Manchester City Council
Report for Resolution

Report to: Executive – 8 February 2017
Resources and Governance Scrutiny - 20 February 2017

Central Clinical Commissioning Group Board – January 2017
North Clinical Commissioning Group Board – January 2017
South Clinical Commissioning Group Board – January 2017

Subject: Locality Plan – Financial Report – Closing the Funding Gap 2017/21, Update: Three Year Budget Strategy 2017-20

Report of: Joint Director Health and Social Care Integration
City Treasurer, Chief Finance Officer, Manchester Clinical Commissioning Groups

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Summary

This report proposes the approach to be taken across health and social care organisations in Manchester to improve health and social care outcomes for residents, by radically transforming the health and social care system, and in the process aim to close the 'do nothing' funding gap of £134m that will materialise by 2021. Whilst the strategy being developed was perceived to close the gap, the failure of the Local Government Finance Settlement to recognise the growing pressures on social care and the impact of the NHS settlement and tariff changes has meant that the level of progress to closing the gap will not be as envisaged and without additional funding for social care, will not be achieved. There is a responsibility to ensure that the position is affordable and work is underway to bridge the remaining gap in order that a final balanced budget for the Council and Clinical Commissioning Groups can be presented for approval to the Council and Clinical Commissioning Group Boards.

As a joint report, it will be presented to the City Council's Executive and each of the Clinical Commissioning Group's Boards.

Recommendations

The Executive is recommended to approve the final proposals in this report and that these are included in the budget to Council.

Wards Affected: All

Manchester Strategy outcomes	Summary of the contribution to the strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	Supporting the Corporate Core in driving forward the growth agenda with a particular focus on integrated commissioning and delivery which will focus on utilising available resources effectively and developing a diversity of providers including entrepreneurs and social enterprises. This will provide opportunities for local jobs
A highly skilled city: world class and home grown talent sustaining the city's economic success	Integrated commissioning will focus on utilising available resources to connect local people to education and employment opportunities, promoting independence and reducing worklessness. Working with schools to engage and support our communities.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	The focus is on changing behaviours to promote independence, early intervention and prevention, the development of evidence-based interventions to inform new delivery models integration with partners where appropriate.
A liveable and low carbon city: a destination of choice to live, visit, work	Development of integrated health and social care models and local commissioning arrangements that connect services and evidence-based interventions to local people and enable families and their workers to influence commissioning decisions aligned to locally identified needs. Schools as community hubs playing an essential role in reaching out to communities and leading early intervention and prevention approaches at a local level
A connected city: world class infrastructure and connectivity to drive growth	N/A

Full details are in the body of the report, along with any implications for

- Equal Opportunities Policy
- Risk Management
- Legal Considerations

Financial Consequences - Revenue

The proposals set out in this report form part of the revenue budget submitted to the Executive on 8 February 2017.

Financial Consequences - Capital

There are no capital consequences arsing specifically from this report.

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

GM Strategic Plan – Taking Charge of Our Health and Social Care
Manchester Locality Plan
Locality Plan – Financial Report – Closing the Funding Gap 2017/21 Executive October 2016

1.0. Introduction and Background

1.1. This report is the accompanying budget strategy to the Locality Plan: closing the funding gap 2017/21 report considered by the Executive and the Manchester Clinical Commissioning Group (MCCG) Boards between October – November 2016. It provides further information on the specific proposals to close the financial gap reported for the health and care system and should be read in the context of steps being taken to remodel the health and care system in Manchester through investment and reform which aims to secure improvements in health and care outcomes for residents and financial sustainability for the system by 2021.

1.2. Following six years of challenging austerity measures, social care is now being severely stress tested nationwide. Coupled with the level of demand and expectations on the health service and the requirement to deliver £22bn of health efficiencies there are significant financial and clinical challenges, which for Manchester is set down in the Locality Plan in terms of a 'do-nothing' £134m financial gap over the five years 2016-21.

1.3. The severe pressures across health and social care system and particular issues with pressures in social care are national issues and well documented. Alongside reduced social care budgets, across the country older people are living longer as well as younger people with disabilities and there are escalating levels of acuity and complexity of needs, including dementia. This is not just a Manchester problem, nationally, adult social care cannot realistically continue in the way it is organised now into the foreseeable future. 2016/17 was the last year the Council and MCCGs could undertake independent financial planning and 2017-20 is fundamentally a **'one system'** approach with the strategic direction described in the Locality Plan (three pillars), jointly agreed transformation investment priorities, a pooled fund and care models which have been developed in partnership.

1.4. This report is primarily focused on the commissioners' component of the financial challenge.

2.0. Financial Challenge

2.1. At a locality level and based upon 2016/17 opening budgets, Manchester spends a total of £1.137bn on health and social care services, excluding specialist services. This includes circa £907m on adults' health and care, £119m on children's health and care and £111m on the other services. Spending is projected to increase to £1.204bn by 2020/21. Of note, £57m of City Council services relating primarily to children's social care and safeguarding has been deemed out of scope from the Locality Plan reform pillars, leaving £1.080bn in scope.

2.2. Financial modelling has been undertaken to calculate a five year health and care financial plan for Manchester for the years 2016/17 to 2020/21 which is detailed in the Locality Plan. Taking account of pressures and demographic changes over the period, together with the estimated changes in resources for

health and social care, the whole economy 'do nothing' gap rises from £47m 2017/18 to £134m 2020/21. This position also assumes full delivery of 2016/17 efficiency requirements (which if undelivered, will increase future savings requirements). The financial gap across 2016/17 to 2020/21, by partner, is shown in the table below. The £66m pressure shown for acute providers reflects a share for Manchester.

2.3. The acute providers' total gap over the same period is estimated to be £211m, i.e. £145m greater than the value assumed in the Manchester Locality Plan. This reflects the non-Manchester element of acute provider business. The City Council element is further analysed between in and out of scope for the Locality Plan.

	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000	Total £'000
Manchester City Council						
- In Scope		17,980	6,534	2,550	4,635	31,699
- Out of Scope		4,279	3,515	3,575	3,368	14,737
CCG's	-11,104	13,381	11,146	12,863	-5,101	21,185
Acute Providers	11,618	11,613	14,134	16,634	11,912	65,911
	514	**47,253**	**35,329**	**35,622**	**14,814**	**133,532**

2.4. This report is focused on the commissioners' efficiency plans against the above target. Further work is required to establish the system wide implications of the plans in terms of 'cashability', particularly in relation to the targeted activity reductions, enabled through the development of new models of care supported by the Greater Manchester Transformation Fund. Clearly if deflections away from the acute sector are successful at scale, the flexibility for acute providers to exit from their existing cost base will become a key consideration requiring significant work.

2.5. The element of the above table which represents the three year <u>commissioner</u> savings target in scope for this report is as follow:

	2017/18 £'000	2018/19 £'000	2019/20 £'000	Total £'000
Manchester City Council				
- In Scope	17,980	6,534	2,550	27,064
CCG's	13,381	11,146	12,863	37,390
	31,361	**17,680**	**15,413**	**64,454**

Note the financial information contained in the above tables reflects the financial model in the Locality Plan.

2.6. The critical assumptions in the financial strategy include:

<u>City Council</u>

The above incorporated the following additional financial resources and budget pressures:

(i) A share of the overall funding reductions faced by the Council (GM local authorities are facing an average reduction of 29% in their funding available over the current Spending Review period) alongside the additional resources which have been identified for social care as follows:

- Improved Better Care Fund (IBCF) of £3.3m for 2017/18, £14.8m for 2018/19 and £24.4m for 2019/20. Whilst announced as additional funding, £800m of the national £1.5bn IBCF total is met from reductions to other grants received by local authorities, namely the New Homes Bonus (NHB); and

- The 2% additional social care precept per annum. 2% is worth £2.67m in 2017/18.

The profile of the Council reductions reflects the front loading of the reductions to Revenue Support Grant and back loading of the additional funding for social care via the Improved Better Care Fund.

(ii) Provision for the Council's estimated costs of inflation, the costs of implementing the National Living Wage and provision for the additional costs of demographic growth as set out in the table below.

Budgeted Pressures for Adult Social Care 2017/18 to 2019/20

	2017/18 £'000	**2018/19 £'000**	**2019/20 £'000**	**Total £'000**
Apportionment of pay and non pay inflation	2,522	1,977	1,990	6,489
National Living Wage costs for commissioned services	4,258	4,258	4,258	12,774
Demographic pressures	5,585	2,585	2,585	10,755
Total	**12,365**	**8,820**	**8,833**	**30,018**

Manchester Clinical Commissioning Groups

i) CCG allocations remain in line with sums (notified and indicative) outlined in NHS England's planning guidance of December 2015.

ii) Expenditure growth remains in line with agreed locality plan assumptions, inclusive of demographic and non-demographic pressures. Whilst assumptions will be reviewed and re-confirmed for the January 2017 locality plan update, the most material anticipated change relates to the introduction of the new 'National Tariff' (known as 'HRG4+') from 2017/18 (i.e. the payment and pricing structure for remunerating acute care providers for hospital activity), which was not foreseen, nor included, in the original financial model to 2020/21. This

impact could be in the region of £4.3m. Material additional efficiencies will be required if no further recurrent allocations are provided by NHSE.

iii) Delivery of all 'business rules' in each year to 2020/21 (including surpluses and contingencies), as required by NHS planning guidance.

iv) NHS providers are facing unprecedented financial pressures. Planning for contractual agreements in this context inevitably leads to challenges as providers seek to safeguard services to deliver quality patient care, whilst commissioners strive to agree affordable quanta, inclusive of the impact of strategic change programmes over time. The NHS contracting and planning round for 2017-2019 has concluded, three months earlier than ever required. Final agreements and financial decisions will be reflected in the updated locality plan – for both providers and commissioners – in January 2017, and are expected to have an impact on the values included in paragraph 2.2.

2.7. Updated City Council Position

The City Council's in-year budget position on Adult Social Care is increasingly challenging. This alongside future demographic projections and the financial settlement information received 15th December, have necessitated a significant reconsideration of expectations on the potential of the integrated health and social care system to deliver savings in line with the profile in table 2.5 above.

The Local Government Finance Settlement

In the lead up to the Finance Settlement there was considerable speculation that there would be additional funding for social care. However the announcement contained no additional funding for social care for Manchester and over the three year period the Council is £1.2m worse off. The main changes are as follows:

- The core principle of an additional social care council tax precept of 2% a year will continue to apply but with the added flexibility that the social care precept can be increased by up to 3% in 2017/18 and 2018/19 although the 6% over three years cannot be exceeded. If the Council decides to do this the Council tax increase will be 4.99% in 2017/18 and 2018/19. Whilst the extra 1% will generate additional income in 2017/18 and 2018/19 this is only bringing forward, rather than adding to, the level of resources available;

	2017/18 £'000	**2018/19 £'000**	**2019/20 £'000**
Additional 2% for Social Care	2,659	2,773	2,891
Additional 3% for Social Care	3,988	4,292	0
Variation	**1,329**	**1,519**	**-2,891**

- There is an additional one off adult social care grant of £240m nationally of which Manchester will receive £2.7m. The New Homes Bonus Grant will be reduced nationally by £240m to fund the Social Care Grant. The Council will lose more funding in NHB than it gains for social care with a net impact of a reduction of £0.907m in 2017/18; and

- It is also worth noting that the Public Health Grant reduces in line with the figures published last year, which reflect a cash reduction of 9.6% in addition to the £200 million of savings that were announced in 2015/16. The savings are phased in at 2.2% in 2016/17, 2.5% in 2017/18 and 2.6% in each of the following two years. As part of 100% business rates pilot the grant will be excluded from the grant conditions.

Increasing Demographic Pressures

There are significant pressures on social care budgets. The full detail is set out in the Adult Social Care report elsewhere on the agenda. In summary they relate to:

- The full year effect costs of placements for people with Learning Disabilities alongside an increased allowance for new demand for people transitioning from Children's Services as well as adults whose parents are no longer able to cope with their care. It should be noted that the full year effect cost of the care for those transferring out of Calderstones as a result of the Winterbourne View judgement is c£3.5m. It has been assumed that this will be covered by associated dowry payments from the NHS;

- The rising demand for home care, with the number of commissioned hours rising by almost 23% between April 2015 and October 2016 with a rising underlying level of demand that needs to be recognised to avoid putting unsustainable pressure on the whole health and social care system; and

- The continued demand for placements for people with mental health needs, including for older people with dementia and supporting people who are homeless. These costs are in line with those previously allowed for.

Budgeted Pressures for Adult Social Care 2017/18 to 2019/20

	2017/18 £'000	**2018/19 £'000**	**2019/20 £'000**	**Total £'000**
Apportionment of pay and non pay inflation	2,522	1,977	1,990	6,489
National Living Wage costs for commissioned services	4,258	4,258	4,258	12,774
Demographic pressures	5,585	2,585	2,585	10,755
Total	**12,365**	**8,820**	**8,833**	**30,018**
Additional Demographic Pressures	4,676	69	69	4,814
Total	**17,041**	**8,889**	**8,902**	**34,832**

The above will bring an increase in the total demographic pressures in 2017/18 from £5.585m to £10.261m and a total of £15.569m by 2019/20 rather than the £10.755m originally allowed for. These additional pressures alongside the lack of any additional funding in the settlement threaten to put the locality plan into an unsustainable position and pose serious questions as to whether it is realistic for the £17.980m social care financial gap to be closed in 2017/18.

Unless there is a change to the funding of social care nationally, this level of savings will ultimately have to be achieved to put the health and social care economy onto a sustainable footing. However, implementing significant cuts in Council spend will not help if all that happens is people are at risk staying in hospitals longer than necessary. Research demonstrates that every £1 cut in social care creates a 35p pressure for the NHS. Unless the development of new care models is accelerated there will continue to be an over spend and the system impacts will worsen. This places increasing importance on delivering the service change and transformation set out in this report.

2.8. In the light of the above, the Council is proposing to establish a realistic level of funding to contribute to the pooled budget and is proposing to close part of the locality plan gap through the additional input of Council resources. This will include using the 3% council tax social care precept increase to support adult social care in the first two years.

2.9. The table below sets out the additional resources that the Council is contributing to support the closure of the locality plan gap. The table highlights a net reduction from the £27.064m gap /savings target across the three years reduced by £8.304m in 2017/18 rising to £10.250m 2019/20. In order to achieve this will cost the Council an additional £12.980m in 2017/18 rising to £15.064m in 2019/20 as the additional pressures included were not originally budgeted for.

	2017/18 **£'000**	**2018/19** **£'000**	**2019/20** **£'000**	**Total** **£'000**
Locality Plan Target /Council Savings Target	**17,980**	**6,534**	**2,550**	**27,064**
Proposed City Council Target	5,000	3,000	4,000	12,000
Reduction In Target	-12,980	-3,534	1,450	-15,064
Add Additional ASC Pressures	4,676	69	69	4,814
Net Reduction	-8,304	-3,465	1,519	-10,250
Revised Social Care Locality Plan Gap /Savings Target	**9,676**	**3,069**	**4,069**	**16,814**

2.10. The core level of funding, or 'social care expenditure limit' which the Council would look to contribute to the health and social care pooled budget is set out in the table below (excludes Public Health). The aim is to transparently set out the funding for pressures being addressed and the additional funding allocated to reduce the overall Locality Plan financial gap.

	2017/18 £m	2018/19 £m	2019/20 £m
Base Budget	**157.69**	**156.63**	**154.81**
Apportionment of pay and non pay inflation	2.52	4.50	6.49
National Living Wage costs for commissioned services	4.26	8.52	12.77
Demographic pressures	10.26	12.91	15.57
Sub Total Additional Funding	17.04	25.93	34.83
Sub Total Contribution	**174.73**	**182.56**	**189.64**
Savings Target met from Local	-5.00	-8.00	-12.00
Add Additional Social Care Pressures	-4.68	-4.75	-4.82
Total Savings Requirement	-9.68	-12.75	-16.82
Total Pooled Budget Contribution	**165.05**	**169.81**	**172.82**
Net Increase to Contribution	**7.36**	**13.18**	**18.01**
Year on Year change		**5.82**	**4.83**

It should be noted that whilst it is expected the pool will deliver savings of £17m by the end of the three years, the contribution includes gross £34.8m additional investment into adult social care and a net addition of £18m once the savings target has been taken into account.

2.11. Updated MCCGs Position

The financial information contained in the above tables reflects the financial model in the Locality Plan, which was created at a point in time. As plans have developed / NHS planning guidance issued, these numbers have been refined. The changes for 2017/18 in relation to the CCGs are summarised below:

	2017/18 £'000	2018/19 £'000	2019/20 £'000	Total £'000
MCCG's	13,381	11,146	12,863	37,390
Revisions arising from NHS Planning Guidance	1,708	0	0	1,708
	15,089	**11,146**	**12,863**	**39,098**

2.12. The update to the three year commissioner savings target in scope for this report, following the above updated is as follows:

	2017/18 £'000	2018/19 £'000	2019/20 £'000	Total £'000
Locality Plan Target	31,361	17,680	15,413	**64,454**
City Council Revisions	-8,304	-3,465	1,519	**-10,250**
MCCG's Revisions	1,708	0	0	**1,708**
Revised Target	**24,765**	**14,215**	**16,932**	**55,912**

3.0. Key Enablers

3.1. One Finance System

Since 2015/16, the City Council and Manchester Clinical Commissioning Groups have operated a pooled fund, under a Section 75 agreement, to hold minimum mandated Better Care Fund (BCF) resources (2015/16: £38.586m revenue). From 2016/17, the pooled fund was expanded to include budgets covering the deemed scope of 'One Team' (Neighbourhood teams, Intermediate care and Re-ablement), increasing the recurrent revenue resources to £80.047m. The intention to expand the pooled fund substantially from 2017/18 is considered a key enabler to fully integrating health and social care. This is because a joint pool is more likely to encourage system-wide financial decisions, with a joint focus upon closing the funding gap and provides the mechanism for funding to flow around the whole health and social care system.

The work on developing the pooled fund agreement is underway and critically will include the development of risk and benefits share agreements on overspends and in relation to savings, respectively. Fundamentally, commissioners' strategy, derived from national integration policy, to is to facilitate a change in funding flows from more acute based care into lower cost community provision, reshaping the cost base of the proposed Local Care Organisation and to sustain the investment in new care models. This will be managed across the system, recognising the need for sustainable acute service post-community reform.

3.2. Transformation Fund Investment

Securing investment in new service models and the delivery of a reformed health and care system is currently underway with the evaluation of Manchester's submission for substantial transformation funding being undertaken throughout December and into the New Year. Investment is required to enable the whole health and care system to act more effectively and efficiently and will be key to levering the remodelling of the system that is required to improve health and care outcomes and close the funding gap.

Within the context of integrated health and care services within the community, investment is sought to support a strengthened approach to prevention, wellbeing and self-care; to secure a strengthened and a standardised offer of care support for all communities across the City through integrated neighbourhood teams; supporting people to be independent and live in their own homes and communities for longer; and improving access to appropriate services, to prevent recourse to costly acute sector support ahead of when it is needed.

The Transformation Fund provides the opportunity to enhance the developing neighbourhood teams. This will strengthen our community based infrastructure, through standardisation, and consistency in service provision. It equally enables our system to connect people, services and local assets through non traditional services delivered by non statutory organisations

3.3. Workforce and Organisational Development

The level of reform required to deliver the savings needed is dependent upon a significant cultural shift for staff right across the health and social care system which will drive new ways of working. Staff will come together to work in integrated teams which focus first and foremost on the person in the context of their family, community and neighbourhood rather than presenting issues or conditions. The ability of staff to work in an agile way within neighbourhoods which connect people to a diverse range of community based support and which enables people to take more responsibility for their own health and well-being, to self-care more and for longer and to access care when they need it closer to home are key. Equipping staff with evidence of what works will promote evidence-driven ways of working, connecting front-line practice to commissioning decisions will drive intelligence-lead commissioning and equipping staff to work in strength-based ways which start from the point of "what matters to you" rather than "what is the matter with you" will transform the relationship between professionals and service users and patients.

Alongside this, as new organisational models are formed, staff will be brought together to work in integrated teams that cross professional and organisational boundaries. There will be significant opportunities to learn new skills, benefit from new career pathways and to move around the system in a much more agile way to access new jobs and new opportunities.

The scale of change for staff should not be underestimated. It will be essential to ensure that there is strong engagement with staff so they understand the changes that are happening and just as importantly, bring their experiences and expertise to help to shape the design of new ways of working. Investment in change programmes and organisational development will be critical to achieving and embedding these changes which will not happen through organisational redesign alone. This work has now begun for staff whom are impacted by the development of the single commissioning function. A comprehensive programme of staff engagement is in place and the outputs from this are being utilised to help shape the vision, values and behaviours for the new commissioning function and to inform the design of the change management programme. The next phase of engagement will connect staff to the co-design of new commissioning function arrangements and the design of new care models. Important learning is already emerging from this work which will be applicable across the broader locality workforce plan.

3.4. ICT

ICT is a key enabler to delivering joined up health and social care.

Work is on going to implement an integrated ICT solution for the day to day operation of the 12 Integrated Neighbourhood Teams to ensure staff can plug back into the system when they have been working in the community using mobile technology. This includes things like access to their own systems to record and update case files and shared printing. Health and Social care

systems are being updated and mobile working is being rolled out to staff who will be working in the community.

A new online portal for service users will be available in Spring which will enable people to complete online self assessments and signpost them to local community assets

There is a wider strategic options appraisal underway to agree the way forward for sharing records across the partners. This includes the use of the Manchester Care Record and its connectivity to Manchester providers and the wider GM systems.

3.5. Estates

Facilities that provide an appropriate and well maintained environment in which co-located teams can work together and hold multi-disciplinary team meetings enable the full benefits of integration to be realised.

Across health and social care, there are currently a significant number of community facilities. The majority of them are older, shared buildings which are often cramped, however, there are a fewer number of relatively new builds and larger buildings that can be used to create an environment for health and care integrated teams to work in. This has been recognised within the Manchester Strategic Estates Plan that has recently been agreed, and as a result an implementation plan is in place which maximises the available facilities in preparation for the integrated teams.

Twelve existing health and social care buildings have been identified as locality bases for the teams and planning is underway to prepare them. The preparation of the first building which is in the central locality is complete and staff are fully co-located there, and in a further building in the north there is a team that is partially co-located.

In addition, there are strategic estates plans in development for larger and more wide ranging accommodation for integration that would include housing partners and other public sector partners. Examples of these include developing plans for a new build in Gorton, in addition to developments of existing sites in North Manchester General and Withington Community Hospital.

3.6. Investment in Early Help Underpinned by the ‘Our Manchester’ Approach

The vision for Early Help extends to families and working age adults as well as older adults. It is critical that there is investment into services which provide more upstream intervention to prevent the need for more reactive expensive care either in residential, nursing or acute hospital beds and deflect the need for more expensive interventions at several touch points in some ones life. The focus needs to be on self and personalised care maximising the strengths of citizens and their community assets, to enable citizens to do more for themselves, intervene earlier, particularly with those cohorts that do not meet

statutory thresholds but have complex lives and are at risk of requiring high cost packages of care e.g. to prevent unnecessary hospital admissions or delay admission into residential or nursing care. Through a key worker approach Early Help for Adults enables citizens to navigate and access the right services at the right time avoiding higher cost interventions.

The current model of adult social work is based on a traditional model of care assessment, purchasing and delivery of services. The financial challenges faced are compounded by this over dependence on a system of state service provision. To implement change, radical review and innovation is required. The new model, underpinned by the 'Our Manchester' approach, will integrate a strengthened front door and triage function with clear pathways to integrated Early Help hubs and Integrated Neighbourhood Teams. This will be for more complex cases and provide opportunities to deflect demand at each level of interaction. The population group is those of 'rising risk' and work with adults with health and social care needs at an earlier stage, working with families to identify needs whilst taking a strength based approach to encourage self care and tailoring support around citizens, their family and community.

This ability to build relationships and engage with all citizen groups enables social workers to use their specialist skills in supporting families to support themselves. This is crucial in reducing demand for services across adults and children's services.

4.0. Approach to Securing Financial Sustainability

4.1. Developing the savings plan to deliver a financially sustainable health and social care system has needed recognition of emerging components from the transformational programme, i.e. the creation and expectations of the Single Commissioning Function and Local Care Organisation; the work on GM models of care for home care and residential and nursing care and the fundamental importance of the GM transformation fund bid; and a new joint approach to business as usual arrangements used to delivering savings options through efficiencies, redesign and joint commissioning arrangements.

4.2. The scale of the challenge is unprecedented and as such, making progress has been difficult. Whilst acknowledging that the overall strategy and one system is the right way, it is complicated and constrained by organisational history and culture, differing financial rules and regulations, an understandable hesitance to accept additional financial risk and in particular, the substantial pressures on Adult Social Care.

4.3. This report is a staging post, work on finalising the three year savings programme will continue into 2017 and this recognises there may be further consultation requirements and implementation of some areas mid-year with the consequent part year affect. Critically, at this stage there are no proposals which reduce the service offer.

4.4. The Adult Social Care Directorate Budget report, elsewhere on the agenda, includes substantial proposals to address the budget pressures experienced in

2016/17 following it becoming clear that the 2016/17 budget insufficiently recognised demographic pressures and to include more sophisticated forecasting for the three year budget 2017-20. These proposals bring the Adult Social Care budget onto a more stable footing prior to inclusion in the pooled fund from 2017/18.

5.0. Change Programme

5.1. 2% Efficiency Targets on Providers

The submission to GM for Transformation Funding included a commitment to a core budget assumption of a requirement for providers to achieve a 2% business as usual efficiency target over the three year plan, as summarised in the table below.

Area	2017/18 £'000	2018/19 £'000	2019/20 £'000	Total £'000
Acute Providers	10,724	10,724	10,724	32,172
Other Providers	5,694	5,886	6,000	17,580
Total	**16,418**	**16,610**	**16,724**	**49,752**

The Acute Provider target above will contribute towards the Acute Providers element of the financial gap, out of scope from this report as detailed at section 2.3. The Other Provider target has been incorporated but only from 2018/19 predicated on the timetable for development and full implementation of new delivery models across GM.

Transformation

5.2. Local Care Organisation

Commissioners and Providers worked together in summer 2016, with support from PWC, to develop an overall architecture for the emerging models of care required to be delivered through a Local Care Organisation (LCO). During a series of workshops a model was agreed that shows how the various services and providers come together to deliver the new models of care in a coordinated way across Manchester. This organisational architecture is at **Appendix 1**.

At the same time, a number of proposals were produced to indicate how, with investment, various parts of the model could be developed and rolled out across the City to standardise the provision of care.

The bids, totalling circa £60m, formed the basis of Manchester's GM Transformation Fund submission for out of hospital care. It was recognised that review, further detailed business planning and prioritisation would be required to assess the feasibility of each potential proposal and alignment with the care models, Cost Benefit Analysis (CBA) and overall affordability levels.

An initial review of the bids was conducted with involvement from a range of partners, against a set of criteria, agreed by the Executive finance group of the Manchester Transformation Fund Accountability Board on 11 November 2016. Work has been done more recently to cluster key investment bids around the two primary cohorts – Adults with long term conditions and Frail elderly – and to consider the delivery of associated financial benefits. Consideration was given to:

- Which proposals might make the biggest efficiency impact year 2017/18. (e.g. based upon previous pilots or other evidence)
- Which are evidence based
- Which could it be scaled up at pace
- Which could be implemented and delivered promptly for 2017/18 or 2018/19

This approach serves to provide assurance that the system is ready to transform and innovate 'as one' and to draw down the investment from the GM Transformation Fund in line with an agreed strategy to support investment in community services to improve outcomes for people and contribute to the wider financial sustainability of the system. The proposed prioritisation of the investment bids from a commissioner perspective is set out in Table 1.

Table 1 Proposed prioritisation of investment requests.

Front Door			
Start	**2017/18**	**2018/19**	**2019/20**
Q1	• Primary care referral pathways (GPSIs)		
Q2	• Enhanced Contact Officer Roles • Assistive Technology		

Neighbourhood Teams			
Start	**2017/18**	**2018/19**	**2019/20**
Q1	• Carers' support	• Palliative Care	
Q2	• Reablement • Community Urgent Care		
Q4	• Extra Care		

Acute Discharge			
Start	**2017/18**	**2018/19**	**2019/20**
Q1	• Home from Hospital		

High Impact Primary Care			
Start	**2017/18**	**2018/19**	**2019/20**
Q1	• Enhanced GP appointments		
Q3	• Specialist clinical input		

Locality Delivery			
Start	**2017/18**	**2018/19**	**2019/20**
Q1	• 7 Day GP Access • Housing Options for Older People	• Community connectors	
Q2	• Early Help Hubs • Homecare Residential and Nursing Care		

The model is based on the following key elements:

- An Enhanced Front Door. (EFD)
- A High Impact Primary Care Offer (HIPC)
- 12 Integrated Neighbourhood Teams (INTs)
- Locality and citywide services
- Acute Discharge

Underpinned with a number of key enablers such as shared ICT systems, a significant focus on workforce and a shared estate (see section 3 above).

Enhanced Front Door

Social care referrals and referrals from Primary Care to Social Care are managed through a recently improved and streamlined contact centre. In line with requirements of the new Care Act, further development work is underway to develop a Citizen's Portal to enable online self assessment, purchase of services through an e-marketplace and the development of e-financial accounts. The intention is to develop this into a wider Virtual Front Door across health and social care.

The evidence base from Calderdale shows that by adding some enhanced contact officer roles at the front door, up to 70% of requests and referrals can be dealt with, triaged and managed away from the High Impact primary Care Teams (HIPC) and Integrated neighbourhood Teams (INTs). When equipment and assistive technology is added to the mix, the potential to manage and reduce demand through an enhanced front door is increased further.

High Impact Primary Care offer

Recent data analysis of the registered population in Manchester shows that there are approximately 11,000 people who are living with frailty and other long term conditions who are considered to be at relatively high risk of an unplanned hospital admission. Currently the quality and access to health and care services is too reactive, variable and too many people end up in hospital based services for episodic care.

Evidence from around the world shows pro-active intensive primary care led support for older people with frailty and other long term conditions shows a significant reduction in admissions to hospital, out patient attendances and better patient satisfaction.

The High Impact Primary Care (HIPC) offer will establish dedicated and co-located multi-disciplinary teams, led by general practice. The team will work with neighbourhood health and care colleagues to case find those people in the local area who are recognised as frail and / or living with complex long term conditions and who are at risk of hospital admissions and delayed transfers of care. The HIPC team will proactively support people identified through assignment of key workers, establishment and implementation of patient and carer led care plans. Each HIPC team will support c1000 patients with pro-active care meetings on a monthly basis with each person being supported through this service. Local delivery of clinical, mental and social care services will be supported by rapid access to specialist advice, diagnostics and opinion from the wider health and care system.

Integrated Neighbourhood Teams

The Integrated Neighbourhood Team development to date has focussed primarily on the integration of Social Care staff including, Social Work and Primary Assessors, District Nursing, ACMs, Reablement and Intermediate Care. The teams will be using the multidisciplinary case. management method piloted successfully in the city over the last two years.

Some examples of the core offer are include, but are not limited to:

- Single Trusted Assessment;
- Person-Centred care using the strength based approach focusing on what each individual wants to achieve;
- Personalised and Collaborative Care Planning; and
- Multi-specialty decision making to reduce unnecessary duplication and patient hand-offs.

All 12 Integrated Neighbourhood Teams will have gone live by April 2017 and be focussed on reducing acute readmissions, reducing reliance on emergency social care services and reducing duplication and hand-offs. Work has already begun with Primary Care colleagues to integrate with the Integrated Neighbourhood Teams to help manage demand on higher acuity services.

Locality and Community Services

The model also recognises the importance of locality based deflection teams such as intermediate care, urgent community response services and reablement and proposes some enhanced new services such as reablement for people with complex needs and a citywide discharge to assess model. There is evidence of excellent practice that has been tested in pockets of the City and this now needs standardising across the City and rolling out City-wide. Examples include the work with Care Homes in the South, the new integrated Community Assessment and Support Service (CASS) in the North and the potential to create a single citywide community intravenous therapy team.

The role of the primary care, voluntary and community sector, the use of local community networks and assets and the wider Our Manchester approach are

vital components of the new whole system approach, e.g. a Home from Hospital Service and a new model for Homecare.

Acute Discharge

The three Manchester CCGs already commission a post discharge support service where patients are contacted by telephone to ensure they are safe and well. In North Manchester, this offer has been increased to include an enhanced offer to patients to take them home, ensure the house is warm, prepare a meal and take medication. The service links closely with health and social care services. It is proposed to extend this across the City. The service, available 7 days a week would take home approx 4-5 patients per day, per site and the impact is expected to increase the number of patients whose discharge is safe and effective and reduce the no of patients being readmitted to hospital.

Financial Sustainability

The LCO is expected to contribute £49m to the savings required in Manchester's health and social care system over the period to 2020/21, including £37.6m by 2019/20.

In the October 2016 LCO Prospectus, this was estimated to include, by 2020/21:

- £19.7m from 2% per annum of efficiency savings from the health and care services in scope of the LCO.
- £11.4m from Cost Benefit Analysis work undertaken as part of Manchester's bid to the GM Transformation Fund. This bid to GM requests £49m to fund one-off and double-running costs from implementing new models of care. The CBA shows how this investment should lead to reductions in demand for acute activity (A&E attendances, Outpatient appointments, Elective and Non-Elective admissions, Acute length of stay), Prescribing and Social Care.

The CBA was initially based on five key population cohorts that place a disproportionately high demand on acute activity. These cohorts will be the initial focus for the new models of care involved in implementing the LCO. There are also prevention cohorts for adults and children with significant medium-term risks.

The CBA has recently been updated to include the High Impact Primary Care model for the 2% of patients creating the greatest demand, and how this will make a more positive impact on reducing their levels of acute activity. Also, revised phasing of the implementation, with 2017/18 to start with the two cohorts of frail older people and adults with multiple long term conditions, and the remaining five cohorts in 2018/19.

The CBA considers how the LCO activity will improve a set of outcome metrics that will lead to activity reductions in the areas outlined above. These have

been tested by clinicians and system leaders for being both achievable and ambitious. The assumptions are compared to a 'do nothing' scenario and reduced for 'optimism bias' to account for the general tendency of modelling assumptions to be overly optimistic.

The CBA has then been further adjusted to show:

- Commissioner tariff savings – the numbers below represent the savings that Commissioners can make from reduced tariff payments to providers as activity reduces.

- Cashability - It is recognised that Providers will not be able to immediately reduce fixed cost elements. Further work is needed to refine and understand the cashable savings that providers can make and the resulting implications for the system. These numbers are not shown below.

The CBA also shows the proportion of savings that would be needed to be retained for reinvestment, rather than cashed. The reinvestment element would be used to sustain the new models of care beyond the period for which Manchester is bidding to GM for funding. This was originally set to 50% in each year but has now been adjusted to ramp up more gradually, with no savings now set aside for reinvestment in 2017/18.

The CBA has also been updated to review the costs of each proposal to:

- eliminate duplication;
- manage overall spending within affordable sums;
- apply assumptions about likely start dates based upon experience of implementation plans (e.g. recruitment / procurement timescales, to show that some projects will realistically take longer to start); and
- de-prioritise some projects with lower impact in the earlier years.

The LCO CBA is being developed alongside the Single Hospital System CBA to show how these pillars of the plan are mutually dependent and to give assurance that the benefits will not be double-counted

The updated CBA benefits are shown below. The contribution this is estimated to make to closing the gap is now £15.9m by 2019/20.

	2017/18 £'000	**2018/19 £'000**	**2019/20 £'000**	**Total £'000**
CBA benefits	8,128	13,578	13,594	35,300
Commissioner tariff savings	3,648	9,430	10,327	23,405
Amount required for reinvestment	0	2,357	5,164	7,521
Contribution to the gap	**3,648**	**7,073**	**5,163**	**15,884**

5.3. Single Hospital Service

The Single Hospital Service (SHS) pillar of the Locality Plan will involve creating a new single acute provider organisation. This will require a complex

transaction to merge two Foundation Trusts (UHSM and CMFT) and then transfer a major service (NMGH) from a third Trust (Pennine Acute). A key milestone was the submission of a firm draft bid to the Competition and Markets Authority on 8 December for approval.

Detailed Benefits Analysis is now under way to show specifically how the savings will be generated, from a series of 14 clinical pathways such as cardiac, urology and women's health. Benefits are expected include improved efficiency, quality of care, patient experience, workforce development and research and innovation. This analysis will align with the CBA of the Local Care Organisation to show how the reductions in demand from transformation of out-of-hospital care will fit with a new model of in-hospital care for the patients that still require in-hospital care. The analysis will be completed by the end of January 2017. Of critical consideration, is the need to align cost and income reductions associated with hospital activity redirected to alternative community provision, as well as ensuring no double counting of benefits (e.g. through business as usual 2% per annum efficiencies and length of stay savings).

5.4. Single Commissioning Function Set up

As the first step to developing the Single Commissioning Function a joint application by the three CCGs has been submitted seeking approval from NHS England to merge to form a new Manchester CCG from April 2017. The NHSE assessment panel has considered the tests for merger in NHS England's guidance and the CCG Regulations. It has been determined that the requirements for authorisation as a new single CCG have been met, subject to the formal agreement of the GP memberships and Governing Bodies of the CCGs, and the submission of additional information such as the proposed constitution of the new CCG.

The new organisation will then form a partnership agreement with the City Council to create the Single Commissioning Function. Significant efficiencies will follow the creation of one CCG Board structure and through the development of a new joint commissioning establishment structure. The current 'As Is' cost is detailed in the table below. The CCG costs are inclusive of back office functions. The timetable to develop a new integrated establishment structure and Board arrangements is March 2017. In the interim, a £1m saving target is included for 2017/18. Developing single commissioning arrangements between the City Council and CCGs will create the opportunity for joint posts at a senior level, the opportunity to release budgets for currently vacant posts and create efficiencies relating to costs such as office accommodation.

Area	**Current Cost £'000**	**FTE**
CCG's	10,041	177.27
City Council: Commissioning	2,496	56.76
City Council: Public Health	2,169	36.36
	14,706	**270.39**

5.5. GM Model: Residential and Nursing Care and Homecare

Adult Social Care – Radical Reform at Scale and Pace represents a fundamental review across GM commissioned by Wider Leadership Team in April 2016. Developing a new model for residential and nursing care in GM is being hosted by the Strategic Director (ASC) City Council. Existing arrangements are no longer fit for purpose and typified by poor quality, poor outcomes, providers leaving the market and a lack of integration. There is considerable scope to improve consistency and quality in provision, creating opportunities for innovation and more collaborative working. Significant attention is being placed on the national 'Enhanced Care in Care Homes' framework, including learning from the six vanguard sites. This model is focused on:

(i) Providing joined up primary, community and secondary, social care to residents of care/ nursing homes and Extra Care Living Schemes (ECLS) via a range of in-reach services; and

(ii) To deliver person-centred integrated preventative care that promotes independence and supports individuals in an appropriate housing option of their choosing. Following a number of workshops, the intention is to develop a cost benefit analysis to invest in enhanced care model. It is expected this will take 3 months to develop and realistically any impact on the budget cannot be estimated at this stage but would be expected to impact from 2018/19.

Similarly, in respect of homecare, Trafford are leading on behalf of GM. In addition, the North West Directors of ASC have commissioned New Economy to develop a cost benefit analysis and full evidence review on new care models. Manchester has experienced some level of turbulence in the homecare market over the last 12 months. The strategy for 2017/18 is stabilisation ahead of future transformation. There is the specific opportunity to integrate health and social care commissioning of homecare as part of the contract renewal for 2017/18.

5.6. New Mental Health Provider

Greater Manchester West Foundation Trust is the preferred provider to take over mental health services currently provided by Manchester Mental Health and Social Care Trust. The plan is that this transaction will take place in 2016/17. The envisaged reforms to mental health services are expected to contribute a total of £4.9m savings by 2019/20 after netting off reinvestment requirements. In 2017/18, the expected realisation of savings is £0.155m.

Business As Usual

5.7. Joint Commissioning

A key savings workstream now operational is the development of an integrated approach to commissioning high cost packages of care or specific

provision types, eg. Home Care and to strengthen future joint planning of provision requirements. The City Council and CCG's currently separately commission from the same providers and through the integrated approach, expect to safely reduce placement/contract costs, determine and secure value for money and achieve a better matching of provision to needs to deliver improved outcomes. In the medium term, the work should inform the development of business cases to develop future care provision, intelligence led market development will increase sufficiency across the city, manage demand and ensure quality for all placements and reduce the number of placements outside the City. The approach should also ensure better contract management.

This is a significant undertaking with approximately £123m of contracts in scope. There are substantial data collection requirements to fully record existing placement information in a consistent database that allows analysis on numbers, levels of need/complexity into bandings, length of placements, use of spot or block payment arrangements etc.

The intent is a programme of contract reviews will emerge that will be undertaken over a period of time using the latest and best approach to contract negotiations from all existing Commissioner skills and experience. The structure of the programme will be completed by the end of January for onward implementation.

This programme will also critically link to work to improve the sophistication of demographics modelling and how this is used to set a strategy for a minimum 5 year commissioning strategy. In the interim, an indicative £1m saving target per annum 2017-20 has been included.

5.8. <u>Operational Plan shared 'Commissioning Plan' for the single health and care system</u>

Partners have developed an operational plan of schemes which reflect efficiencies, redesign and organising services differently, without impact on eligibility or the health and social care offer. The vast majority of proposals are health related schemes, responding to new pressures to manage demand within agreed resources whilst delivering the required 'business rules'.

The programme also reflects the scale of efficiencies that has already been released from adult social care since the implementation of austerity measures in 2010.

NHS 'Right Care' information (a benchmarking methodology which identifies areas of unwarranted variation) is underpinning this work by highlighting areas of opportunity to reduce variation, improve efficiency and quality and experience for patients.

The shared Operational Plan can be broadly summarised against delivering:

- Financial sustainability across the health and care system;

- Quality and performance requirements and improvements across the City; and
- Transformation – i.e. Years 2 and 3 of the Locality Plan.

Ultimately through the delivery of these elements, the Manchester Health and Care system should reduce health inequalities, improve health and wellbeing for the Manchester population and Manchester should become a more progressive and equitable city.

At this stage, proposals for 2017/18 are indicative, business case and implementation proposals are still to be developed. The 2017/18 proposals are:

(i) Medicines Optimisation (£3.780m)

The Medicines Optimisation programme focuses on two main themes:

- The optimisation of medicines, at the point of prescription issue (using script switch) and the targeting of specific medications to switch to more cost effective alternatives, in addition to targeting medicines waste.

- Developing effective joint working with other citywide leads to identify additional opportunities, targeting Long Term Condition, specifically Respiratory, Diabetes and Mental Health.

(ii) Reduction of Out of Area Placements for patients experiencing Mental Health Issues (£0.345m)

In 2016/17 there has been a programme of work which has resulted in patients who were receiving care out of area purchased through the spot placements being moved to Braeburn House on a block contract. The continuation of this scheme will realise savings for 2017/18.

(iii) Public Health (2017/18 £0.600m, 2018/19 £0.545m)

Wellbeing Service - The new Wellbeing Service, “buzz”, provided by the Manchester Mental Health and Social Care Trust (MMHSCT), has been re-modelled following the Council approved reductions in public health funding. The new service has been operational since 1 April 2016 following close working between public health commissioners and the provider to agree the detailed service model, specification and outcomes. The initial operation of the service has gone well with a successful official launch on 22nd November 2016, involving a wide range of representatives from stakeholder and partner organisations.

A key element of the new service is capacity building within communities via a network of neighbourhood health workers who will support the development of local capacity and infrastructure, linking with community groups. This function incorporates the staff of the

former MCC Zest Healthy Living Service which have been aligned with and managed by the new buzz service during 2016/17. This process has identified £0.140m efficiencies that will not impact on the frontline delivery of this service, vacant posts have not been filled as buzz staff will cover the responsibilities in the new citywide model. Furthermore North Manchester Clinical Commissioning Group has agreed to invest in extra capacity in the north of the city, pending final approval of the outline business case.

Sexual Health - Specialist sexual and reproductive health services were tendered during the autumn/winter of 2015/16 with new services mobilised on the 1st July 2016. The commissioning process included setting aside a contingency budget of £0.460m to offset any shortfall in the achieving the planned re-charges to other Greater Manchester local authorities. The re-charge process has been fully implemented successfully so this contingency is identified as an efficiency for 2017/18.

2018/19 (£0.545m)
Proposals cover efficiencies from primary care public health contracts (£0.345m) which will be achieved through a joint review with the Clinical Commissioning Groups as part of the Single Commissioning Function. £0.200m will be saved from public health staff costs and overheads from the integration of functions at a Manchester and Greater Manchester level. These will be achieved through natural turnover and staff moving on to other roles within the Single Commissioning Function and the Greater Manchester Unified Population Health System.

(iv) Primary Care Productivity - other re-procurement (£0.658m)

Other contracts subject to a re-procurement exercise.

(v) Review of Out of Area High Cost Care Packages (£0.150m)

Savings in relation to out of area placements will be realised to the value of £0.150m in 2017/18.

(vi) Review of line management arrangements in Adult Social Care following the development of the Local Care Organisation (£0.510m)

A review of line management is expected to realise savings.

(vii) Planned Care (£0.273m)

The Planned Care schemes are predominantly focused on working with the clinicians and providers, using benchmarking and audit data to ensure that planned / elective care is appropriate and cost effective, and further reduce spend on ineffective or lower priority care by stricter application of effective use of resources policies.

(viii) Urgent Care (£0.320m)

There are two main areas of focus for the savings schemes; Ambulatory Care and Complex Community Response. Within Ambulatory care analysis has identified four areas with scope for improvement against national benchmarks, which may provide an initial focus for improvement in zero day Length of Stay offer, which are Gastroenteritis, Congestive cardiac failure, Hypoglycaemia and Falls. For each of these areas there will be a review of existing models. Complex Community Response is the city wide roll out of the North Manchester Crisis response model which is based on a short term crisis intervention, which keeps people who would otherwise have been admitted to hospital being cared for predominantly in their own homes.

(ix) Long Term Conditions (£2.250m)

Right Care identified significant unwarranted variation across Manchester CCGs in Respiratory Disease. A deep dive to understand the data and look for opportunities to improve outcomes and realise the savings. An initial scheme to reduce non-elective admissions for patients with COPD, Pneumonia, and Asthma was identified. However, it was also acknowledged that the opportunities spanned children's and adults, and a system wide approach - for example, spanning primary care (linking in to the primary care standards in 2017/18), planned care, medicines optimisation, and urgent care is required. A Task force has therefore been established to take a city view approach on respiratory that will identify short, medium and long term savings opportunities. Other Long Term Condition opportunities are also being identified, although for 2017/18, the priority is proposed to be a focus on respiratory.

(x) Primary Care Standards (£1.847m)

A specific scheme is being developed to address the variation in Primary care activity, which again is in line with Right Care methodology. This scheme will focus on reducing variation in elective hospital activity, both outpatient referrals and inpatient episodes, through improved management in the community. The approach will reflect and support the transition to integrated community based care through the LCO, and for Practices working in federated models in neighbourhoods. For example, there is potential to also set target reductions at the level of the neighbourhood. It should also be noted however, that low spend on elective activity is not always the most appropriate position clinically, as it may well represent either late presentation of conditions, or lack of optimal clinical care. Therefore, a standards based approach will be adopted.

5.9 Prioritisation of Investment

As the models of care delivered through the LCO with single pathways into the Single Hospital Service develop, we will scale up investment in effective models of care and scale back models which add little value. Decisions will be required, based upon evidence, of which interventions are having a positive impact, and which interventions and pathways are being less effective and we will prioritise our resources accordingly. This will form part of our work during 2017/18 in preparation for subsequent years.

6.0. The Total Programme

6.1. The 3 year target detailed in 2.12. above is £55.912m with £24.765m in 2017/18. This report is a staging post in the development of the savings strategy. The options identified to date are summarised below and detailed at Appendix 2.

	2017/18	2018/19	2019/20	Total
	£'000	£'000	£'000	£'000
Revised Commissioner Target	**24,765**	**14,215**	**16,932**	**55,912**
2% Provider Efficiencies		5,886	6,000	11,886
Transformation Fund Benefits	3,648	7,072	5,163	15,883
Single Commissioning Function	1,000	0	0	1,000
GM Models: Homecare, Residential and Nursing Care	0	TBC	TBC	TBC
New Mental Health Provider	155	2,355	2,355	4,865
Joint Commissioning Review: High Cost Packages	1,000	1,000	1,000	3,000
Other Efficiencies: Operational Plan	10,733	545		11,278
	16,536	**16,858**	**14,518**	**47,912**
Shortfall (-)	**-8,229**	**2,643**	**-2,414**	**-8,000**

6.2 The programme savings have been risk assessed based on the current information available for their deliverability to realise savings in 2017/18. The table below RAG rates the schemes and also shows the potential savings that could be realised.

2017/18 Summary Programme Savings	£'000
Target	**24,765**
Green	
Medicines Optimisation	3,780
Primary Care Productivity	658
Mental Health Out of Area Placements	345
Public Health	600
Sub total	**5,383**
Amber	
Joint Commissioning Review: High Cost Packages	1,000
Single Commissioning Function Set Up	1,000

CHC - Out of Area Placements	150
New Mental Health Provider	155
Review of line management arrangements in Adult Social Care following the development of the Local Care Organisation	510
Sub total	**2,815**
Sub total - Amber and Green	**8,198**
Red	
Transformation Fund Benefits (LCO)	3,648
Planned Care	273
Urgent Care	320
Long Term Conditions - Respiratory	2,250
Primary Care Standards	1,847
Sub total	**8,338**
Total of Red, Amber, Green	**16,536**
2017/18 Shortfall	**8,229**

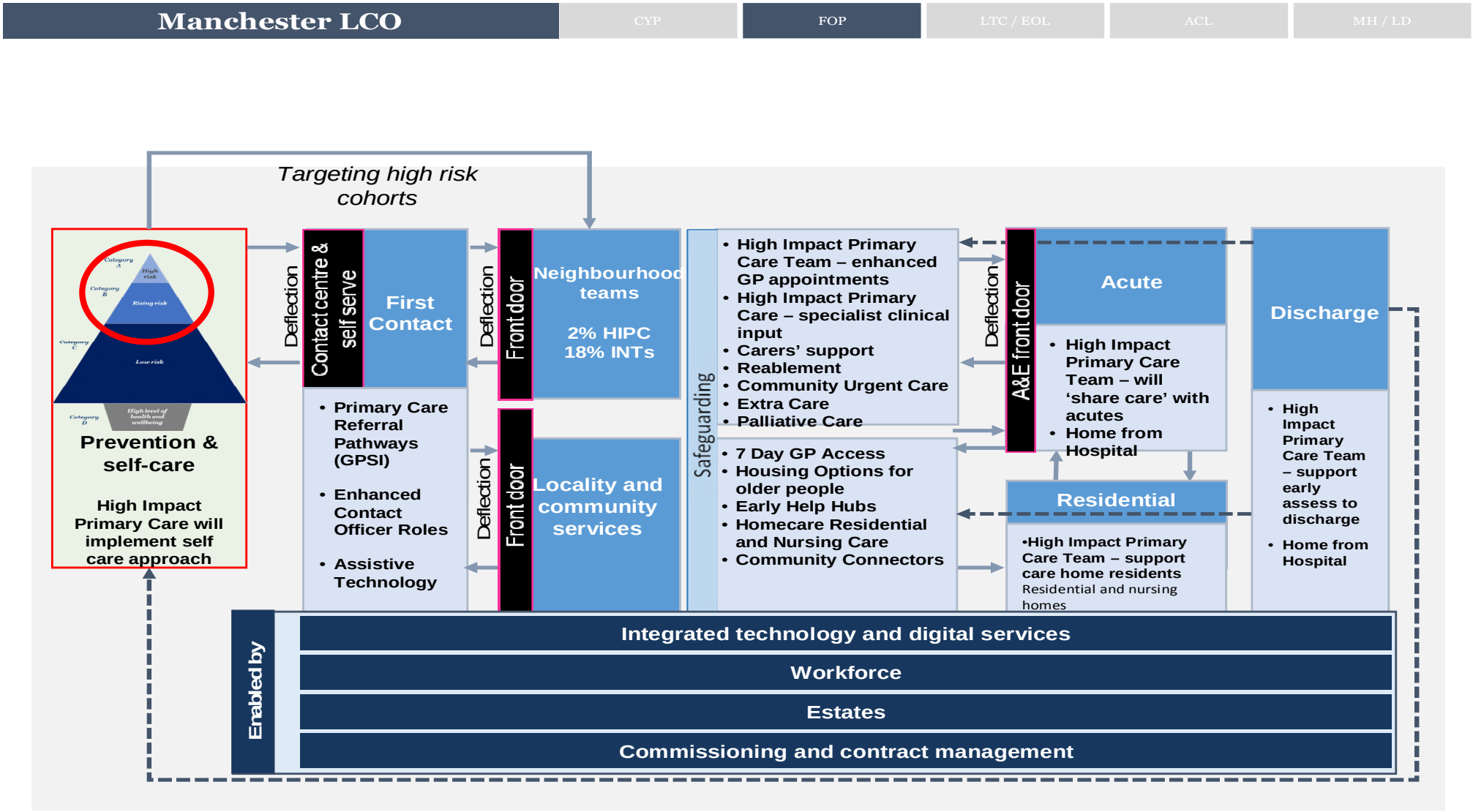
6.3. Although significant progress has been made, the failure of the Finance Settlement to recognise the growing pressures on Adult Social Care and the changes in the NHS settlement mean that this has not been achieved. Whilst funding continues to lag behind the growth in demand and unavoidable cost pressures, such as the implementation of the National Living Wage, it is unlikely that the gap will be closed.

7.0. Budget Consultation

7.1. The Council's Budget consultation process started in July 2016 with an eight week budget conversation, listening to what people valued most and what the Council needs to consider while developing the options for required savings or efficiencies. The second stage of consultation, for the budget options, was an opportunity for people to comment on the options and outline the impact they would have on them, their family and their community. One of the things that most matters to the Manchester people is protecting vulnerable people and the responses to these consultations have informed the development of the Council's proposed budget. This includes a proposal to raise Council Tax by 3% to support Adult Social Care. A third and final phase of consultation for the proposed budget starts on 3 January until 10 February 2017.

The high level direction detailed in the Locality Plan Financial Report – Closing the Funding Gap 2017-21 will be part of this consultation process as work on finalising the three year savings programme continues into 2017. There may be further consultation requirements that emerge as new care models are developed and from the specific areas detailed in this report. This will be determined early in 2017. Critically, at this stage there are no proposals which reduce the service offer and therefore, it is understood that there is not a requirement for statutory consultation activity.

Appendix 1 – The Organisational Architecture



Appendix 2

	2017/18 £''000	2018/19 £'000	2019/20 £'000	Total £'000	2017/18 Deliverability RAG
Commissioner Target	**31,361**	**17,680**	**15,413**	**64,454**	
Less: City Council Reduction	**-12,980**	**-3,534**	**1,450**	**-15,064**	
Add: Support to ASC budget	**4,676**	**69**	**69**	**4,814**	
Add: MCCG Revisions	**1,708**			**1,708**	
Revised Commissioner Target	**24,765**	**14,215**	**16,932**	**55,912**	
2% Provider Efficiencies:					
Other Providers		5,886	6,000	11,886	R
Sub-Total		**5,886**	**6,000**	**11,886**	
Transformation:					
Local Care Organisation CBA	3,648	7,072	5,163	15,883	R
Single Commissioning Function – set up	1,000			1,000	A
GM Models Homecare, Residential and Nursing Care		TBC	TBC	TBC	
New Mental Health Provider	155	2,355	2,355	4,865	A
Sub-total	**4,803**	**9,427**	**7,518**	**21,748**	
Joint Commissioning Review of High Cost Packages	**1,000**	**1,000**	**1,000**	**3,000**	A
Other Efficiencies:					
Medicines Management	3,780			3,780	G
Mental Health	345			345	G
Public Health	600	545		1,145	G
Primary Care Productivity	658			658	G
CHC – Out of City	150			150	A
Review of line management arrangements in ASC following the development of the SCF and the LCO	510			510	A
Planned Care	273			273	R
Urgent Care	320			320	R
Long Term Conditions	2,250			2,250	R
Primary Care	1,847			1,847	R
Sub-total	**10,733**	**545**		**11,278**	
Total	**16,536**	**16,858**	**14,518**	**47,912**	
Shortfall (-)	**-8,229**	**2,643**	**-2,414**	**-8,000**	