate directly with primary medical services delivered under general medical services, personal medical services and alternative provider medical services contracts, and integration would not follow a whole population funding model impacting on benefits |
| **Fully integrated**: single contract for all health and care services (children's and adults) operating under a single whole-population budget | This could include primary medical services as part of the full range of services in scope, under a contract held by the Accountable Care delivery organisation. Best reflects the logic of the new accountable care model with the greatest freedom to secure the benefits of a fully integrated health and care system. | Most complicated route to take as this is furthest away from the status quo |

8.2 After local deliberation it was felt that although some form of fully integrated model of Accountable Care is the likely most desirable option in the long term, as it offers the most opportunity to deliver the full benefits on an integrated system, it is equally the case that formal integration on this scale would represent significant risks to all organisations involved.

[13] New Care Models: Integrated primary and acute care systems (PACS) – describing the care model and the business model (2016)

This further emphasises the need for a transitional year of Accountable Care in shadow form, under a virtual alliance arrangement, which will allow for the collaborative learning and evaluation to take place between the ESBT Programme partners and other key partners, to further develop the modelling and evidence base locally for increased levels of formal integration, designing the appropriate contractual and funding arrangements to suit local preferences.

## 9 Organisational form options

9.1 In order to encourage more coordinated care between health and care providers, an Accountable Care delivery vehicle will have to bring together a range of services that currently sit across a number of different providers. Local discussions have also taken account of the need to develop and agree an organisational form, and also decide how the prospective Accountable Care providers will relate to GP Practices, other staff groups, and providers in the independent and voluntary sector, as well as the communities where they provide services.

9.2 A number of options are available to be explored in order that local determination of organisational form can take place. This would build on the virtual alliance arrangements so that the Accountable Care delivery vehicle can be a formal legal entity, or group of entities acting together, capable of bearing financial risk and which has clear governance and accountability arrangements in place for both clinical and care quality and financial management. Suggested options to explore as part of local determination include:

- Using NHS legislation to establish a new NHS Trust Board, to include social care and Public Health provision
- Partners on the ESBT Programme Board forming a limited company or limited liability partnership (LLP) e.g. a forming a corporate joint venture vehicle to deliver the single contract for the whole population
- Other organisational models such as Community Interest Companies and Mutual Companies

**Report to:** **Cabinet**

**Date of meeting:** **15 November 2016**

**By:** **Director of Communities, Economy and Transport**

**Title:** **East Sussex Superfast Broadband – Next Steps**

**Purpose:** **To report coverage levels of Superfast Broadband in East Sussex on completion of phase 1 through the e-Sussex project and to inform of plans to increase coverage even higher**

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***RECOMMENDATIONS:*** **Cabinet is recommended to:**

**(1)** ***n*****ote progress to date on the rollout of superfast broadband in East Sussex;**

**(2)** **approve the proposals for a third phase of procurement for broadband infrastructure and related services; and**

**(3)** **agree to delegate to the Director of Communities, Economy and Transport authority to continue with necessary action to give effect to this**

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## 1 Background Information

1.1 In 2011 the Government made £530m available to support the rollout of Next Generation Access (NGA / fibre) infrastructure across the United Kingdom. East Sussex (including Brighton and Hove) received an allocation of £10.64m, which was amongst the top ten allocations in the country, indicating the severity of market failure (lack of private sector investment) which existed in the county at that time. Funding was allocated to provide superfast broadband to 90% of premises in the UK by early 2016, and access to basic broadband of at least 2mbps for all by end 2015. This funding was required to be matched locally.

1.2 Further funding was made available by Government to extend superfast coverage to 95% of the UK by December 2017. Please note that these targets are for UK-wide coverage and do not indicate coverage targets at county, or sub-county, level.

1.3 In December 2012 Cabinet approved procurement of necessary broadband infrastructure access and related services through the Broadband Delivery UK (BDUK) framework agreement. Use of the BDUK framework agreement ensured state aid compliancy, cost effective procurement and a quick route to market. Two procurements took place under the framework (Phase 1 in 2013 and Phase 2 in 2015). Two separate contracts were awarded to BT (in May 2013 and in June 2015), the other supplier on the framework (Fujitsu) having declined to bid in the first instance and then being removed from the framework in 2015.

1.4 In 2012, only around 3% of the county had access to superfast broadband through investment by the private sector (known as the commercial rollout). Forecasts were that the commercial rollout would increase coverage to around 50%. BT's commercial activity has now largely completed and Virgin Media is just beginning a programme of investment in East Sussex. Whilst ESCC has no direct influence over the commercial investment decisions of either, we work with both to unblock potential barriers to rollout and also continue to lobby for improvements in privately funded areas where the project is not allowed to work.

## 2 Supporting Information

2.1 East Sussex has been very successful in terms of Broadband intervention under the e-Sussex programme, with Phase 1 complete and Phase 2 now underway.

2.2 As at September 2016, 70,433 additional premises across e-Sussex are now connected to fibre infrastructure and of these 82% (57,755) can get superfast speeds (24mbps and above). These are premises that would otherwise not have access to Superfast Broadband and are on top of the 270,000 premises in the county that already have access to Superfast Broadband. This outcome has exceeded the original contracted projections.

2.3 Delivery of phase 2 has now commenced with planning and initial delivery. It is anticipated that a further 5,000 premises will have access to superfast speeds of 24mbps and above by the end of the phase in December 2017.

2.4 It is forecast that this will leave some 20,000 premises with access speeds below 24mbps. This has an impact on the ability of businesses to run successfully, particularly home-based businesses, and for the wider community in accessing online services.

2.5 Both contracts include a Gainshare mechanism whereby if the supplier makes additional income above expected levels, funding is returned by the supplier and retained in the contract for further investment. This has already happened in East Sussex, where current take up is running at 32% against a national forecast of 20%. The programme is therefore in a very strong position to extend the coverage of superfast broadband still further and potentially reuse an estimated £3m of Gainshare funding. If this funding is not recommitted it remains in the contract until the end of the seven year state aid period.

2.6 BDUK have confirmed with the European Commission that BT as supplier does not have automatic right to this funding and that it should be further tested within the market prior to commitment, ie by running an open procurement under the Public Sector Procurement Regulations (2006)

2.7 The UK government, through BDUK, is asking Local Authorities now to undertake a third round of procurement activity using this Gainshare and other funding to continue to push superfast coverage as far and as quickly as possible. The Broadband Framework used previously is no longer in place and so a replacement approach has been developed

2.8 BDUK have provided template documentation which ensures state aid compliancy, cost effective procurement and reduced legal costs but which also, importantly, enables the opportunity to locally tailor documents to suit local need. Smaller, local suppliers are actively encouraged to engage with this process.

2.9 No further funding is being sought from East Sussex County Council sources.

2.10 The current plan is to continue to follow the UK Government approach and pursue additional superfast coverage using the template documentation. It is also proposed that this documentation includes the following additional objectives:

- Aim for as close to 100% superfast coverage as possible
- Prioritise those on the lowest speeds. Specifically, prioritise those on speeds of less than 15Mbps over those on speeds of 15-30Mbps. We will wish to prioritise any remaining rural trading estates that may not yet have benefitted from the project in order to reflect the Council's priority of driving economic growth
- Clear visibility of which premises will be connected and when, along with clarity of those not being connected *with* estimated cost to connect these hardest to reach premises.
- Create an environment where smaller, local suppliers can help deliver further coverage.

**3 Conclusion and Recommendations**

3.1 East Sussex is now in a position where 95-96% superfast coverage is predicted by the end of 2017 (from a baseline in 2012 where only 3% of premises had superfast coverage). The e-Sussex project has been very successful and there is now an opportunity to pursue as close to 100% coverage as possible, with no further capital funding being required from the Authority

3.2 Cabinet is therefore recommended to: note progress to date; approve proposals for a third phase of procurement activity for broadband infrastructure and related services, as described at 2.6, 2.8 and 2.10 above; and delegate to the Director of Communities, Economy and Transport authority to continue to take necessary action to give effect to this.

RUPERT CLUBB
Director of Communities, Economy and Transport

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LOCAL MEMBERS

All.

BACKGROUND DOCUMENTS

www.esussex.org

Report to: **Cabinet**

Date: **15 November 2016**

By: **Chief Operating Officer**

Title of report: **Treasury Management – Stewardship Report 2015/16**

Purpose of report: **To present a review of the Council's performance on treasury management for the year 2015/16 and Mid Year review for 2016/17, and no changes to the Treasury Management Policy and Strategy are recommended.**

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**RECOMMENDATION: The Cabinet is recommended to note the Treasury Management performance in 2015/16 incorporating the Mid Year review for the first half of 2016/17**

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## 1. Background

1.1 The annual stewardship report reviews the Council's treasury management performance and Mid Year report is required by the Code of Practice for Treasury Management.

## 2. Supporting Information

2.1 The Council's treasury management activities are regulated by a variety of professional codes and statutes and guidance. The Council has adopted the CIPFA Code of Practice for Treasury Management in the Public Sector and operates treasury management service in compliance with this Code. These require that the prime objective of the treasury management activity is the effective management of risk, and that its borrowing activities are undertaken in a prudent, affordable and sustainable basis and treasury management practices demonstrate a low risk approach. The Code requires the regular reporting of treasury management activities to:

- Forecast the likely activity for the forthcoming year (in the Annual Treasury Strategy Report ); and
- Review actual activity for the preceding year (this Stewardship report).
- A mid year review

2.2 This report sets out:

- A summary of the original strategy agreed for 2015/16 and the economic factors affecting this strategy (Appendix A).
- The treasury management activity during the year (Appendix B);
- The treasury management mid year activity for 2016/17 (Appendix C);
- The Prudential Indicators, which relate to the Treasury function, Minimum Revenue Policy (MRP) and compliance with limits (Appendix D).

## 3. The economic conditions compared to our Strategy for 2015/16

3.1The strategy and the economic conditions prevailing in 2015/16 are set out in Appendix A which is attached to this report. 2015/16 continued the challenging environment of the previous years, with concerns over the states of the UK economy and of European countries. The main implications have been continuing counterparty risk and low investment returns.

## 4. The Treasury activity during the year on short term investments and borrowing

The Treasury Management Strategy

4.1 The strategy for 2015/16, agreed in January 2015, continued the prudent approach and ensured that all investments were only to the highest quality rated banks and only up to a period of two years. A more prudent approach was adopted throughout 2015/16 because of the uncertainties in the market and the emphasis was to be able to pre-empt/react quickly if market conditions worsen.

Short term lending

4.2 The total amount received in short term interest for 2015/16 was £2.2m at an average rate of 0.73%. This was above the average base rates in the same period (0.50%) and against a backdrop of ensuring, so far as possible in the current financial climate, the security of principal and the minimisation of risk. This Council has continued to follow a prudent approach with security and liquidity as the main criteria before yield.

Long term borrowing

4.3 Details of long term borrowing are included in Appendix B of the report. The important points are:

- Total of £20m borrowed during 2015/16 from the Public Works Loan Board (PWLB) for a 15-16 year fixed maturity period at an average rate of 2.75%.
- The average interest rate of all debt at 31 March 2016 (£275m) was 5.03%.
- Although a proactive approach has been taken to repayment and restructuring of debt, no cost effective opportunities arose during the year, because there has been a considerable widening of the difference between new borrowing and repayment rates, which has made PWLB debt restructuring now much less attractive.

## 5. Treasury Management Mid Year Review 2016/17

5.1 The Treasury Management and Annual Investment Strategy for 2016/17 were approved by the Cabinet on 26 January 2016, the average rate of return for investments to 30 September 2016 was 0.70%.

5.2 Further PWLB borrowing of £5m was undertaken in June 2016 for a 20 year fixed maturity period again at an attractive rate of 2.71%.

5.3 During 2016/17 debt to be repaid to the PWLB totals £4.6m, this historic debt is at an average rate of 8.2%.

5.4 The Minimum Revenue Provision is under review with an update to follow within the financial year.

## 6. Prudential Indicators which relate to the Treasury function and compliance with limits

6.1 The Council is required by the CIPFA Prudential Code to report the actual prudential indicators after the end of each year. There are eight indicators which relate to treasury management and they are set out in Appendix D.

## 7. Conclusion and reason for recommendation

7.1 This report updates the Cabinet and fulfils the requirement to submit an annual/half yearly report in the form prescribed in the Treasury Management Code of Practice. Short term lending throughout the year saw returns increase steadily from 0.66% to 0.73%. This reflects the objective to ensure so far as possible in the financial climate, a prudent approach with security and liquidity as the main criteria before yield. Exposure to future risk continues to be minimised through proactive and constant review of the treasury management policy. The emphasis must continue to be able to pre-empt/react quickly if market conditions worsen.

**KEVIN FOSTER**
**Chief Operating Officer**

Contact Officer: Ola Owolabi Tel No. 01273 482017

BACKGROUND DOCUMENTS

Cabinet 27 January 2015 Treasury Management Strategy for 2015/16
26 January 2016 Treasury Management Strategy for 2016/17

CIPFA Prudential Code and Treasury Management in the Public Services- Code of practice
Local Government Act 2003 Local Government Investments guidance

**A summary of the strategy agreed for 2015/16 and the economic factors affecting this strategy**

## 1. Background information

1.1 Cabinet receive an annual Treasury Management Strategy report in January 2015, which sets out the proposed strategy for the year ahead. This strategy includes the limits and criteria for organisations to be used for the investment of cash surpluses and has to be approved by the Council.

1.2 This Council has always adopted a prudent approach to its investment strategy and in the last few years, there have been regular changes to the list of the approved organisations used for investment of short term surpluses. This list is regularly reviewed to ensure that the Council is able to invest in the best available rates consistent with low risk; the organisations are regularly monitored to ensure that their financial strength and low risk has been maintained.

1.3 When the original strategy for 2015/16 was drawn up in January 2015, the money markets were still concerned about global credit events. In this climate ensuring the security of investments continues to be difficult and caution has to be taken on where surplus funds can be invested.

1.4 At the same time, the Treasury Management Policy Statement was agreed as unchanged for 2015/16.

East Sussex County Council defined its treasury management activities as:

"The management of the organisation's cash flows, its banking, money market and capital market transactions (other than those of the Pension Fund) the effective management of the risks associated with those activities; and the pursuit of optimum performance consistent with those risks."

The Council regards the successful identification, monitoring and management of risk to be the prime criteria by which the effectiveness of its treasury management activities will be measured. Accordingly, the analysis and reporting of treasury management activities will focus on their risk implications for the organisation.

This authority acknowledges that effective treasury management will provide support towards the achievement of its business and service objectives. It is therefore committed to the principles of achieving best value in treasury management, and to employing suitable performance measurement techniques, within the context of effective risk management.

## 2. Investment

2.1 When the strategy was agreed in January 2015, it emphasised the continued importance of taking account of the current and predicted future state of the financial sector. The Treasury Management advisors (Capita Asset Services) commented on short term interest rates, the UK economy, inflation, the outlook for long term interest rates and these factors were taken into account when setting the strategy.

2.3 Officers regularly review the investment portfolio, counterparty risk and construction, and use market data, information on government support for banks and the credit ratings of that government support. Latest market information is arrived at by reading the financial press and through city contacts as well as access to the key brokers involved in the London money markets.

2.4 This Council in addition to other tools uses the creditworthiness service provided by Capita Asset Services. This service employs a sophisticated modelling approach utilising credit ratings from the three main credit rating agencies - Fitch, Moody's and Standard and Poor's. The credit ratings of counterparties are supplemented with the following overlays:

- credit watches and credit outlooks from credit rating agencies;
- credit default swap (CDS) spreads to give early warning of likely changes in credit ratings; and

- sovereign ratings to select counterparties from only the most creditworthy countries.

2.4 The strategy going forward was to continue with the policy of ensuring minimum risk but was also intended to deliver secure investment income of at least bank rate on the Councils cash balances.

2.5 As was clear from the events globally and nationally since 2008, it is impossible in practical terms to eliminate all credit risk.

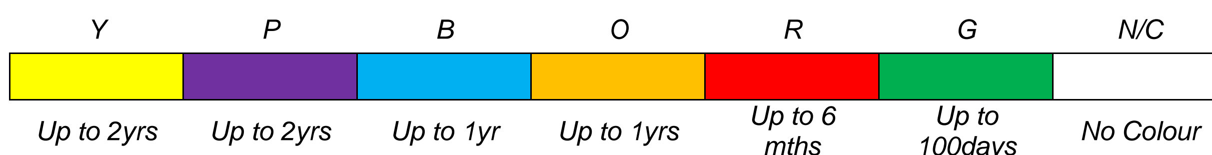
2.6 The strategy aimed to ensure that in the economic climate it was essential that a prudent approach was maintained. This would be achieved through investing with selected banks and funds which met the Council's rating criteria. The emphasis would continue on security (protection of the capital sum invested) and liquidity (keeping money readily available for expenditure when needed) rather than yield.

2.7 The Council's investment policy has regard to the DCLG's Guidance on Local Government Investments ("the Guidance") and the 2011 revised CIPFA Treasury Management in Public Services Code of Practice and Cross Capita Asset Services al Guidance Notes ("the CIPFA TM Code"). The Council's investment priorities will be security first, liquidity second, and then return.

2.8 Investment instruments identified for use in the financial year are listed in section 3.2 and 3.4 under the 'Specified and Non-Specified' Investments categories. Counterparty limits will be as set through the Council's Treasury Management Practices – Schedules.

2.9 The weighted scoring system produces an end product of a series of colour coded bands which indicate the relative creditworthiness of counterparties. These colour codes are used by the Council to determine the suggested duration for investments, i.e., using counterparties within the following durational bands provided they have a minimum AA+ sovereign rating from three rating agencies:

- Yellow 2 years
- Purple 2 years
- Blue 1 year (only applies to nationalised or semi nationalised UK Banks)
- Orange 1 year
- Red 6 months
- Green 3 months
- No Colour, not to be used




The Capita Asset Services credit worthiness service uses a wider array of information than just primary ratings and by using a risk weighted scoring system, does not give undue influence to just one agency's ratings.

Typically the minimum credit ratings criteria the Authority use, will be a short term rating (Fitch or equivalents) of short term rating F1, long term rating A-, viability rating of A-, and a support rating of 1. There may be occasions when the counterparty ratings from one rating agency are marginally lower than these ratings but may still be used. In these instances consideration will be given to the whole range of ratings available, or other topical market information, to support their use.
All credit ratings will be monitored daily. The Authority is alerted to changes to ratings of all three agencies through its use of the Capita Asset Services credit worthiness service.

- if a downgrade results in the counterparty or investment scheme no longer meeting the Authority's minimum criteria, its further use as a new investment will be withdrawn immediately.
- in addition to the use of credit ratings the Authority will be advised of information in movements in Credit Default Swap against the iTraxx benchmark and other market data on a weekly basis. Extreme market movements may result in downgrade of an institution or removal from the Authority's lending list.

The Capita Asset Services methodology was revised in October 2015 and determines the maximum investment duration under the credit rating criteria. Key features of Capita Asset Services credit rating policy are:

- a mathematical based scoring system is used taking ratings from all three credit rating agencies;
- negative and positive watches and outlooks used by the credit rating agencies form part of the input to determine a counterparty's time band (i.e. 3, 6, 9, 12 months etc.).
- CDS spreads are used in Capita Asset Services creditworthiness service as it is accepted that credit rating agencies lag market events and thus do not provide investors with the most instantaneous and "up to date" picture of the credit quality of a particular institution. CDS spreads provide perceived market sentiment regarding the credit quality of an institution.
- After a score is generated from the inputs a maximum time limit (duration) is assigned and this is known as the Capita Asset Services colour which is associated with a maximum suggested time boundary.

2.10 All of the investments were classified as Specified (i.e., investment is sterling denominated and has a maximum maturity of 1 year) and non-Specified Investments (i.e., any other type of investment not defined as Specified). These investments were sterling investments for up to two years maturity with institutions deemed to be high credit quality or with the UK Government (Debt Management Account Deposit Facility). These were considered low risk assets where the possibility of loss of principal or investment income was small.

2.11 Investment instruments identified for use in the financial year under the 'Non-Specified and Specified' Investments categories. The Council funds would be invested as follows:-

**3. Specified Investments**

3.1 An investment is a specified investment if all of the following apply:

- the investment is denominated in sterling and any payments or repayments in respect of the investment are payable only in sterling;
- the investment is not a long term investment (i.e. up to 1 year);
- the making of the investment is not defined as capital expenditure by virtue of regulation 25(1)(d) of the Local Authorities (Capital Finance and Accounting) (England) Regulations 2003 [SI 3146 as amended];
- the investment is made with a body or in an investment scheme of high credit quality (see below) or with one of the following public-sector bodies:
    - The United Kingdom Government;
    - A local authority in England or Wales (as defined under section 23 of the 2003 Act) or a similar body in Scotland or Northern Ireland; and
    - High credit quality is defined as a minimum credit rating as outlined in section 4.2 of this strategy.

3.2 The use of Specified Investments

Investment instruments identified for use in the financial year are as follows:

- The Table below set out the types of investments that fall into each category, counterparties available to the Council, and the limits placed on each of these. A detailed list of each investment type is available in the Treasury Management Practices guidance notes;
- All investments will be within the UK or AAA sovereign rated countries.
- The Council's investments in Lloyds Banking Group were based on the fact that this group is part-nationalised by UK Government, and any changes to their credit ratings will impact on the duration of the Council investment with the Group.

Criteria for specified Investments:

| Counterparty | Country/Domicile | Instrument | Maximum investments | Max. maturity period |
|---|---|---|---|---|
| Debt Management and Depost Facilities (DMADF) | UK | Term Deposits | unlimited | 12 months |
| Government Treasury blls | UK | Term Deposits | unlimited | 12 months |
| Local Authorities | UK | Term Deposits | unlimited | 12 months |
| *RBS/NatWest Group*<br>• *Royal Bank of Scotland*<br>• *NatWest* | UK | Term Deposits (including callable deposits), Certificate of Deposits | £60m | 1 yr |
| *Lloyds Banking Group*<br>• *Lloyds Bank*<br>• *Bank of Scotland* | UK | | £60m | 1 yr |
| *Barclays* | UK | | £60m | 1 yr |
| *Santander UK* | UK | | £60m | 1 yr |
| *HSBC* | UK | | £60m | 1 yr |
| Individual Money Market Funds | UK/Ireland/ domiciled | AAA rated Money Market Funds | £60m | Liquidity/instant access |
| *Counterparties in select countries (non-UK) with a Sovereign Rating of at least AAA* | | | | |
| Australia & New Zealand Banking Group | Australia | Term Deposits/Call Accounts | £60m | 1 yr |
| Commonwealth Bank of Australia | Australia | Term Deposits/Call Accounts | £60m | 1 yr |
| National Australia Bank | Australia | Term Deposits/Call Accounts | £60m | 1 yr |
| Westpac Banking Corporation | Australia | Term Deposits/Call Accounts | £60m | 1 yr |
| Royal Bank of Canada | Canada | Term Deposits/Call Accounts | £60m | 1 yr |
| Toronto Dominion | Canada | Term Deposits/Call Accounts | £60m | 1 yr |

| Nordea Bank Finland | Finland | Term Deposits/Call Accounts | £60m | 1 yr |
|---|---|---|---|---|
| Cooperatieve Centrale Raiffeisen Boerenlleenbank BA | Netherlands | Term Deposits/Call Accounts | £60m | 1 yr |
| Development Bank of Singapore | Singapore | Term Deposits/Call Accounts | £60m | 1 yr |
| Oversea Chinese Banking Corp | Singapore | Term Deposits/Call Accounts | £60m | 1 yr |
| United Overseas Bank | Singapore | Term Deposits/Call Accounts | £60m | 1 yr |
| Svenska Handelsbanken | Sweden | Term Deposits/Call Accounts | £60m | 1 yr |
| Nordea Bank AB | Sweden | Term Deposits/Call Accounts | £60m | 1 yr |

3.3 All Money Market Funds used are monitored and chosen by the size of fund, rating agency recommendation, exposure to other Countries (Sovereign debt), weighted average maturity and weighted average life of fund investment and counterparty quality.

**Non Specified Investments**

3.4 Non-Specified investments are any other type of investment (i.e. not defined as specified above). The identification and rationale supporting the selection of these other investments and the maximum limits to be applied are set out in the table below. Non specified investments would include any sterling investments.

| Non-Specified Investment | Minimum credit criteria | Maximum investments | Max. maturity period |
|---|---|---|---|
| UK Local Authorities | Government Backed | £60m | 2 years |

3.5 The council had no exposure in Non-Specified investments during the 2015/16.

**4. The economy in 2015/16 – Commentary from Capita Asset Services (Treasury Management Advisors) in May 2016.**

4.1 Market expectations for the first increase in Bank Rate moved considerably during 2015/16, starting at quarter 3 2015 but soon moving back to quarter 1 2016. However, by the end of the year, market expectations had moved back radically to quarter 2 2018 due to many fears including concerns that China's economic growth could be heading towards a hard landing; the potential destabilisation of some emerging market countries particularly exposed to the Chinese economic slowdown; and the continuation of the collapse in oil prices during 2015 together with continuing Eurozone growth uncertainties.

4.2 These concerns have caused sharp market volatility in equity prices during the year with corresponding impacts on bond prices and bond yields due to safe haven flows. Bank Rate, therefore, remained unchanged at 0.5% for the seventh successive year. Economic growth (GDP) in the UK surged strongly during both 2013/14 and 2014/15 to make the UK the top performing advanced economy in 2014. However, 2015 has been disappointing with growth falling steadily from an annual rate of 2.9% in quarter 1 2015 to 2.1% in quarter 4.

4.3 The Funding for Lending Scheme, announced in July 2012, resulted in a flood of cheap credit being made available to banks which then resulted in money market investment rates falling materially. These rates continued at very low levels during 2015/16.

4.4 The sharp volatility in equity markets during the year was reflected in sharp volatility in bond yields. However, the overall dominant trend in bond yields since July 2015 has been for yields to fall to historically low levels as forecasts for inflation have repeatedly been revised downwards and expectations of increases in central rates have been pushed back. In addition, a notable trend in the year was that several central banks introduced negative interest rates as a measure to stimulate the creation of credit and hence economic growth.

4.5 The ECB had announced in January 2015 that it would undertake a full blown quantitative easing programme of purchases of Eurozone government and other bonds starting in March at €60bn per month. This put downward pressure on Eurozone bond yields. There was a further increase in this programme of QE in December 2015. The anti-austerity government in Greece, elected in January 2015 eventually agreed to implement an acceptable programme of cuts to meet EU demands after causing major fears of a breakup of the Eurozone. Nevertheless, there are continuing concerns that a Greek exit has only been delayed.

4.6 The UK elected a majority Conservative Government in May 2015, removing one potential concern but introducing another due to the promise of a referendum on the UK remaining part of the EU. The government maintained its tight fiscal policy stance but the more recent downturn in expectations for economic growth has made it more difficult to return the public sector net borrowing to a balanced annual position within the period of this parliament.

**Appendix B**

**The Treasury Management activity during the year 2015/16**

## 1. Short term lending interest rates

1.1 Base interest rate remained at 0.50% throughout 2015/16. The rate is the lowest ever rate and the rate has remained unchanged for the longest period on record. The last change was over five years ago in March 2009.

1.2 There have been continued uncertainties in the markets during the year to date as set out in Section 4 of Appendix A.

1.3 The strategy for 2015/16, agreed in January 2015, continued the prudent approach and ensured that all investments were only to the highest quality rated banks using Capita's colour coded credit methodology.

1.4 The total amount received in short term interest for 2015/16 was £2.2m at an average rate of 0.73%. This was above the average of base rates in the same period (0.5%) and against a backdrop of ensuring, so far as possible in the financial climate, the security of principal and the minimisation of risk.

## 2. Long term borrowing

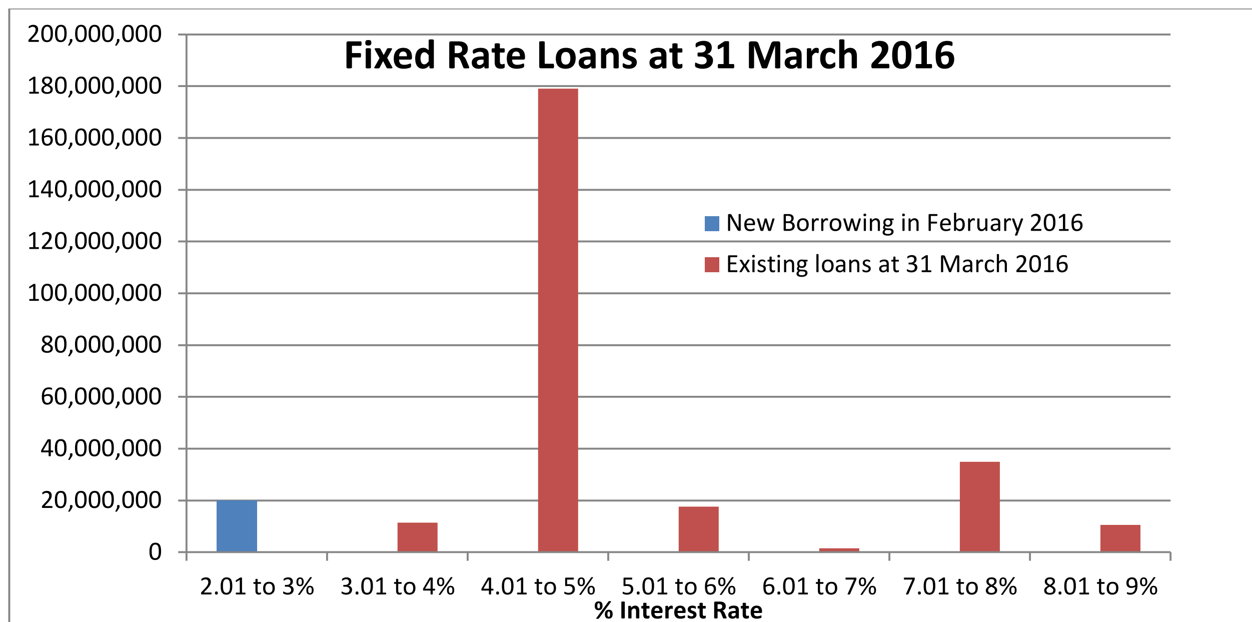
2.1 The Council's strategy was to maintain external borrowing below the level of the CFR – known as internal borrowing. However in the financial climate of low interest rates Officers constantly reviewed the need to borrow taking into consideration the potential increases in borrrowing costs, the need to finance new capital expenditure, refinancing maturing debt, and the cost of carry that might incur a revenue loss between borrowing costs and investment returns.

2.2 In February 2016 the Council took advantage of attractive PWLB rates and borrowed £20m in order to generate cash for the future capital programme. This fixed term borrowing was in the 15 to 16 maturity period the average rate taken was 2.75% with £10m maturing in 2031 and 2032 respectively.

2.3 The average interest rate of all debt at 31 March 2016 of £275m was 5.03%. No beneficial rescheduling of debt has been available, due to a considerable widening of the difference between new borrowing and repayment rates, which has made PWLB debt restructuring now much less attractive. Consideration would have to be given to the large premiums (cash payments) which would be incurred by prematurely repaying existing PWLB loans. It is very unlikely that these could be justified on value for money grounds if using replacement PWLB refinancing.

2.4 Our opportunity to restructure our debt has been significantly reduced since October 2010 as a result of the PWLB increasing all of its lending rates by 1% as part of the Government's Comprehensive Spending Review. However, it did not increase the rate of interest used for repaying debt so that not only the cost of our future borrowing has increased but our opportunity to restructure our debt when market conditions allow has been significantly reduced.

2.5 The range of interest rates payable in all of the loans is illustrated in the graph below:




## 3. Short term borrowing

3.1 No borrowing was undertaken on a short-term basis during 2015/16 to date to cover temporary overdraft situations.

## 4 Treasury Management Advisers

4.1 The Strategy for 2015/16 explained that the Council uses Capita as its treasury management consultant on a range of services which include:

- Technical support on treasury matters, capital finance issues and advice on reporting;
- Economic and interest rate analysis;
- Debt services which includes advice on the timing of borrowing;
- Debt rescheduling advice surrounding the existing portfolio;
- Generic investment advice on interest rates, timing and investment instruments;
- Credit ratings from the three main credit rating agencies and other market information;
- Assistance with training on treasury matters

Whilst the advisers provide support to the internal treasury function, under current market rules and the CIPFA Code of Practice the final decision on treasury matters remained with the Council. This service remains subject to regular review.

4.2 Capita is the largest provider of Treasury Management advice services to local authorities in the UK and they claim to be the market leading treasury management service provider to their clients. The advice has been and will continue to be monitored regularly to ensure a continued excellent advisory service.

**Appendix C**

## The Treasury Management Activity Mid-Year Report - 2016/17

### 1. Background

1.1 As part of the Council's governance arrangements for its treasury management activities, the Audit, Best Value and Community Services Scrutiny Committee is charged with oversight of the Council's treasury management activities. To enable the Committee to fulfil this role, the Committee receives regular reports on treasury management issues and activities. Reports on treasury activity are discussed on a monthly basis with the Chief Finance Officer and the content of these reports is used as a basis for this report to the Committee.

1.2 The Treasury Management and Annual Investment Strategy for 2016/17 were approved by the Cabinet 26 January 2016 and there have been no policy changes to date. This report considers treasury management activity over six months of the financial year.

### Summary of financial implications

1.3 In June 2016 the Council borrowed a further £5m from the Public Works Loan Board (PWLB). The term was a 20 years fixed loan at a rate of 2.71%. Record low borrowing rates have been made available due to the fall in UK Gilt yields following market nervousness around macro economic factors and subsequent flight to quality for investors seeking safe havens.

1.4 The level of Council debt at 30 September 2016 was £277.4m with one loan totalling £1.98m maturing with the PWLB on 31 December 2016. The forecast for interest paid on long-term debt in 2016/17 is approximately £13.5m and is within the budgeted provision. The average balance of investments of approximately £290m generated investments income of £1m to September 2016. The forecast for 2016/17 is £1.8m.

### 2. Treasury Management Strategy

2.1 The Council approved the 2016/17 treasury management strategy at its meeting on 26 January 2016. The Council's stated investment strategy is to prudently manage an investment policy achieving first of all, security (protecting the capital sum from loss), liquidity (keeping money readily available for expenditure when needed), and to consider what yield can be obtained consistent with those priorities.

2.2 The Council's exposure to security and interest rate risk could have been reduced by taking advantage of record low borrowing rates from the PWLB in total £25m since February 2016. Rescheduling any existing loans under the current economic conditions the costs of doing so in terms of interest and premium payable would be prohibitive.

2.3 The Chief Finance Officer is pleased to report that all treasury management activity undertaken from April 2016 to September 2016 period broadly complied with the approved strategy, the CIPFA Code of Practice, and the relevant legislative provisions.

### 3. Economic Review

3.1 The Bank of England May Inflation Report included a forecast for growth for 2016 of 2.0% and 2.3% for 2017 on the assumption that the referendum result was a vote to remain. The Governor of the Bank of England, Mark Carney, warned that a vote for Brexit would be likely to cause a slowing in growth, particularly from a reduction in business investment, due to the uncertainty of whether the UK would have continuing full access, (i.e. without tariffs), to the EU single market. In his 30 June and 1 July speeches, Carney indicated that the Monetary Policy Committee (MPC), would be likely to cut Bank Rate and would consider doing further quantitative easing purchasing of gilts, in order to support growth.

3.2 The Inflation Report forecast was notably subdued with inflation barely getting back up to the 2% target within the 2-3 year time horizon. However, the falls in the price of oil and food twelve months ago will be falling out of the calculation of CPI during 2016 and in addition, the recent 10% fall in the value of sterling is likely to result in a 3% increase in CPI over a time period of 3-4 years. There is therefore likely to be an acceleration in the pace of increase in inflation which could make life interesting for an MPC which wants to help promote growth in the economy by keeping Bank Rate low.

3.3 The American economy had a patchy 2015 – quarter 1 0.6% (annualised), 3.9% in quarter 2, 2.0% in quarter 3 and 1.4% in quarter 4, leaving growth in 2015 as a whole at 2.4%. Quarter 1 of 2016 came in at +1.1% but forward indicators are pointing towards a pickup in growth in the rest of 2016. The Fed embarked on its long anticipated first increase in rates at its December meeting. At that point, confidence was high that there would then be four more increases to come in 2016. Since then, more downbeat news on the international scene and then the Brexit vote, has caused a re-emergence of caution over the timing and pace of further increases. It is likely there will now be only one more increase in 2016.

3.4 In the Eurozone, the ECB commenced in March 2015 its massive €1.1 trillion programme of quantitative easing to buy high credit quality government and other debt of selected EZ countries at a rate of €60bn per month; this was intended to run initially to September 2016. In response to a continuation of weak growth, at the ECB's December meeting, this programme was extended to March 2017 but was not increased in terms of the amount of monthly purchases. At its December and March meetings it progressively cut its deposit facility rate to reach -0.4% and its main refinancing rate from 0.05% to zero. At its March meeting, it also increased its monthly asset purchases to €80bn. This programme of monetary easing has had a limited positive effect in helping a recovery in consumer and business confidence and a start to some improvement in economic growth. GDP growth rose by 0.6% in quarter 1 2016 (1.7% y/y) and is expected to continue growing but at only a modest pace. The ECB is also struggling to get inflation up from near zero towards its target of 2%.

**Interest Rate Forecast**

3.5 The Council's treasury advisor, Capita Asset Services (CAS), has provided the following forecast:

| | Sep-16 | Dec-16 | Mar-17 | Jun-17 | Sep-17 | Dec-17 | Mar-18 | Jun-18 | Sep-18 | Dec-18 | Mar-19 | Jun-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bank rate | 0.25% | 0.25% | 0.25% | 0.25% | 0.25% | 0.25% | 0.25% | 0.50% | 0.50% | 0.50% | 0.50% | 0.50% |
| 5yr PWLB rate | 1.00% | 1.10% | 1.10% | 1.10% | 1.10% | 1.10% | 1.10% | 1.20% | 1.20% | 1.20% | 1.30% | 1.30% |
| 10yr PWLB rate | 1.60% | 1.60% | 1.60% | 1.70% | 1.70% | 1.70% | 1.70% | 1.80% | 1.80% | 1.80% | 1.80% | 1.90% |
| 25yr PWLB rate | 2.40% | 2.40% | 2.40% | 2.50% | 2.50% | 2.50% | 2.50% | 2.50% | 2.60% | 2.60% | 2.70% | 2.70% |
| 50yr PWLB rate | 2.20% | 2.20% | 2.20% | 2.30% | 2.30% | 2.30% | 2.30% | 2.40% | 2.40% | 2.40% | 2.50% | 2.50% |

3.6 CAS stated it undertook a quarterly review of its interest rate forecasts on 4 July 2016 after letting markets settle down somewhat after the Brexit result of the referendum on 23 June. It is generally agreed that this outcome will result in a slowing in growth in the second half of 2016 at a time when the Bank of England has only limited ammunition in its armoury to promote growth by using monetary policy. CAS therefore expect that Bank Rate will be cut by 0.25%, by quarter 2 of 2016 when the BOE has a greater opportunity to report in depth on its research and findings.

3.7 Bank Rate could even be cut to 0% or 0.10% over 2016/17. Thereafter, CAS do not expect the MPC to take any further action on Bank Rate in 2016 or 2017 as we expect the pace of recovery of growth to be weak during a period of great uncertainty as to the final agreement between the UK and the EU on arrangements after Brexit. However, the MPC may also consider renewing a programme of quantitative easing; the prospect of further purchases of gilts in this way has already resulted in 10 year gilt yields falling below 1% for the first time ever. Bank Rate is not anticipated to start rising until quarter 2 2018 and for further increases then to be at a slower pace than before.

3.8 Mark Carney, has repeatedly stated that increases in Bank Rate will be slow and gradual after they do start. The MPC is concerned about the impact of increases on many heavily indebted consumers, especially when the growth in average disposable income is still weak and for some consumers, who have had no increases in pay, could be non-existent (other than through some falls in prices).

**Appendix D**

**Prudential Indicators which relate to the Treasury function and compliance with limits**

1.1 The Council is required by the Prudential Code to report the actual prudential indicators after the end of each year. There are eight indicators which relate to treasury management and they are set on an annual basis and monitored, they comprise:-:

- Operational and authorised borrowing limits which includes short term borrowing (paragraph 1.2 below)
- Interest rate exposure (paragraph 1.3 below)
- Interest rate on long term borrowing (paragraph 1.4 below)
- Maturity structure of investments (paragraph 1.5 below)
- Compliance with the Treasury Management Code of Practice (paragraph 1.6 below)
- Interest on investments (paragraph 1.7 below)
- Capital Financing Requirement and Minimum Revenue Provision (paragraph 1.8 below)

1.2 **Operational and authorised borrowing limits.**

The tables below sets out the estimate and projected capital financing requirement and long-term borrowing in 2015/16

| | **Capital Financing Requirement** | **2015/16 Estimate** | **2015/16 Actual** |
|---|---|---|---|
| | | **£m** | **£m** |
| | **Capital Financing Requirement at 1 April 2015** | **361** | **361** |
| add | Financing of new assets | 7 | - |
| less | Provision for repayment of debt | (16) | (14) |
| less | Long term capital loan* | - | (3) |
| | **Capital Financing Requirement at 31 March 2016** | **352** | **344** |
| add | Short Term Borrowing | 10 | 10 |
| | **Operational Boundary** | **362** | **354** |
| add | Short Term Borrowing | 20 | 20 |
| | **Authorised Limit** | **382** | **374** |

| | **Actual Borrowing** | **2015/16 Actual** |
|---|---|---|
| | | **£m** |
| | **Long Term Borrowing at 1 April 2015** | **259** |
| less | Loan redemptions | (4) |
| add | New Borrowing | 20 |
| | **Long Term Borrowing at 31 March 2016** | **275** |

*The capital loan relates to an outstanding loan with other local authority.

The Capital Financing Requirement includes PFI Schemes and Finance Leases.

The actual Authorised Limit for 2015/16 of £374m reflected the move to International Financial Reporting Standards (IFRS) and previously agreed Private Finance Initiative (PFI) contracts and some leases (being reclassified as finance leases instead of operating leases) coming onto the Council's Balance Sheets as long term liabilities. This new accounting treatment impacted on the Authorised Limit.

The Operational boundary for borrowing was based on the same estimates as the authorised limit. It reflected directly the authorised borrowing limit estimate with additional amount for a short term borrowing to allow, for example, for unusual cash movements. The Operational boundary represents a key management tool for in year monitoring and long term borrowing control.

The Authorised limit was consistent with the Council's current commitments, existing plans and the proposals for capital expenditure and financing, and with its approved treasury management policy statement and practices. It was based on the estimate of most likely, prudent but not worst case scenario, with in addition sufficient headroom (short term borrowing) over and above this to allow for day to day operational management, for example unusual cash movements or late receipt of income. Risk analysis and risk management strategies were taken into account as were plans for capital expenditure, estimates of the capital financing requirement and estimates of cash flow requirements for all purposes.

The Authorised limit is the "Affordable Borrowing Limit" required by S3 of the Local Government Act 2003 and must not be breached. The Long Term borrowing at 31st March 2016 of £275m is under the Operational boundary and Authorised limit set for 2015/16. The Operational boundary and Authorised limit have not been exceeded during the year.

1.3 **Interest rate exposure**

The Council continued the practice of seeking to secure competitive fixed interest rate exposure for 2015/16. There are three debt related treasury activity limits. The purpose of these are to restrain the activity of the treasury function within certain limits, thereby managing risk and reducing the impact of any adverse movement in interest rates. However, if these are set to be too restrictive they will impair the opportunities to reduce costs or improve performance. The indicators are:

- Upper limits on variable interest rate exposure. This identifies a maximum limit for variable interest rates based upon the debt position net of investments;
- Upper limits on fixed interest rate exposure. This is similar to the previous indicator and covers a maximum limit on fixed interest rates;
- Maturity structure of borrowing. These gross limits are set to reduce the council's exposure to large fixed rate sums falling due for refinancing, and are required for upper and lower limits.

| | **2015/16** | **2016/17** | **2017/18** |
|---|---|---|---|
| **Interest rate exposure** | **Upper** | **Upper** | **Upper** |
| Limits on fixed interest rates based on net debt | 100% | 100% | 100% |
| Limits on variable interest rates based on net debt | 15% | 15% | 15% |
| **Maturity structure of fixed interest rate borrowing 2015/16** | | | |
| | **Lower** | **Upper** | **Actual 2015/16** |
| Under 12 months | 0% | 25% | 2% |
| 12 months and within 24 months | 0% | 40% | 2% |
| 24 months and within 5 years | 0% | 60% | 4% |
| 5 years and within 10 years | 0% | 80% | 9% |
| 10 years and within 20 years | 0% | 80% | 24% |
| 20 years and within 30 years | 0% | 80% | 13% |
| 30 years and within 40 years | 0% | 80% | 34% |
| 40 years and above | 0% | 80% | 13% |

The Council has not exceeded the limits set in 2015/16. Not more than £20m of debt should mature in any financial year and not more than 15% to mature in any two consecutive financial years. New borrowing has been undertaken giving due consideration to the debt maturity profile, ensuring that an acceptable amount of debt is due to mature in any one financial year. This helps to minimise the authority's exposure to the risk of having to replace a large amount of debt in any one year or period

when interest rates may be unfavourable. The bar chart in the attached Annex 1 shows the maturity profile.

### 1.4 Interest rate on long term borrowing

The rate of interest taken on any new long term borrowing has been defined with the assistance of Capita Asset Services (CAS). The Accounts and Pensions Team have set up a recording process to monitor set trigger rates and work to an agreed protocol for potential future borrowing activity to fund the capital programme.

### 1.5 Maturity structure of investments

The Investment Guidance issued by the government, allowed local authorities the freedom to invest for more than for one year. All investments over one year were to be classified as Non-Specified Investments. The Council had taken advantage of this freedom and non-Specified Investments are allowed to be held within our overall portfolio of investments and in line with our prudent approach in our strategy, no new long term investments (over 364 days) have been taken in 2014/15.

### 1.6 Compliance with the Treasury Management Code of Practice

East Sussex County Council has adopted the CIPFA *Code of Practice for Treasury Management in the Public Services.*

### 1.7 Interest on investments

1.7.1. The table below sets out the average monthly rate received on our investments and compares it to the Bank of England Base rate to reflect both the interest rates available in the market and limitation in the use of counterparties.

| Month | Amount £'000 | Monthly rate | Margin against Base Rate |
|---|---|---|---|
| April | 165 | 0.66% | 0.16% |
| May | 169 | 0.66% | 0.16% |
| June | 168 | 0.67% | 0.17% |
| July | 180 | 0.68% | 0.18% |
| August | 186 | 0.69% | 0.19% |
| September | 181 | 0.71% | 0.21% |
| October | 188 | 0.73% | 0.23% |
| November | 190 | 0.78% | 0.28% |
| December | 190 | 0.78% | 0.28% |
| January | 181 | 0.78% | 0.28% |
| February | 179 | 0.77% | 0.27% |
| March | 187 | 0.76% | 0.26% |
| **Total for 2015/16** | **2,164** | **0.73%** | **0.22%** |

1.7.2. The total amount received in short term interest for the year was £2.2m at an average rate of 0.73%. This was above the average of base rates in the same period (0.5%) but ensuring, so far as possible in the financial climate, the security of principal and the minimisation of risk. This Council has continued to follow a prudent approach with security and liquidity as the main criteria before yield.

### 1.8 Capital Financing Requirement and Minimum Revenue Provision (MRP)

1.8.1. The Council's underlying need to borrow for capital expenditure is termed the Capital Financing Requirement (CFR). This figure is a gauge of the Council's indebtedness. The CFR results from the capital activity of the Council and resources used to pay for the capital spend. It represents the 2014/15 unfinanced capital expenditure (see below table), and prior years' net or unfinanced capital expenditure which has not yet been paid for by revenue or other resources.

1.8.2. Part of the Council's treasury activities is to address the funding requirements for this borrowing need. Depending on the capital expenditure programme, the treasury service organises the Council's cash position to ensure that sufficient cash is available to meet the capital plans and cash flow requirements. This may be sourced through borrowing from external bodies (such as the Government, through the Public Works Loan Board [PWLB] or the money markets), or utilising temporary cash resources within the Council.

1.8.3. Reducing the CFR – the Council's underlying borrowing need (CFR) is not allowed to rise indefinitely. Statutory controls are in place to ensure that capital assets are broadly charged to revenue over the life of the asset. The Council is required to make an annual revenue charge, called the Minimum Revenue Provision – MRP, to reduce the CFR. This is effectively a repayment of the borrowing need. This differs from the treasury management arrangements which ensure that cash is available to meet capital commitments. External debt can also be borrowed or repaid at any time, but this does not change the CFR.

1.8.4 The total CFR can also be reduced by:

- the application of additional capital financing resources (such as unapplied capital receipts); or
- charging more than the statutory revenue charge (MRP) each year through a Voluntary Revenue Provision (VRP).

1.8.5. The Council's 2015/16 MRP Policy (as required by CLG Guidance) was approved as part of the Treasury Management Strategy Report for 2015/16 on 28 January 2015.

1.8.6. The Council's CFR for the year is shown below, and represents a key prudential indicator. It includes PFI and leasing schemes on the balance sheet, which increase the Council's borrowing need. No borrowing is actually required against these schemes as a borrowing facility is included in the contract.

*CFR including appropriate balances and MRP charges for PFI Schemes and Finance Leases.*

| | **2015/16 Actual** | **2016/17 Estimate** | **2017/18 Estimate** | **2018/19 Estimate** |
|---|---|---|---|---|
| | **£m** | **£m** | **£m** | **£m** |
| **Total CFR** | **344** | **374** | **380** | **370** |
| **Movement in CFR** | (17) | 30 | 6 | (10) |

**MINIMUM REVENUE PROVISION (MRP) POLICY STATEMENT 2016/17 ONWARDS**

The statutory requirement for local authorities to charge the Revenue Account each year with a specific sum for debt repayment. A variety of options is provided to councils to determine for the financial year an amount of minimum revenue provision (MRP) that it considers to be prudent. This replaces the previous requirement that the minimum sum should be 4% of the Council's Capital Financing Requirement (CFR).

A Statement on the Council's policy for its annual MRP should be submitted to the Full Council for approval before the start the financial year to which the provision relate. The Council is therefore legally obliged to have regard to CLG MRP guidance in the same way as applies to other statutory guidance such as the CIPFA Prudential Code, the CIPFA Treasury Management Code and the CLG guidance on Investments.

The MRP guidance offers four options under which MRP might be made, with an overriding recommendation that the Council should make prudent provision to redeem its debt liability over a period which is commensurate with that over which the capital expenditure is estimated to provide benefits (i.e. estimated useful life of the asset being financed).

The guidance also requires an annual review of MRP policy being undertaken and it is appropriate that this is done as part of this annual Treasury Management Policy and Strategy.

The International Financial Reporting Standards (IFRS) involves Private Finance Initiative (PFI) contracts and some leases (being reclassified as finance leases instead of operating leases) coming onto the Council's Balance Sheet as long term liabilities. This accounting treatment impacts on the Capital Financing Requirement with an annual MRP provision being required.

To ensure that this change has no overall financial impact on Local Authorities, the Government has updated their "Statutory MRP Guidance" which allows MRP to be equivalent to the existing lease rental payments and "capital repayment element" of annual payments. The implications of these changes are reflected in the Council's MRP policy for 2016/17.

The policy recommended for adoption from 1 April 2016 retains the key elements of the policy previously approved including provisions regarding PFI, closed landfill, and finance leases. The policy for 2016/17 is therefore as follows:-

For capital expenditure incurred before 1 April 2008 or which in the future will be Supported Capital Expenditure, the MRP policy will be:

- Based on based on the non-housing CFR, i.e., The Council currently set aside a Minimum Repayment Provision based on basic MRP of 4% each year to pay for past capital expenditure and to reduce its CFR.

From 1 April 2008 for all unsupported borrowing the MRP policy will be:

- Asset Life Method – MRP will be based on the estimated life of the assets, in accordance with the proposed regulations (this option will be applied for any expenditure capitalised under a Capitalisation Direction).

- Asset Life Method (annuity method) The Council will also be adopting the annuity method, - MRP calculated according to the flow of benefits from the asset, and where the principal repayments increase over the life of the asset. The policy is being adopted as a result of any PFI's, closed landfill, and finance lease assets coming on the balance sheet and any related MRP will be equivalent to the "capital repayment element" of the annual service charge payable to the PFI Operator and for finance leases, MRP will also be equivalent to the "capital repayment (principal) element" of the annual rental payable under the lease agreement.

Under both methods, the Council has the option to charge more than the statutory MRP each year through a Voluntary Revenue Provision (VRP).

In view of the variety of different types of capital expenditure incurred by the Council, which is not in all cases capable of being related to an individual asset, asset lives will be assessed on a basis which most reasonably reflects the anticipated period of benefit that arises from the expenditure. Also whatever type of expenditure is involved, it will be grouped together in a manner which reflects the nature of the main component of expenditure.

This approach also allows the Council to defer the introduction of an MRP charge for new capital projects/land purchases until the year after the new asset becomes operational rather than in the year borrowing is required to finance the capital spending. This approach is beneficial for projects that take more than one year to complete and is therefore included as part of the MRP policy.

A review of the Council's MRP Policy will be undertaken and reported to Members as part of the Treasury Management Strategy report for 2017/18 in February 2017.

**Annex 1**