Manchester City Council
Report for Resolution

Report to: Health Scrutiny Committee – 5 January 2017

Subject: Locality Plan and Adult Social Care Budget Report and Update

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

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Summary

At its meeting on the 8th November, the Committee received details of the Council's anticipated financial position for the period 2017/18 to 2019/20.

At that meeting and the subsequent meeting in December Members received reports on the work underway 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.

This report and the attached appendices details: the current progress towards implementing the Locality Plan (appendix 1); the Three Year Budget Strategy underpinning the Plan (appendix 2); and the relationship of the Adult Social Care Budget and Business Plan (appendix 3) to this work.

Recommendations

Health Scrutiny Committee is invited:

To review and comment on the Report on the Locality Plan.
To review and comment on the Locality Plan budget strategy 2017-20; and
To review and comment on the Adult Social Care Budget and Business Plan

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Wards Affected: All

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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 – A Healthier Manchester
Executive Report (Oct 2016) Locality Plan – Financial Report – Closing the Funding Gap 2017/21

1.0 Introduction

1.1 As set out in previous reports the financial challenge facing health and social care is significant. To address the total 'do nothing' funding gap of £134m by 2021, will be through whole system reform that all health and care partners are engaged in

1.2 Attached at Appendix 1 is an update report on the progress towards implementing the Locality Plan. It sets the context for the Three Year Funding Strategy (Appendix 2), and locates the Adult Social Care three year budget and business plan (Appendix 3) within that process.

1.3 This report and the attached appendices reflect the complexity and interdependency of all health and care partner organisations in working better together to deliver a unified and integrated health and care system, which is more clearly focussed on improving health and care outcomes while also becoming more financially sustainable.

1.4 The reports attached as appendices are due to be considered by the Council's Executive on the 11th January, and will inform the budget setting process.

1.5 As previously acknowledged both nationally and locally, cuts in individual parts of the health and care system tend to have a counter-productive impact elsewhere. This is particularly the case within social care where efforts to reduce demand upon the acute hospital sector can invariably drive up costs in providing social care system.

1.6 Setting a funding strategy for a unified health and care system over a 3 year period is both unprecedented but essential to enable health and care partners to deliver the ambition contained in the Locality Plan. It is for this reason that the theme of the Funding Strategy is one of investment and reform rather than the traditionally recognised 'cuts' approach. As a consequence this report does not outline proposals for specific 'cuts' to adult social care services, but rather details the areas where through investment and reform savings in the health care system will be secured.

1.7 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.

1.8 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.

2.0 Transformation

Detailed below are the areas of focus for transformation where through investment working very differently savings will be secured in 2017/18.

2.1 Local Care Organisation – £3,648k

Commissioners and Providers worked together in summer 2016, with support from PWC, to develop an overall architecture for services to be delivered through the emerging 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 new models of care in a coordinated way across Manchester. This organisational architecture is at Appendix 1.

2.1.1 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.

2.1.2 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.

2.1.3 An initial review of the bids was conducted, with a range of partners, against a set of agreed 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

2.1.4 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		

2.1.5 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

2.1.6 Enhanced Front Door

2.1.7 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.

2.1.8 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.

2.2 High Impact Primary Care offer

2.2.1 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.

2.2.2 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, outpatient attendances and better patient satisfaction.

2.2.3 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.

2.3 Integrated Neighbourhood Teams

2.3.1 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.

2.3.2 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.

2.3.3 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.

2.4 Locality and Community Services

2.4.1 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.

2.4.2 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.

2.5 Acute Discharge

2.5.1 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.

3.0 Financial Sustainability

3.1 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.

3.2 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. The bid to GM Transformation Fund requests funding for 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.

3.3 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.

3.4 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.

3.5 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.

3.6 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.

3.7 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
- deprioritise some projects with lower impact in the earlier years.

4.0 Single Hospital Service

4.1 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 is the submission of a firm draft bid to the Competition and Markets Authority on 8 December for approval.

5.0 Single Commissioning Function Set up

5.1 An application to NHS England to establish NHS Manchester CCG with effect from 1st April 2017 has been submitted. The new organisation will then form a partnership agreement with the City Council to create the Single Commissioning Function. The strategic direction follows a detailed option appraisal supported by Deloitte. Significant efficiencies will follow the creation of one CCG Board structure and through the development of a new joint commissioning establishment structure. 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 Council and CCGs will create the opportunity for joint posts at a senior level, the opportunity to release budgets for current vacant posts and create efficiencies relating to costs such as back office accommodation.

6.0 GM Model: Residential and Nursing Care and Homecare

6.1 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.

6.2 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.

7.0 New Mental Health Provider

7.1 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 expected realisation of savings is £155k.

8.0 Business As Usual 2017/18

8.1 Joint Commissioning – £1m

8.1.1 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.

8.1.2 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.

8.1.3 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.

8.1.4 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.

9.0 Operational Plan shared 'Commissioning Plan' for the single health and care system

9.1 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'.

9.2 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.

9.3 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.

9.4 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.

9.5 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.

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

10.0 Medicines Optimisation (£3.780m)

10.1 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.

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

10.3 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.

11.0 Public Health (£0.600m)

11.1 Wellbeing Service

11.1.1 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.

11.1.2 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.

11.2 Sexual Health

11.2.1 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.

11.3 Primary Care Productivity – Other re-procurement (£0.658m)

11.3.1 Other contracts subject to a re-procurement exercise.

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

12.1 The Continuing Health Care team have been reviewing some high cost cases. This work is very intensive and progress is restricted by lack of specific dedicated resources. A proposal is being formulated for targeted action on reviewing these cases. Investment will be a required for additional specific

high expertise and experienced skilled resources, to concentrate on these very difficult high cost cases, however, it will deliver more cost effective care.

12.2 Review of line management arrangements in ASC following the development of the Single Commissioning Function (£0.510m)

A review of line management is expected to realise £0.510m savings.

13.0 Planned Care (£273k)

13.1 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.

14.0 Urgent Care (£320k)

14.1 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, Congestgive 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.

15.0 Long Term Conditions (£2,250m)

15.1 Right Care benchmarking analysis 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 acknowledges that the opportunities spanned childrens 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.

16.0 Primary Care Standards (£1.847m)

16.1 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 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.

17.0 Prioritisation of Investment

17.1 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.