Manchester City Council
Report for Information

Report to: Executive – 7 February 2018
Health Scrutiny Committee – 27 February 2018
Resources and Governance Scrutiny Committee - 19 February 2018

Subject: The Manchester Local Care Organisation

Report of: The Chief Executive, the Executive Director for Strategic Commissioning (DASS), the City Treasurer, the City Solicitor

Summary

This report provides an update on arrangements which the Council will enter into to create the Manchester Local Care Organisation (LCO). The LCO is a key component of the Manchester Locality Plan to integrate health and social care services supported by the GM health and social care devolution agreement.

The report recommends that the Council endorses a progress report on the Business Plan for the first year of operation of the LCO 2018/19 with indicative plans for 2019/20. Further longer-term business plans for the LCO will be submitted to the Executive for approval before 2019.

The report seeks approval to the Council entering into a Partnering Agreement with local NHS partners to govern the terms upon which the Council will be a partner within the LCO.

The report also seeks approval to the Manchester Agreement which formalises the joint commitment of organisations to the Locality Plan, “Our Healthier Manchester”. Amongst other things this agreement includes the performance outputs of the new care models within the LCO, the benefits of these in terms of better outcomes for Manchester people and the principles of financial risk and gain share between partners.

Recommendations:

That the Executive:-

1. endorse the progress on the Local Care Organisation (LCO) Business Plan attached at Appendix A to this report, as the basis for establishing the Manchester LCO, beginning from 1st April 2018 and covering its first year of operation 2018/19

2. agree to enter into a Partnering Agreement with Manchester University Foundation Trust (MFT), Manchester Primary Care Partnership (MPCP), Greater Manchester Mental Health Trust (GMMHT) and Manchester Clinical Commissioning Group (MCCG) to establish the Manchester LCO

3. agree to enter into the Manchester Agreement attached at Appendix B to this report which relates to investments from the Greater Manchester Transformation Fund, Adult Social Care Grant and other sources to the implementation of new models of service delivery through the LCO and to enable such investments to be monitored for their impact on improved outcomes for residents and financial sustainability of the City's health and social care services

4. delegate authority to the Chief Executive, the Executive Director for Strategic Commissioning (DASS), the City Treasurer and the City Solicitor – after consultation with the Executive Members for Adult Health and Wellbeing, and for Finance and Human Resources – to agree the final terms of the Partnering Agreement and the LCO Business Plan for 2018/19

5. note the statutory responsibilities for adult social care remain with the Council and that the arrangements set out in section 5 of this report for one of the Council's representatives on the LCO Partnership Board and the Director of Adult Services, who will be a Member of the LCO Executive Team, to be authorised to undertake certain of those functions will be, in both cases, on the basis of accountability to the Executive Director for Strategic Commissioning (DASS)

6. note the financial consequences of the LCO on the Council's budget as set out elsewhere on this agenda

7. authorise officers to proceed with the deployment of staff and services to the LCO in accordance with the Business Plan and the HR protocol to be included within the Partnering Agreement.

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	Support Manchester residents to improve their health and wellbeing so they can benefit more from jobs created in the city.
A highly skilled city: world class and home grown talent sustaining the city's economic success	Improve health and wellbeing so Manchester residents are better able to access the skills and learning they need to find and sustain jobs. Improve career pathways in health and social care and support residents to access these opportunities.
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	Radically improve health outcomes and reduce health inequalities across the city. Integrate health and social care, and support people to make healthier choices, so that people have the right care at the right place at the right time.

A liveable and low carbon city: a destination of choice to live, visit, work	Better connect health and social care services to local people. Communities playing a stronger part in looking after residents in their neighbourhood, including those who are unwell, vulnerable, socially isolated and lonely.
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 financial plan of the Local Care Organisation relating to Adult Social Care aligns to the City Council's planned investment for 2018/19 and its indicative plans for 2019/20. These will be reported to Executive on 7 February as part of the suite of budget reports.

Funding for the LCO is included within the recommended section 75 pooled fund contribution as set out in the Adult Social Care budget report.

Additional costs of establishing the LCO are being met by partners.

Financial Consequences – Capital

There are no specific capital investment requirements arising 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 – A Healthier Manchester

1.0 Introduction

1.1 A key priority of the Our Manchester Strategy is to radically improve health and care outcomes, through public services coming together in new ways to transform and integrate services. This involves putting people at the heart of these joined-up services, a greater focus on preventing illness, helping older people to stay independent for longer, and recognising the importance of work as a health outcome and health as a work outcome. The Locality Plan, "Our Healthier Manchester", represents the first five years of transformational change needed to deliver this vision. The Council and its partners are now in the second year of implementing the Locality Plan. The plan sets out how Manchester is taking advantage of the devolution of health and social care spending and decision making to Greater Manchester.

1.2 At its meeting on 8 February 2017, the Executive received a comprehensive update on the progress towards implementing the Locality Plan. Manchester currently has some of the poorest health outcomes in the country, and there are very significant health inequalities within the city. The Locality Plan aims to overcome the significant financial and capacity challenges facing health and social care in order to reduce these inequalities and to become clinically and financially sustainable.

1.3 The plan sets out the complex, ambitious set of reforms that are needed to integrate services for residents. This includes developing a Local Care Organisation (LCO) for integrating out-of-hospital care, a single hospital service for integrating in-hospital care, and a single commissioning function for health and social care.

1.4 The Locality Plan is fully aligned with the Our Manchester approach to change ways of working. This will mean supporting more residents to become independent and resilient, and better connected to the assets and networks in places and communities. Services will be reformed so that they are built around citizens and communities rather than organisational silos.

1.5 Since the update to the Executive in February 2017 significant progress has been made. Manchester Health and Care Commissioning (MHCC) has been established as the City's single commissioning function for health and social care. CMFT and UHSM have merged to form Manchester University Hospital Trust (MFT) as the first stage of forming the single hospital service; the second stage of merging North Manchester District General Hospital with MFT will now follow. The transformation of the city's mental health services has begun with the transfer of services to the GM Mental Health Trust (GMMHT).

1.6 Progress on the Locality Plan has reached a point where the Health and Wellbeing Board has agreed to the Plan being refreshed. The refresh marks a shift of emphasis, from changing and simplifying the city's organisational arrangements for health and social care (creating MHCC, MFT, GMMHT and the LCO), to focus more on delivering better services and improved outcomes. The refresh will fully embrace the principles of the Our Manchester approach. The Health and Wellbeing Board received an update on the refresh on 17th

January and the final draft will be submitted to a future meeting of the Executive for approval.

1.7 The Executive in February 2017 also received a specific report on progress towards developing the LCO and approved proposals for an LCO provider selection process. This report updates the Executive on changes to the provider selection process envisaged last February and on proposals to establish the LCO from April this year.

2.0 The LCO Provider Selection Process

2.1 The procurement process envisaged in the report to the February 2017 Executive was a single contract between MHCC and a single provider or consortium of providers acting together. It has not been possible to award a single contract for health and care so far because of legal and financial issues, including implications for VAT costs to the Council. These are national constraints outside of the control of partners locally.

2.2 To maintain progress, the selection process will now be a two phase approach. Phase 1 will be the 2018/19 starting position for the LCO. Clear delegations will be outlined in a Partnering Agreement. The agreement will also set out the services from partner organisations that will be within the remit of the LCO Executive. The LCO Executive will assume responsibility for the management of the agreed in scope services.

2.3 Under this arrangement, all existing health and social care contracts will remain with the current providers, and this phase is expected to last until at least April 2019.

2.4 The scope and timescales of implementing Phase 2 are currently under discussion with MHCC. This will cover how the LCO will progress to a different contractual mechanism, specifically in regards to health, from April 2019 onwards, subject to the ongoing procurement process. The procurement process is therefore continuing, although it should be noted that the bid from existing public sector providers is the only bid going forward.

3.0 The LCO Business Plan

3.1 An update on the LCO Business Plan is attached at Appendix A to this report. This will be a one year plan for 2018/19, with indicative figures for 2019/20. More detailed Business Plans covering future years will be submitted to the Executive for approval as the LCO develops.

3.2 The progress and work required to support the establishment of the LCO in 2018/19, along with the range of activities and assurance required for this to be agreed is set out in the Business Plan update.

3.2 The vision of the LCO vision “leading local care, improving lives in Manchester, with you”. The LCO will support people to live healthy, independent, fulfilling lives and be part of a thriving and supportive community.

The LCO is being developed with the Our Manchester approach at the core of its teams to ensure that it delivers strengths based and asset based approaches at neighbourhood level.

3.3 The implementation of 12 integrated neighbourhood teams covering all areas of the city is well progressed with nine teams co-located and plans for the remaining three in place. Recruitment planning is underway to neighbourhood leadership roles in February 2018. The teams will comprise health, social care, and partners from the voluntary, community and social enterprise sector. Engagement with stakeholders at a local level is being extended, including the involvement of all Councillors in their Ward representative role.

4.0 Scope and Phasing

4.1 In 2018/19 the LCO will bring together directly provided adult social care services, community health services and additional primary care services. In 2019/20 there will be further services brought in from mental health, primary care, community health, and commissioned adult social care services.

4.2 Further developments of the Business Plan covering future years will include details of commissioned adult social care services, including home care, residential care and learning disability services moving to the LCO in 2019/20, and aspects of Children's services, including Early Help Hubs, in 2020/21. This is important as the Partnering Agreement and delegations so far focus on directly provided adult social care services.

5.0 Governance of the LCO

5.1 <u>Partnering Agreement.</u>

5.1.1 It is proposed that the City Council enters into a Partnering Agreement with MFT, GMMHT, MPCP and Manchester Clinical Commissioning Group (the CCG part of MHCC) to formally establish the LCO and ensure the delivery of integrated health and social care services.

5.1.2 For the reasons set out at section 2.1 of this report it is not possible at this time to establish the LCO as a single legal entity. However all of the partner organisations wish to work together as closely as possible to deliver a seamless integrated service that meets the objectives of the Locality Plan. The Agreement sets out the governance arrangements for the LCO Board and Executive; the relationship of the parties to the LCO; the reserved matters and delegations to the Board members and Executive officers; scope of services; risk and gain share arrangements and a HR protocol.

5.1.3 The Agreement is for a ten-year term with provision for regular review and assessment, including whether it is possible to establish the LCO as a legal entity.

5.1.4 A provider organisation may withdraw from the Partnering Agreement only if its commissioning contract is terminated or if there is a change of law. In the

event of termination the terminating party will have to pay all reasonable the costs incurred by the other parties.

5.2 LCO Board and Executive

5.2.1 The role of the LCO Board is to maintain strategic oversight of and accountability for the LCO; to support the LCO Executive; and to exercise any relevant functions of the host partner. Each of the four provider partners (MCC, MFT, GMMHT, MPCP) will have two places on the Board and one vote. The Board have been meeting in shadow form for some months and the Council has been represented by the Executive Member for Adults, Health and Wellbeing and the Deputy Chief Executive. It is proposed that this arrangement continues.

5.2.2 The Council posts of Director of Adult Services and Director of Social Care Development will be members of the LCO Executive. Both posts will report to the LCO Chief Executive, while maintaining a line of accountability to the Executive Director for Strategic Commissioning (DASS).

5.3 Decision Making

5.3.1 As the LCO is not a partnership and not a legal entity, it is not appropriate or possible to delegate any functions to the Board or Executive. However as the majority of adult social care functions will be exercised through the LCO it is important to ensure that all decisions are taken lawfully and partners understand the Council's decision making processes.

5.3.2 The Executive Director for Strategic Commissioning currently has delegated authority as the statutory DASS to carry out all adult social care functions of the Council. This will not change. The delivery of adult social care will be undertaken by MCC staff operating within the ambit of the LCO, with line management through to both the LCO Chief Executive and the Executive Director for Strategic Commissioning.

5.3.3 The Executive Director for Strategic Commissioning will authorise the Director of Adult Services to perform the majority of adult social care functions except those that must remain with the DASS as the statutory accountable officer.

5.3.4 To the extent that certain decisions need to be undertaken at LCO Board level, the Executive Director for Strategic Commissioning will authorise the Deputy Chief Executive to carry out those functions after consultation with the Executive Member on the LCO Board.

5.3.5 The Agreement also makes provision for those decisions which must be made by full Council or statutory officers to remain with those decision makers, and for the LCO Executive to attend and provide information to the relevant Council's Scrutiny Committees.

6.0 Workforce Implications of the LCO

6.1 There are circa 980 council staff who will transition to deliver services through the LCO over the next two to three years. These include Social Workers and Primary Assessment Officers.

6.2 An HR protocol has been developed which sets out principles to guide how the LCO partners will work together to manage the change and support staff to move to partnership working. These principles introduce a common framework, which all parties agree to, that recognises, complements and incorporates the existing policies and procedures of partner organisations. The principles are also intended to be an important benchmark of how we intend to work together in the future. They ensure collaboration and a shared perspective in relation to how we manage our employees.

6.3 Communication and consultation with trade unions, is being managed through an LCO Partnership Forum which meets on a monthly basis. All relevant organisations are present at this meeting where key updates and topics affecting the workforce are discussed and consulted on. It is essential that all in scope staff receive clear and effective communication about the creation of the LCO, and what this means for them, and these meetings ensure that all emerging issues are captured and debated. A substructure group has also been set up to allow focus for discussion and resolution on some of the more challenging issues that may affect the workforce.

6.4 The HR protocol and related workforce issues will be reported to the Personnel Committee on 7th February 2018.

7.0 Budget implications of the LCO

7.1 A summary of the financial plan for the first year of the LCO (2018/19) and indicative figures for 2019/20 appears at section 8 of Appendix A. The specific assumptions and risks relating to the Council's budget for adult social care are also set out in the Appendix. The financial risks are related to the underfunding of adult social care nationally. These implications have been included in the budget reports which appear elsewhere on this agenda.

7.2 The LCO will benefit from investment of £16.7m during 2018/19 primarily from the GM Transformation Fund secured as part of the GM Devolution Agreement, and to a lesser extent the Adult Social Care Grant.

7.3 The success of the LCO will depend on the investment of these additional resources into new models of integrated care services. The new service models have been designed to reduce demand for acute health and care services by focussing on defined cohorts of people and intervening earlier before problems escalate and through prevention. The new models of care will be phased in during 2018/19 and are described in section 7 of Appendix A.

8.0 Manchester Agreement

8.1 Long term financial sustainability of the LCO will depend on the financial benefits of the reductions in demand from the new models of care being turned into cashable savings, which can be transferred to the LCO in future years to replace the one-off investments with ongoing revenue funding. The Manchester Agreement includes a new joint performance framework to track investments to improved outputs and outcomes, and an evaluation framework to demonstrate how the improvements are driving outcomes.

8.2 The Agreement is attached at Appendix B. The Agreement covers the whole of the Locality Plan, including benefits from the single hospital services. Of particular relevance to the LCO are the agreed measures of activity reduction or financial savings from the new models of care, for example fewer non-elective admissions to hospital.

9.0 Conclusion

9.1 Significant progress has been made to date. The establishment of the LCO in April 2018 will be a substantial change to delivery of health and care services in Manchester. The arrangements for service delivery will engage all key partners as well as stakeholders and service users across the City. It will all be underpinned by the Our Manchester approach focussing on better outcomes for Manchester people and involving and engaging residents in major decisions which affect them.

9.2 Further reports will be brought to the Executive to seek the required further approvals as the LCO develops, based on evaluation.

Report to: LCO Partnership Board
Date: 26th January 2018
Subject: Local Care Organisation 2018/19 Business Plan Update – Version 2
Report of: Michael McCourt, Chief Executive, Manchester Provider Board
Prepared by: Katy Calvin-Thomas, Director of Strategy, Manchester Provider Board

1. Introduction

At its meeting on the 4th January 2018 the LCO Partnership Board requested that the LCO Executive produce a Business Plan by 17th January 2018. This request was made to assure the Partnership Board on progress made to establish the LCO and more specifically to support the Adult Social Care budget discussion at the meeting of Manchester City Council's Executive on 7th February 2018.

The challenges relating to the production of a Business Plan in a truncated timescale were discussed at the Board, these included a continued lack of clarity on the procurement process, and challenges as a result of outstanding due diligence information, required to support the construction of the Business Plan.

Whilst significant progress has been made to produce the Business Plan, there are still a number of key areas which are subject to ongoing discussions and are therefore at a pre-drafting stage. This includes clarification about the procurement process and agreement of the Partnering Agreement (and accompanying schedules) both of which materially affect the Business Plan.

The primary focus of the Business Plan is to set out the progress and work required to support the establishment of the LCO in 2018/19, along with the range of activities and assurances required for this to be agreed. The Plan also includes some detail on 2019/20.

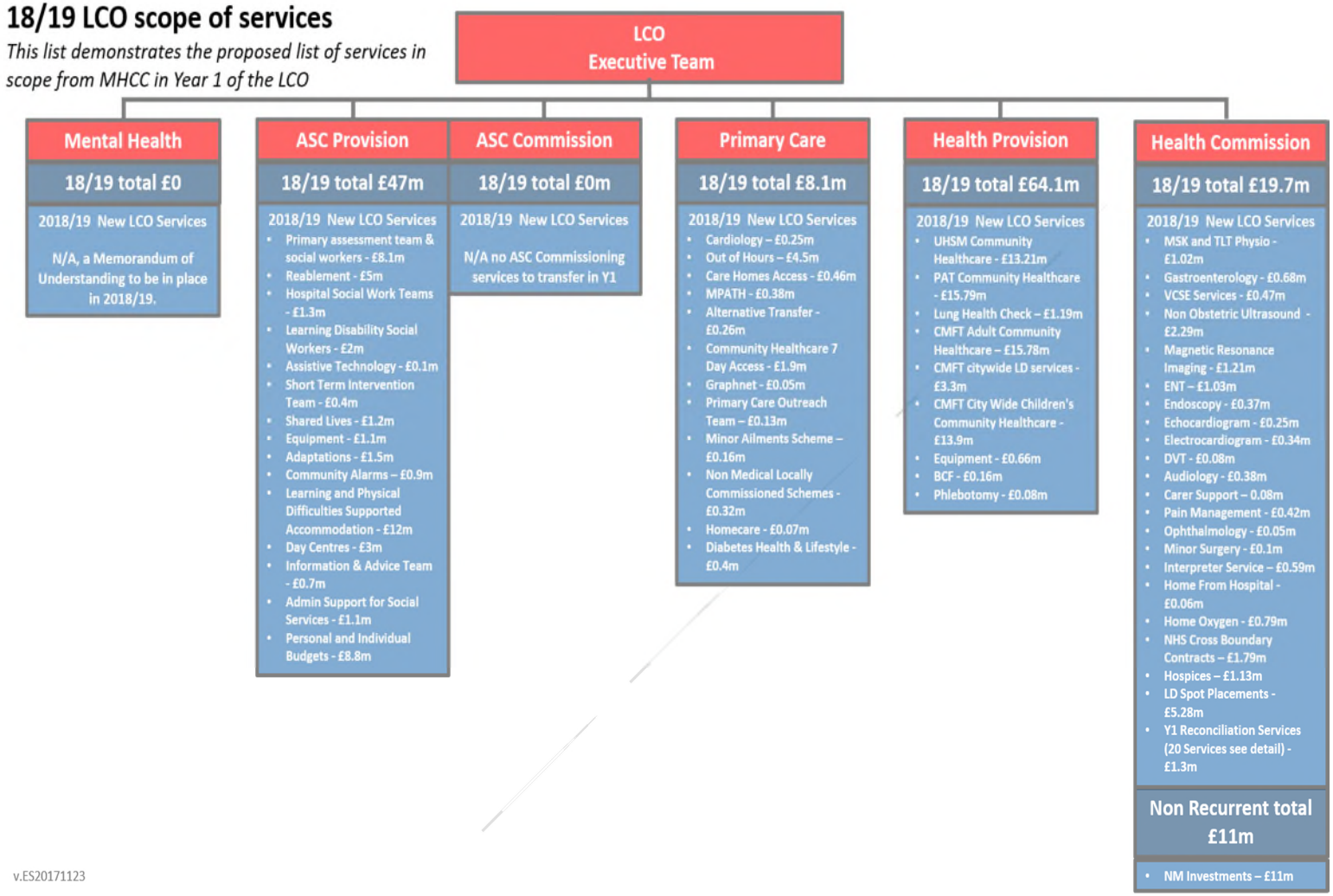
This report provides a detailed update on the progress made to produce the LCO Business Plan. The aim is to support continued progress on readiness for an April 2018 'go live', with substantive draft of the Business Plan being prepared for the end of February 2018 and aligned to the expected completion and signature of the Partnering Agreement.

The paper includes specific updates in regards to:

- LCO Establishment Update;
- LCO Business Plan Framework;
- LCO Strategy;
- LCO Partnering Agreement;
- LCO Target Operating Model and Mobilisation; and
- LCO Financial Plan.

2. LCO 2018/19 Service Scope and Phasing

In 2018/19, the LCO are bringing together directly provided Adult Social Care services, community health services, additional/extended primary care services and a range of healthcare related contracts. A summary of the services which are in scope of the LCO in 2018/19 are detailed below. These were agreed as part of the procurement process in October 2017 with Manchester Health and Care Commissioning (MHCC).


18/19 LCO scope of services
This list demonstrates the proposed list of services in scope from MHCC in Year 1 of the LCO
LCO
Executive Team
Mental Health
18/19 total £0
2018/19 New LCO Services
N/A, a Memorandum of Understanding to be in place in 2018/19.
ASC Provision
18/19 total £47m
2018/19 New LCO Services
Primary assessment team & social workers - £8.1m
Reablement - £5m
Hospital Social Work Teams - £1.3m
Learning Disability Social Workers - £2m
Assistive Technology - £0.1m
Short Term Intervention Team - £0.4m
Shared Lives - £1.2m
Equipment - £1.1m
Adaptations - £1.5m
Community Alarms – £0.9m
Learning and Physical Difficulties Supported Accommodation - £12m
Day Centres - £3m
Information & Advice Team - £0.7m
Admin Support for Social Services - £1.1m
Personal and Individual Budgets - £8.8m
ASC Commission
18/19 total £0m
2018/19 New LCO Services
N/A no ASC Commissioning services to transfer in Y1
Primary Care
18/19 total £8.1m
2018/19 New LCO Services
Cardiology – £0.25m
Out of Hours – £4.5m
Care Homes Access - £0.46m
MPATH - £0.38m
Alternative Transfer - £0.26m
Community Healthcare 7 Day Access - £1.9m
Graphnet - £0.05m
Primary Care Outreach Team – £0.13m
Minor Ailments Scheme – £0.16m
Non Medical Locally Commissioned Schemes - £0.32m
Homecare - £0.07m
Diabetes Health & Lifestyle - £0.4m
Health Provision
18/19 total £64.1m
2018/19 New LCO Services
UHSM Community Healthcare - £13.21m
PAT Community Healthcare - £15.79m
Lung Health Check – £1.19m
CMFT Adult Community Healthcare – £15.78m
CMFT citywide LD services - £3.3m
CMFT City Wide Children's Community Healthcare - £13.9m
Equipment - £0.66m
BCF - £0.16m
Phlebotomy - £0.08m
Health Commission
18/19 total £19.7m
2018/19 New LCO Services
MSK and TLT Physio - £1.02m
Gastroenterology - £0.68m
VCSE Services - £0.47m
Non Obstetric Ultrasound - £2.29m
Magnetic Resonance Imaging - £1.21m
ENT – £1.03m
Endoscopy - £0.37m
Echocardiogram - £0.25m
Electrocardiogram - £0.34m
DVT - £0.08m
Audiology - £0.38m
Carer Support – 0.08m
Pain Management - £0.42m
Ophthalmology - £0.05m
Minor Surgery - £0.1m
Interpreter Service – £0.59m
Home From Hospital - £0.06m
Home Oxygen - £0.79m
NHS Cross Boundary Contracts – £1.79m
Hospices – £1.13m
LD Spot Placements - £5.28m
Y1 Reconciliation Services (20 Services see detail) - £1.3m
Non Recurrent total £11m
NM Investments – £11m
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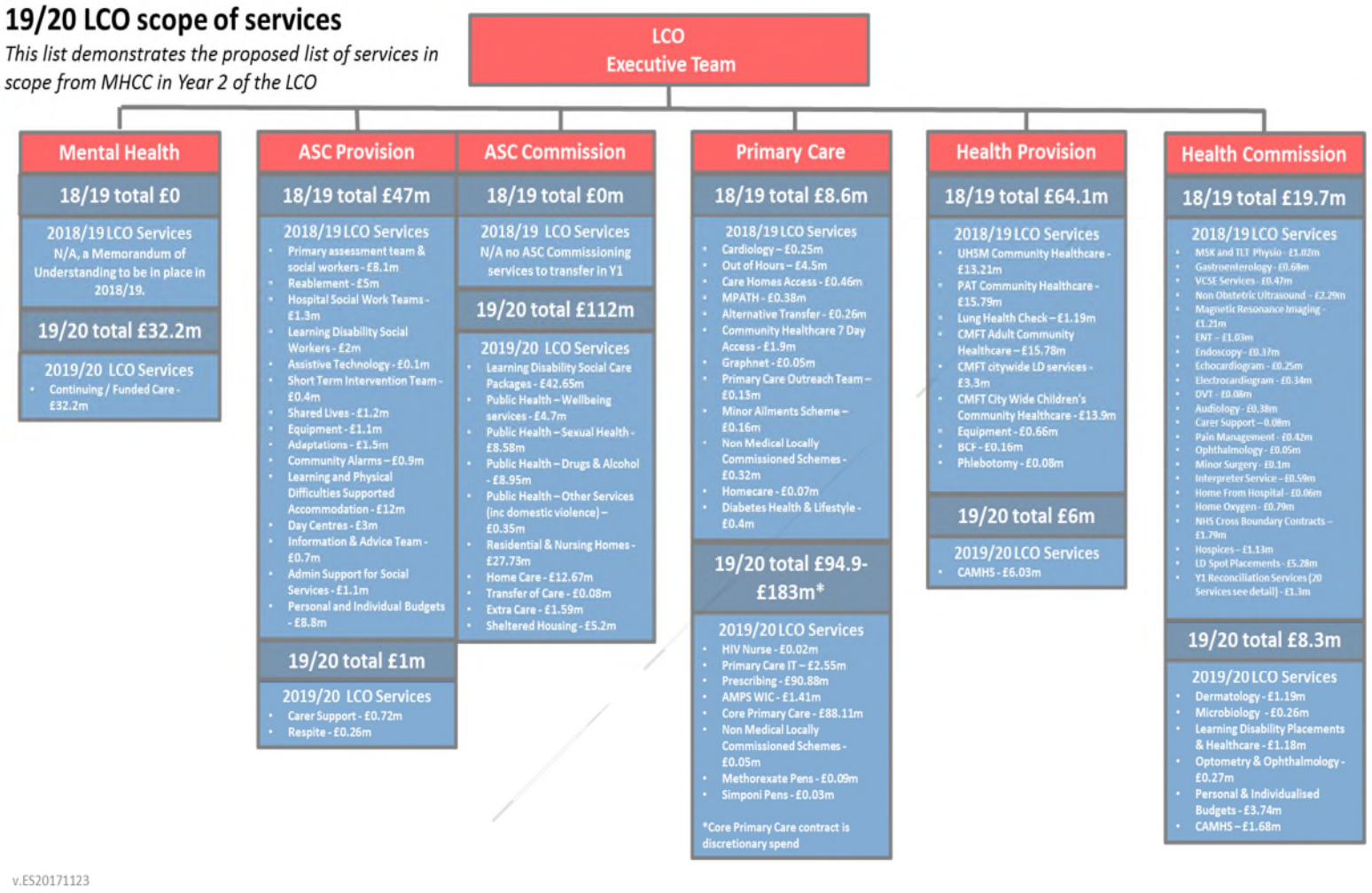
The scope of services for 2019/20 was also agreed in October 2017 and is set out below:



3. LCO Establishment Update

MHCC are currently confirming the future work to establish and commission the LCO. It is clear that there will be a two phase approach, Phase 1 and Phase 2, as set out in their letter dated December 22nd 2017, which has been shared with Partners.

As set out by MHCC, Phase 1 will be the 2018/19 starting position for the LCO. Clear delegations will be outlined in the Partnering Agreement that set out the scope of services that will be delegated from partner organisations to the LCO Executive, who will assume responsibility for the management of the agreed in scope services. Under this arrangement, all of the existing health and social care contracts will remain with the current providers, and at this stage it has been suggested that this phase will potentially last until April 2019.

The scope and timescales of implementing Phase 2 is currently under discussion with MHCC. This will describe how the LCO will progress to a different contractual mechanism, specifically in regards to health, with regard to April 2019 onwards.

As a direct result of the introduction of a Phase 1 and 2 approach by MHCC, the LCO has subsequently revised their due diligence request issued to Partners organisations in order to meet the requirements and expedite the production of the 2018/19 Plan. This means current plans are based on less robust information than was originally envisaged when undertaking due diligence and a business plan on the provisional scope.

When clarity has been received in regard to the future contracting of the LCO, work with Partners will be required to scope the future due diligence request and its extent.

As part of the work to finalise the Partnering Agreement clarity is being sought from MHCC on the nature of both Phase 1 and Phase 2. This will enable Partners to understand future contractual arrangements and the associated due diligence required.

4. LCO Business Plan Framework

The format of the LCO Business Plan, as agreed at the LCO Partnership Board, 4th January 2018. This is described in the table below. In conjunction with the establishment update, the Business Plan is now solely focussed on Phase 1 activities in 2018/19. It is recognised that significant work will be required in year to produce a more robust longer term service and financial strategy, in conjunction with Partner development and a due diligence process.

A current update on progress with each of the sections is included below:

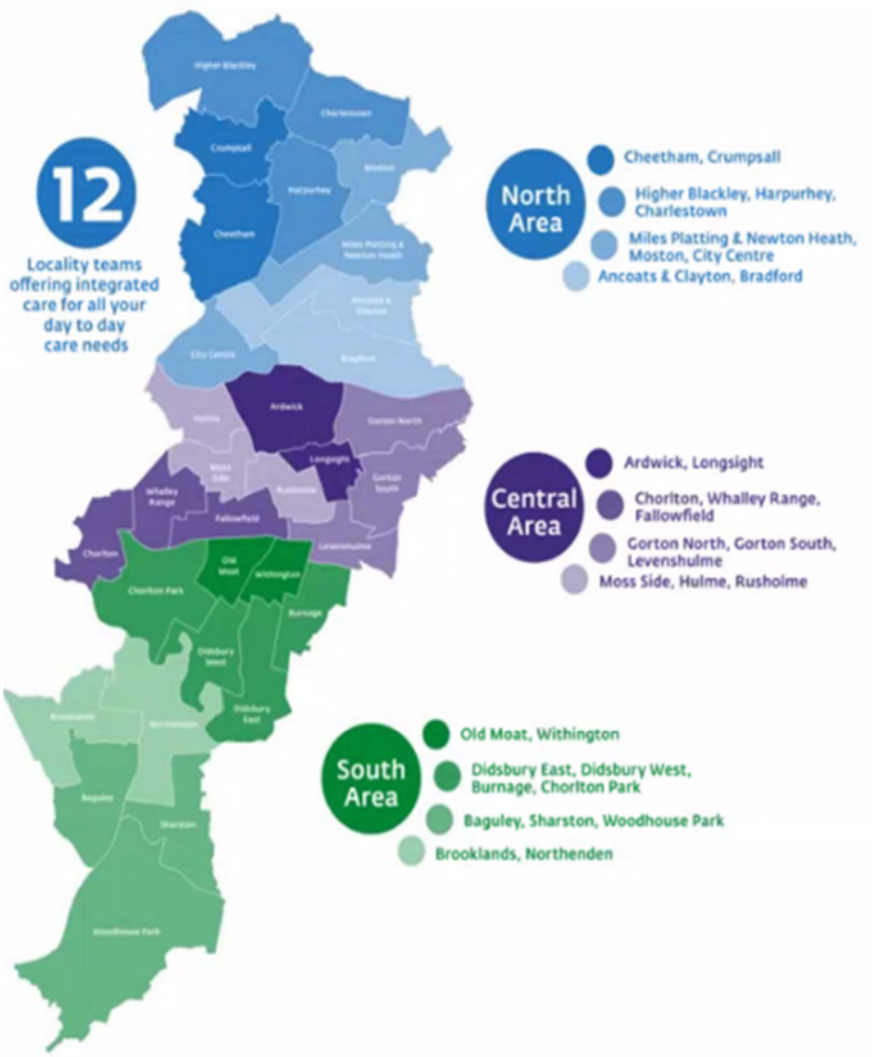
Section	Updated position 17th January 2018
Profile	Work is progressing on organisational model and governance, partnerships and target performance sub sections.
Strategy	Work is still being produced on neighbourhood and organisational objectives.
Service Strategy and Plan 2018/19	Additional work on start-up priorities underway and work to progress 2019/20 priorities.
Financial Plan	This is currently under consideration with partner Finance Directors. A risk remains in relation to assumptions within the Plan and this is being progressed with relevant Partners.
Risk Management	The risk management framework is in place based on current management procedures. Work is ongoing to agree the flow of information to support the risk management in the LCO linked to the delegations.
Leadership and Workforce	This information is outlined in the LCO Proposition.
Governance arrangements	Progressing well, but working on key dependencies with due diligence, phase 1 and phase 2 approaches and Partnering Agreement appendices.

5. LCO Strategy

5.1 LCO Vision

The LCO's vision is 'Leading local care, improving lives in Manchester, with you'. The LCO will support people to live healthy, independent, fulfilling lives and be part of a thriving and supportive community. We want people to have fair and equitable access to health and social care services, receiving effective, safe, compassionate care, closer to their homes.

We are working to ensure we create an organisation which places the 'Our Manchester' approach at the heart of the teams, delivering asset based approaches in local places.


12
Locality teams offering integrated care for all your day to day care needs
North Area
Cheetham, Crumpsall
Higher Blackley, Harpurhey, Charlestown
Miles Platting & Newton Heath, Moston, City Centre
Ancoats & Clayton, Bradford
Central Area
Ardwick, Longsight
Chorlton, Whalley Range, Fallowfield
Gorton North, Gorton South, Levenshulme
Moss Side, Hulme, Rusholme
South Area
Old Moat, Withington
Didsbury East, Didsbury West, Burnage, Chorlton Park
Baguley, Sharston, Woodhouse Park
Brooklands, Northenden

The delivery of integrated neighbourhood teams across all 12 neighbours in Manchester are well progressed, with 8 teams with co-location agreed and plans for the remaining in place. We are planning to begin recruitment to neighbourhood leadership roles in March 2018. These teams will be built from across health, social care and VCSE partners.

Our goals are shown below and we are working on these with people who will become part of the LCO from April and with local residents. We are also working with the Executive Member for Adults Health & Wellbeing to create key links between the LCO, elected members, and neighbourhoods.

5.2 LCO Outcomes

As the LCO becomes operational in 2018/19, a range of outcomes are being agreed with commissioners. The LCO is committed to using our resources more efficiently across the city and to drive up health and care outcomes. In order to deliver these outcomes, we will need to make decisions together with our neighbourhoods about how we use our collective resources to narrow the gap in health, wellbeing and population outcomes over the next 10 years.

The detailed outcomes are included in Appendix 2 (within the draft Partnering Agreement). Work is ongoing to agree indicators to support the understanding of how the LCO is contributing to the delivery of these outcomes, however the high level description of these outcomes is provided below.

Domain	Outcome
Improve health and well-being of people in Manchester	Improvement in number of people supported to stay well and live independently wherever possible
	Fewer people die early from conditions considered preventable
Ensuring Sustainability	Reduction in avoidable non-elective activity in secondary care
	Reduction in overall costs of care packages
Improving outcomes and experience for local people	Improvement in true collaborative working, co-designed with real outcomes
	Improvement in outcomes that matter for local people
Ensuring Equity	Reduction in variation in access and outcomes by place across Manchester
	Reduction in variation in access and outcomes in communities of, identity and experience
Working with others	Improvement in number of children who are school ready
	Improvement in number of households who are economically active

5.3 Key Demographic Trends

The Business Plan will be written to respond to community based health and care need of City of Manchester and its residents. It will be produced recognising that the city has 32 wards and a rapidly growing population of 530,300, of which approximately 50,000 are aged 65 and over.

Manchester's Joint Strategic Needs Assessment contains a broad profile of the health needs of the population in Manchester and some of the factors that contribute to these. In summary:

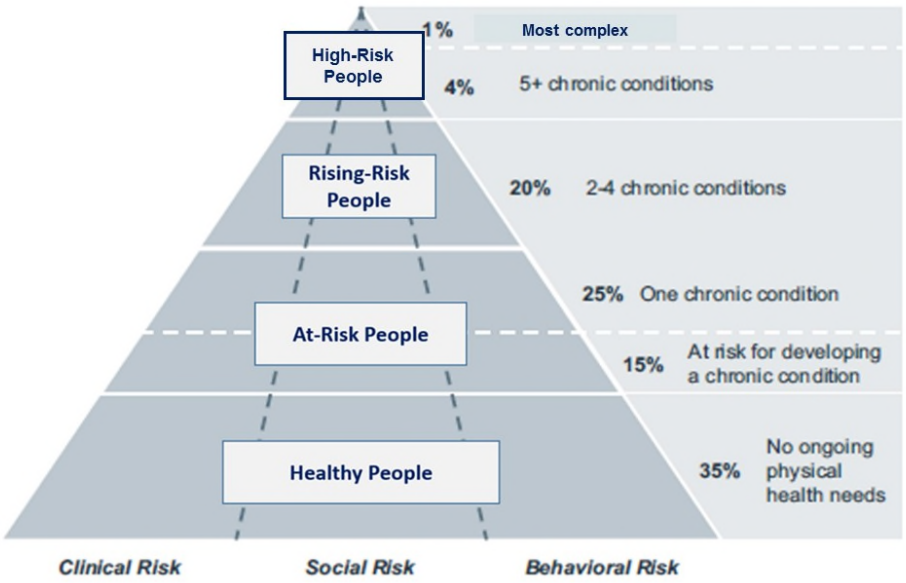
- Manchester is one of the 20% most deprived districts/unitary authorities in England and about 36% (36,300) of children live in low-income families. Over half of all out-of-work benefits claimed in Manchester are for health related reasons (ESA/former incapacity benefit);
- the health of people in Manchester is generally worse than the England average. Life expectancy at birth in Manchester is lower than for the North West and England, with Manchester residents' spending a greater proportion of their lives in ill health. This means that Manchester's population tend to suffer ill health at an earlier age than in other areas;
- life expectancy is 8.2 years lower for men and 6.4 years lower for women in the most deprived areas of Manchester than in the least deprived areas;
- in Year 6, 25.1% (1,422) of children are classified as obese, worse than the average for England;
- Manchester has a higher proportion of working-age people (adults aged 16-64 years) in the city than the North West and England proportions. The older working-age population (50-64 years) is forecast to grow rapidly and is a key target group for the delivery of public health interventions to prevent rising demands on health and care services (current age 30 to 50);
- Manchester's older population (defined as adults aged 65 years and over) tend to live towards the outskirts of the city, in particular in North Manchester and South Manchester. This is impacted by the location of residential and nursing homes. The 3 localities have different populations and therefore different health needs; and
- death rate for conditions considered preventable among under 75s for cardiovascular disease, respiratory disease and cancer is worst in country;
- the rate of smoking related deaths is 509 per 100,000, worse than the average for England. This represents 821 deaths per year.

In order to begin to address these inequalities and poor outcomes, the LCO Service Strategy has adopted a population health approach, focussing resources on key groups where outcomes are currently poor and cost of care is expensive and the lived experience for people is one of being referred between a range of health and care services in an uncoordinated way.

Through the adoption of risk stratification approach it will develop targeted initiatives which make an impact on specific people with a range of complex conditions and focusing resources on improving their outcomes. This is shown below and had led to the development of High Impact Primary Care now in place in three of the 12 neighbourhoods.

5.4 Population Health Model

Our approach within neighbourhoods is to utilise a population health model targeting health, care, and support to the whole population. We have developed and adopted a risk based approach to how we target people who have the most complex need, which is shown below:



This approach has been combined with a focus on service models for the following five population cohorts:

- older people with frailty;
- adults with long-term conditions and/or at the end of life;
- mental health, learning difficulties and dementia;
- children and young people; and
- people with complex lifestyles

This will enable us to maximise the benefits, outcomes and experience for these high-risk groups by delivering intensive support, whilst delivering cost-effective preventative support to the rising risk cohorts. The population health model also enables us to ensure that focus and energy is also given to the 'At risk' and 'Healthy People' groups to develop services that over time will prevent many more people needing more expensive services at the very top of the pyramid. This approach promotes our core strategy of embedding prevention into all the services we offer.

Over the longer term, the LCO will be implementing changes within the neighbourhoods that will seek to address poor health outcomes through working with partners and the public on improving the social determinants of health including housing, education and employment.

5.5 Workforce and Leadership Strategy

A detailed workforce strategy will continue to be developed for the LCO ahead of service commencement in April 2018. The core principles of the strategy will place a strong emphasis on workforce re-design and the development and deployment of new roles to help address current workforce supply gaps across the health and social care system. Early priorities to help reshape the workforce to deliver the LCO service strategy will include some new roles as below:

- GP fellow posts (rotating between primary care and hospital specialties);
- primary care physician associates;
- advanced pharmacists;

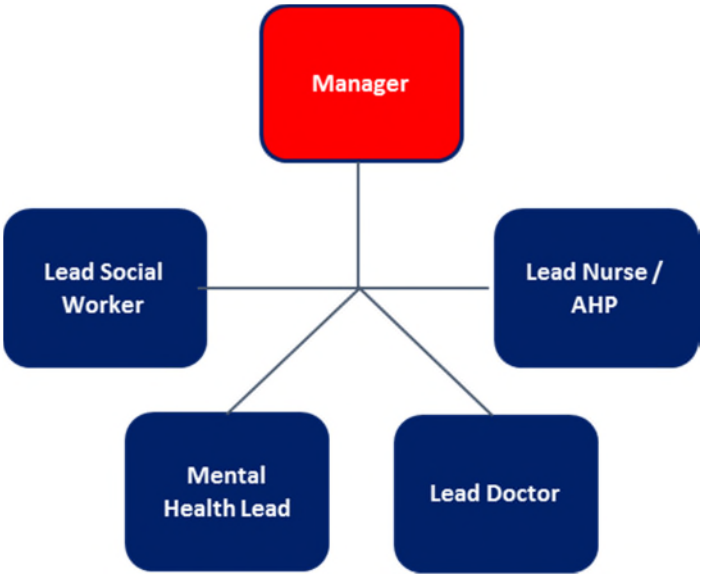
- nursing associates; and
- advanced care practitioners;

Staff working for the LCO will be employed by partner organisations, but the LCO itself will be designed and operate to look and feel like an organisation for those working within it, as well as for those accessing services. Working with partners across the locality, and building on the recruitment and retention strategies of partner employing organisations, the LCO will create an identity, culture and career development framework, to attract and retain staff across all areas of service delivery.

The LCO's organisational development framework is being developed, this will have a strong emphasis on social justice and inclusion. This will provide a working environment for staff working within LCO services that promotes equality and develops the potential of the whole workforce. This will enable the organisation to benefit from the contributions of a diverse and inclusive workforce that is representative of the place in which it is providing services.

In regards to the Integrated Neighbourhood Teams (INT's), a quintet model for leadership team structures has been put forward by the LCO Executive, as outlined below. This includes a single accountable INT Manager supported by a Lead GP, Lead Social Worker, Lead Nurse/AHP and a Lead for Mental Health. This model needs further discussion with staff and trade unions before it is finalised, however the model is built on the same design principles as the corporate governance and would provide a clear line of accountability for operational management and performance, from 12 INTs through localities to the LCO Executive.

The key new investment for the LCO is the development of the INT Manager role, all other roles will be drawn from existing resources.



6. Partnering Agreement

As a result of developments throughout 2017/18, specifically the implications of VAT, the LCO will not be a separate organisation in 2018/19 in contractual terms. Despite

this, all Partners have been working collaboratively to ensure that there is delegated authority and decision making to the LCO Executive to manage the in scope services as agreed with MHCC.

In order to establish the LCO on 1st April 2018, the four statutory partners (Manchester City Council, Manchester University Hospitals NHS Foundation Trust, Greater Manchester Mental Health NHS Trust and Manchester Primary Care Partnership) agreed to develop a Partnering Agreement, with an aim to have it completed and process in which it can be signed off agreed by the end of January 2018. The current draft version of this agreement, which has been developed via a system wide governance working group with equal representation is, attached at Appendix 2.

Work is still ongoing to complete this agreement. A critical aspect of its completion relates to the description and agreement of Phase 1 and Phase 2 in relation to the future contract arrangements for the LCO, which as of yet are not clarified.

Information from Partner organisations in regards to the delegated authority and reserved matters within the Partnering Agreement, was made available to the LCO on 17th January 2018. A timetable to complete this agreement is due to be finalised by the next LCO Partnership Board, 8th February 2018.

In addition to the Partnering Agreement itself, a series of schedules support its development and are in the process of being completed. A full list of the schedules is provided below:

Schedule #	Title	Information
1	LCO Partnership Board/LCO Executive	Description of the role and function of the LCO Partnership Board and LCO Executive.
2	Reserved Matters	Detail of each of the reserved matters for the Partner organisations.
3	Performance Management Framework / Outcomes Framework	The frameworks which the LCO will be measured against for the services it manages.
4	LCO Delegated Authority Framework	The scheme of delegation by which the LCO will manage issues in regards to Performance, Workforce, Safety and Finance on a practical basis.
5	Risk and Gain Share Mechanism	The risk and gain share agreement.
6	Commissioning Contracts	The contract mechanism by which the LCO Partners are bound.
7	LCO Services Scope and Phasing	The agreed scope and phasing of services the LCO will manage in years 1 – 3.
8	LCO Contracting Programme	Detail of the procurement process around phase 1 and 2.
9	MCC Service Level Agreement	The SLA that MCC will hold between itself and the LCO.

10	HR Protocol	Principles by which the HR functions of Partner organisations that will utilised by the LCO.
11	LCO Provisional Resource Assumptions	The resource, both named and financial that is required to operate the LCO and relevant implications to Partners.

7. Target Operating Model and Mobilisation

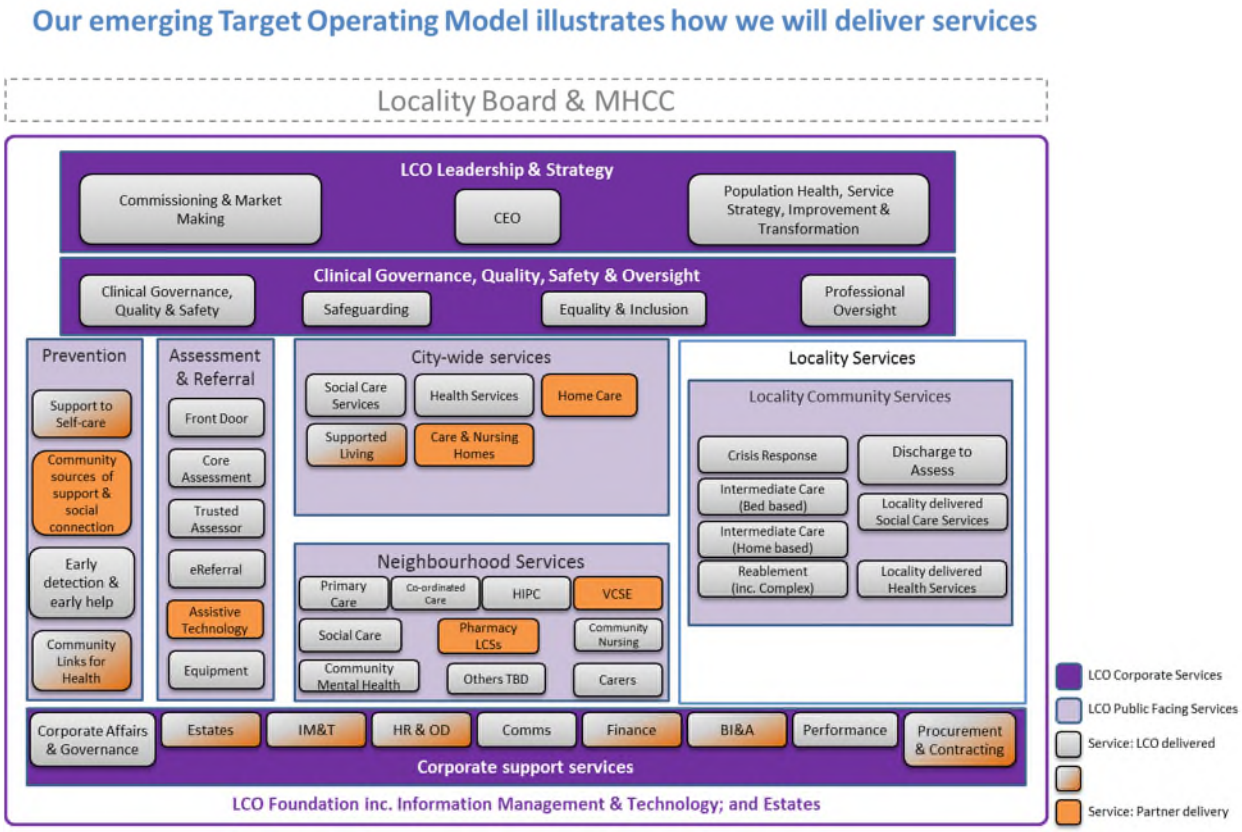
In collaboration with partners (including commissioners) a Target Operating Model (TOM) has been developed. This is provided below.

This outlines how the LCO will plan, manage and organise service delivery, and this will come on stream as in-scope services transition to the LCO over the next 3 years. This takes into consideration both the services that will transition from existing organisations and transformational programmes (new models of care).

The Transformation Fund investment within the LCO is linked to the delivery of a range of service provision benefits for the people of Manchester. These benefits are captured in each of the businesses cases.

Work on the transformation of mainstream community services across the Partners to achieve greater outcomes for people, within the current resource envelope, is beginning within the LCO in 2018/19. This is reflected with relatively modest efficiency assumptions in 2018/19, which rise to around £15 million in 2019/20. There are plans already in place in social care to deliver this and the LCO will begin supporting work on this during 2019/20.

The LCO will operate a distributed leadership model and will look to enable as much service planning and delivery at the neighbourhood level as is possible. The model below enables the LCO to illustrate how the neighbourhood services will interact with services provided at the locality and citywide level and the role that the LCO will take in the Manchester system to manage community and out of hospital services.



In its first year of operation, the priority focus for the LCO will be to:

- Manage the safe transition and operation of current services
- Mobilise, run and evaluate the new models of care
- Manage the interface of services with MHCC, MFT, MPCP, MCC and GMMH
- Establish, manage and develop the LCO corporate functions in the locality context

7.1 Manage the safe transition and operation of current services

A due diligence process is underway to inform and enable the safe transition and operation of current services. In addition, the LCO has worked through a set of operational scenarios on quality, performance, finance and workforce to demonstrate how it will respond to events within the new operating model. These scenarios focused on deployed staff in the first instance and have been shared with partners.

7.2 Mobilise, run and evaluate the new models of care

The following transformation programmes are already mobilising:

- High impact Primary Care (HiPC): the team in North Manchester started to receive referrals w/c 13th November and the services for the Central and South localities plan to be operational before the end of January 2018.
- Reablement: mobilisation commenced and recruitment underway.
- Discharge to assess: mobilisation has commenced and recruitment is underway

- Extracare: 5 flats in Village 135 are now operational.
- Enhanced Home from Hospital: service operational citywide from October 2017.
- Community Links for Health: service operational in North Manchester and process to mobilise in Central and South is underway.

All other transformation programmes are progressing, although some experienced delays caused by a range of issues including:

- Delays in business case approval;
- Delays in money release.

In addition, pressures on transformation funding mean that not all programmes can be funded in full and the LCO is prioritising funding on a phased basis, as agreed by Partnership Board.

These issues will impact on the benefits realisation profile for year 1 and potentially overall.

Through collaboration with system partners, the LCO is working to understand the range of service improvement and transformation that is taking place across and beyond the Manchester system. Our intention is to understand how this work directly and indirectly impacts on the LCO operating model, as well as identify opportunities to consolidate thinking and resources.

7.3 Manage the interface of services with MHCC, MFT, MPCP, MCC and GMMH

The Partnership Agreement will set out the delegation framework from which the interfaces with key system partners and governance will be designed.

7.4 Establish, manage and develop the LCO corporate functions in the locality context

As all in scope contracts will remain with current providers for April 2018, we will be working to ensure we have robust SLAs in place to continue to deliver strongly on performance, workforce and finance during 2018/19.

The LCO also has a key work stream in place to support organisational set up which includes:

- How services will be planned, managed and delivered at neighbourhood, locality and citywide levels;
- Corporate functions being established in line with the accountabilities and responsibilities of each Executive portfolio. This includes organisational structures and proposals for how the LCO will make, share or buy key support services from partners or other organisations. Funding for these are being finalised.
- Defining the LCO identity, organisational development and learning approach and managing the transition of staff working with and deployed into the LCO.
- Establishment of the LCO corporate infrastructure. This is underway with new LCO premises being identified and the supporting IM&T agreed with MCC.

- Defining how the LCO performance will be monitored through LCO governance, the Manchester Agreement, contractual KPIs and the LCO Outcomes Framework.
- Defining clinical accountability and governance models to ensure clinical input into future service improvement programmes, as well discharging agreed clinical, quality and safety responsibilities for the management of transitioning services.

When considered together, the TOM and the mobilisation plan clarify how the LCO will work within the Manchester system to ensure:

- System resilience and demand management;
- LCO infrastructure is in place to manage the safe transfer and operation of transferring services and mobilisation of service improvement programmes;
- Full mobilisation and evaluation of LCO-led service improvement.

The mobilisation of the LCO operating model is enacted through the Partnership Agreement. It is contingent on timely partner compliance with the Due Diligence process, the release of transformation funding and system commitment to a new way of working.

8. Financial Plan

During 2017/18, the LCO have been working with partners to create a Financial Plan for the LCO. It should be reiterated that during 2018/19, the contracts for the LCO are likely to remain with the existing providers. Therefore, preparation of the Financial Plan has proved a challenging task in terms of the timely release of information in regards to direct costs and the ability to engage in a productive dialogue about the disaggregation of overhead costs.

During the procurement process, MHCC indicated that for 2018/19 an Income and Expenditure statement (analysed by contract blocks) for the first three years of the transfer of in-scope services to the LCO would be an acceptable first step. The summary Income and Expenditure (I&E) statement for 2018/19 and the balanced indicative I&E statement for 2019/20 presented below represent a position as at 17th January 2018. Further work will continue into February to further refine the position.

2018/19 Income and Expenditure Position	Total
INCOME	**£m**
Health Care Services - Total	**96.8**
Social Care Services – Total	**59.0**
Investment Funding: Total	**16.7**
Other commissioned: Total	**6.3**
Total Income	**178.8**
PAY (Direct costs)	
Total Pay	**116.4**
NON-PAY (Direct costs**)**	
Total Non Pay	**49.6**
Total Direct Cost Expenditure (nominal)	**166.0**
Contribution to Indirect Costs and Overheads	**12.8**
Assumed Indirect Costs and Overheads	**(12.9)**
Assumed Net Position	**(0.0)**

2019/20 Income and Expenditure Position	Total
INCOME	**£m**
Health Care Services - Total	**322.8**
Social Care Services – Total	**191.3**
Investment Funding: Total	**10.8**
Other commissioned: Total	**6.8**
Total Income	**531.7**
PAY (Direct costs)	
Total Pay	**126.9**
NON-PAY (Direct costs**)**	
Total Non Pay	**397.0**
Total Direct Cost Expenditure (nominal)	**524.0**
Contribution to Indirect Costs and Overheads	**7.8**
Assumed Indirect Costs and Overheads	**(7.8)**
Assumed Net Position	**(0.0)**

8.1 Financial Plan Assumptions

Given the challenge indicated above in terms of creating the Financial Plan for the LCO, a list of key assumptions is provided below:

Adult Social Care

In line with health budgets, the adult social care (ASC) element has been developed on a bottom-up 'expenditure-driven' basis using the 2017/18 recurrent direct cost expenditure base adjusted for known movements.

An overall assumption of break-even on direct cost expenditure has been used to derive contract income values at this stage pending commissioner confirmation. ASC contract values have been pegged to direct cost expenditure and include an allowance for pay and price inflation.

The Adult Social Care component of the LCO financial plan is based on the approved February 2017 Manchester City Council budget assumptions for 2017-20 including the cash limit budget, approved savings programme and the centrally held funding for inflation, demographics and the national living wage (described in the 2017 Locality Plan financial strategy as the 'social care expenditure limit'); this is then updated for:

(i) The agreed scope and annual phasing of service transfers, distinguishing between provision and commissioning 'blocks';
(ii) Separation of gross cost, spending authority for which will transfer (through SLA arrangements) to the LCO Executive through the Director of Social Care and income that will remain with the City Council;

(iii) Alignment with the City Council's budget proposals detailed in the ASC Directorate Budget and Business Plan 2018-20;

(iv) Deployment of the ASC reform grant in line with the decisions made by the City Council and MHCC Executive.

(v) The cost of approved reform schemes, detailed in approved business cases, and the non-recurring investment funding (ASC grant and GM Transformation Fund) and benefits (savings on homecare and residential care) expected;

The resulting budget is a firm cash limit for 2018/19 and indicative budget for 2019/20 and will be managed in accordance with the Partnering Agreement. As accountability for the Social Care budget remains with the Strategic Director Commissioning and DASS, a reduced level of due diligence has been undertaken and the Strategic Director Adult Social Care will discharge authority to spend in 2018/19 on the basis the cash limit allocation approved will have addressed the known material spending pressures to 1st April 2018.

NHS Contracts

NHS contract income this has been informed by NHS commissioning budgets. The

contract values confirmed by commissioners are those based on the forecast Month 4 outturn for 2017/18 and are stated at 2017/18 prices.

NHS expenditure for central and south Manchester has been aligned to the analyses of 2017/18 direct cost budgets.

In relation to North Manchester community services an overall assumption of breakeven against confirmed contract values has been applied, as we are awaiting direct cost information which is due by 19th January 2018.

An overall assumption of breakeven across the health contract block has been assumed based on current position.

Pay and non-pay expenditure has been uplifted to current year values on the basis of NHSI's published Economic Forecast Assumptions.

8.2 Financial Plan Risks

The LCO have recognised the following risks in relation to the financial plan:

(i) The production of the Financial Plan and the information from which it has been built has not yet been subject to full due diligence. Material inaccuracies could exist within the base information which are not identified at this stage. To manage this risk, a conservative approach has been adopted and underpinning assumptions applied. The level of assumptions may impact on the overall robustness of this Financial Plan. Dialogue is ongoing with provider organisations to validate the information received via the Finance Working Group.

(ii) The Financial Plan presents the LCO projected financial performance across each of the six contract 'blocks' (i.e. Adult Social care [ASC] Provision, ASC Commissioning, Mental Health, Primary Care, Health Provision and Health Commissioning) in accordance with the proposed staging of the transfer of in-scope services. Formal conclusion of this process is ongoing.

(iii) The ASC demographics profile of the number of clients eligible to enter service and their acuity of need will always have a level of uncertainty and associated financial risk.

(iv) The budget for 2019/20 is indicative and there is a significant programme of work underway by commissioners on financial sustainability. The pivotal role of the LCO in transforming out of hospital services is integral to the medium term financial strategy.

(v) The Financial Plan recognises that the Manchester City Council Executive has approved ASC budget assumptions for 2017-20 and the latest re-fresh work currently goes through Scrutiny and Executive process.

(vi) There are significant acknowledged risks within the ASC budgets and although responsibility for commissioned services only takes effect from 2019/20, early engagement on the commissioning strategy for residential, nursing and homecare market for 2018/19, before this responsibility transfers, is particularly important.

(vii) The Budget Delivery Plan for Social Care (£4.4m) is assumed to be supported by a detailed programme of work to be developed and implemented with engagement of the LCO.

(viii) A key element of the financial model is sustaining investments following the reduction in one-off funding from grant and TF. The expectation is the LCO cost base will be maintained through funding 'flowing around the system' in line with the investment strategy and forthcoming Manchester Agreement. The risk-reward arrangements are still in development.

(ix) A risk remains around overheads available to the LCO. Whilst the LCO will aim to utilise existing systems, the scale and pace of change required to support financial sustainability will need to be drawn from carving out existing costs in the Partner organisations.

8.3 Financial Plan Summary

Taking into consideration the information provided above:

(i) The I&E Statement for 2018/19 represents the basis of the LCO's proposed direct costs budget for that year on the basis of agreement on the in-scope services. The indicative I&E Statement for 2019/20 presents also a balanced position overall, on the basis that 'at risk' funding recognised in relation to identified financial pressures is agreed with commissioners, and the LCO's corporate structure is funded via the contribution to indirect costs and overheads in respect of transferred services.

(ii) The LCO's ability to deliver the ASC plan as set out is dependent on a number of factors, including:

- early engagement of the LCO in the MHCC's proposals for the Budget Delivery Plan to address the underlying financial gap in 2019/20.;
- the decisions of the Council's Executive on the Budget Investment and Delivery Plan proposals and confirmation of the allocation for the LCO; and
- Confirmation of the proposed ASC grant allocations.

(iii) The resourcing of sufficient capacity to support the target operating model is considered critical to the LCO's ability to deliver to the scale and pace set out within the Prospectus.

9. Recommendations

Further to the information outlined in this paper, the LCO can confirm that based on current available information, we are in a position to begin to operate services in April 2018/19. The LCO Executive and wider team are also cognisant of the requirements that are associated with the implementation and delivery of a LCO to support system wide delivery of transformation benefits and efficiency schemes.

LCO Partnership Board are requested to note and action the following recommendations:

- To note the progress made in regards to producing an LCO Business Plan for 2018/19 and proposed completion by end of February 2018 subject to satisfactory completion of the Partnering Agreement;
- Support the development of a roadmap which will be produced to take the LCO through to go-live in April 2018;
- All Partners to inform what their sign off processes are in relation to the Partnering Agreement and Business Plan;
- Support an assessment of the changes from the initial vision and scope set out in the LCO Prospectus and an impact analysis of this, specifically in regards to benefits realisation; and

Support a commitment to funding neighbourhood team leadership structures and development of the teams

THE MANCHESTER AGREEMENT

Transforming the health & social care system in Manchester – A Partnership Agreement

Version Control:

Version	Date	Summary of Changes	Changed by
DRAFT 0.1	04/08/17	First draft for internal use	AS
DRAFT 0.2	07/08/17	Various, following feedback from MA Delivery Group	AS
DRAFT 0.3	08/08/17	Around gain and loss share and now for release to MTFAB	AS
DRAFT 0.4	11/09/17	Feedback post-MTFAB from a variety of sources, and update	AS
DRAFT 0.5	21/11/17	Final draft with updates to all sections	AS
V1.0	07/12/17	Version for organisational sign off, following November TAB	AS

Distribution:

Name	Area of Responsibility
TAB	Various

INTRODUCTION

The Manchester Agreement (MA) has been produced within the context of hugely ambitions plans to deliver a transformed health and social care system, not just in Manchester but regionally as part of the Greater Manchester (GM) devolution deal.

The Manchester Locality Plan sets the ambition to radically improve people's health in the city and close an estimated £135 million financial gap that there would otherwise be by 2020/21. This will require an unprecedented set of complex, interdependent reforms to the way services are commissioned and provided, encompassing structural, contractual and service delivery transformation.

Large scale investment is being provided to support this transformation through the GM Transformation Fund, additional Government funding for Adult Social Care (ASC), and a range of other sources. Given the scale and complexity of this change, it is vital that all partners have the confidence and assurance that investment in transformation will lead to improved health outcomes and financial sustainability.

The GM Investment Agreement provides the high-level information about what needs to be delivered in return for the investment from the GM Transformation Fund. The Manchester Agreement will sit alongside the GM Investment Agreement to provide additional assurance about how investment and reform will reduce demand in the city. It will detail how partners will collaborate to better understand how the investments being made in new models of care will reduce demand for acute health services, and, through decommissioning, release cashable savings for reinvestment. This will be done by tracking and monitoring key metrics over time, evaluating the impact that the new approaches have on people's lives, and setting out how partners will share risk and reward. Inputs and outputs required from the main programmes of change will be identified, along with how these link to the outcomes and population health impacts required.

This first version of the MA focuses on investment from the GM Transformation Fund (including Mental Health (MH), Local Care Organisation (LCO), Single Hospital Service (SHS), Primary Care (seven-day access, Digital), and related funding sources where funding for transformation projects comes from more than one source (ASC reform funding, for example). Subsequent versions will continue to take account of related work being undertaken at regional level by the GM Health & Social Care Partnership (GMHSCP), and ultimately the broader range of investments required to deliver reform.

The MA, therefore, seeks to further strengthen the partnership between key health and social care partners in Manchester, to better enable the delivery of system wide transformation.

This document has four main sections:

- Section one outlines the vision and strategy for the system,
- Section two describes the approach to performance, benefits and evaluation, with the performance framework itself included as an appendix,

- Section three introduces the principles of risk and gain share that will underpin the MA,
- Section four covers the 'partnership compact', which partners are asked to sign up to.

SECTION ONE – VISION & STRATEGY

1. Background and Introduction

'Taking Charge of our Health and Social Care in Greater Manchester' (2016) is the strategic plan for whole system transformation of integrated health and social care, in which for the first time, local people are taking charge of decisions on the health and care services for Greater Manchester (GM). It outlines five themes on which reform across GM is being focused to support transformation and ensure sustainability of the health and care system. These are: the radical upgrade in population health prevention; standardising community care; standardising acute hospital care; standardising clinical support and back office services and enabling better care.

The Manchester Locality Plan, *'A Healthier Manchester'* (2016), detailed the transformation ambition for health and care services in Manchester for delivery of its part of the Greater Manchester Plan against these themes. It set out the strategic approach to improving the health outcomes of residents of the city, while also moving towards financial and clinical sustainability of health and care services. It was developed in the context of the public consultation which was taking place for the Manchester Strategy - *'Our Manchester'*, in which Manchester City Council asked residents what their ideal Manchester would be. Through the consultation it was found was that residents wanted more efficient public services that joined up and worked together, working towards an ambitious future for the city.

The vision is for Manchester to be in the top flight of world-class cities by 2025, when the city will:

- Have a competitive, dynamic and sustainable economy that draws on its distinctive strengths in science, advanced manufacturing, culture, and creative and digital business - cultivating and encouraging new ideas,
- Possess highly skilled, enterprising and industrious people,
- Be connected, internationally and within the UK,
- Play its full part in limiting the impacts of climate change,
- Be a place where residents from all backgrounds feel safe, can aspire, succeed and live well,
- Be clean, attractive, culturally rich, outward-looking and welcoming.

This is a challenging, exciting and ambitious vision. To make it a reality, the system will have to work together in a new way to get things done. The Locality Plan reflected the shared commitment and vision of the commissioners and providers within the system, who at that time included: North, Central and South Manchester Clinical Commissioning Groups, Manchester City Council, the three acute hospital trusts, and Manchester Mental Health and Social Care Trust. The organisational landscape has now changed, in accordance with the Locality Plan, reflecting the

significant progress that has taken place. This in addition to the publication of Our Manchester, provides the opportunity to refresh the Locality Plan; enabling the system to reflect on progress, re-state the principles of change underpinning the Locality Plan, and describe the overall strategic aims of the system taking into account Our Manchester and the outcomes that will be achieved for the population.

1.1 Our Manchester

The Our Manchester approach simply means having a different conversation with residents and partners, working together to build relationships and really listen to the people we work with. Starting from strengths - what people can do, rather than what they can't do. And all of this is aimed at helping people across the city lead better lives. It puts people at the centre of everything we do:

- Better lives – it's about people,
- Listening – we listen, learn and respond,
- Recognising strengths of individuals and communities – we start from strengths,
- Working together – we build relationships and create conversations.

The delivery of the Locality Plan now needs to be undertaken within the context of the Our Manchester approach. Residents told us that health services were important to them so we need to work together to deliver the best services possible. We'll do this by ensuring the behaviours we exhibit match the approach - we'll work together more and trust those we work with; we'll listen, learn and respond; we'll take responsibility for our own actions and allow ourselves the freedom to try new things. Only by changing the way we work with our residents across the whole system, will we achieve the transformed and sustainable health and care system needed. Most of all, we're all proud and passionate about our city. It is, after all, Our Manchester.

In refreshing the Locality Plan and setting out the vision for this agreement, we are now able to state that when we commission services, we'll do it an Our Manchester way – by listening to what residents tell us is important, by thinking differently about solutions rather than doing the same old things, and by working together across organisations to get the job done.

1.2 Principles of change

The seven principles of change which underpin the Locality Plan, consistent with the Our Manchester approach remain as:

Principle one – People and place of Manchester will have priority above organisational interests,

Principle two – Commissioners and providers will work together on reform and strategic change,

Principle three – Costs will be reduced by better co-ordinated proactive care which keeps people well enough not to need acute or long term care,

Principle four – Waste will be reduced, duplication avoided and activities stopped which have limited or no value.

Principle five – The health and social care system is made up of many independent and interdependent parts which can positively or adversely affect each other. Strong working relationships will be developed within the system with clear aims and a shared vision for the future.

Principle six – There will be partnership with the people of Manchester, the workforce, voluntary and community organisations.

Principle seven – The partnership will work to safeguard children, young people and adults, enhancing their health and well-being and protecting the rights of those in the most vulnerable situations.

2. Our Vision and Strategic Aims

The Locality Plan did set out an ambition for Manchester residents by 2021, however the current refresh of the plan enables the system to incorporate Our Manchester into the strategic aims for the system. The strategic aims are summarised below:

Manchester has transformed in terms of economic growth and infrastructure. However, people's health and wellbeing have not prospered, and in 2017 residents of Manchester still have some of the worst health outcomes in England. Achieving good health is predominantly influenced by the wider determinants of health such as education, housing, employment, and skills.

These strategic aims explicitly commit the health and care system to its role in strengthening the wider determinants of health. The role that the system will play in actively strengthening the wider determinants, reducing dependency, and therefore unlocking the potential of the community to live well and contribute towards the city's growth, is fundamental to the achievement of these aims.

The achievement of the strategic aims will be measured through existing monitored outcome frameworks across the system spanning health, care (which will include this MA) and the wider determinants covered by the Our Manchester strategy.

3. Achieving the Strategy

The Locality Plan outlined the initial approach to delivery of the ambition which was focused on establishing the organisational architecture needed for whole system transformation, effectively the establishment of the three pillars which are:

- ***A single commissioning system*** – this has been established as Manchester Health and Care Commissioning (MHCC); ensuring the efficient commissioning of health and care services on a city wide basis with a single line of accountability for the delivery of services. This approach will integrate spending across health and social care, reducing duplication of service delivery and fragmentation of care,

- ***A Local Care Organisation (LCO)*** delivering integrated and accessible out of hospital services through community based health, primary and social care services within neighbourhoods. Through the combining of resources residents will get integrated services, resulting in improved outcomes (with holistic needs addressed) at reduced cost,

- ***A 'Single Manchester Hospital Service' (SHS)*** – the Manchester University Hospital Foundation Trust (MFT) has been established through a merger of Central Manchester Foundation Trust (CMFT) and University Hospital South Manchester (UHSM), with planning underway to bring North Manchester General Hospital (NMGH) into the Group. An SHS will secure cost efficiencies and strengthen clinical services, through consistent and complementary arrangements for the delivery of acute services achieving a fully aligned hospital model for the city.

These have now either been established (MHCC, MFT) or are in the process of being established, with LCO procurement on track for completion by April 2018. It is important that organisational changes are followed through in their establishment their maturity and how they work together. However, looking forward a new focal point which focuses upon changes to services and our relationship with residents needs to be developed. Three new areas of focus are proposed:

'Our Services'

This means:

- Developing integrated, well-coordinated and proactive care,
- Standardised care which consistently follows evidence based pathways and interventions,
- Connecting with communities, delivering excellent user experience in neighbourhoods where possible,
- Completing organisational changes to commissioning and provision,
- Maximising potential through research and innovation in the city.

'Our People'

This means:

- Addressing the causes of poor health outcomes across Manchester with interventions that will impact on in the short, medium and long term,
- Achieving equity in quality and service provision across the city,
- Engaging and empowering residents in positive lifestyle choices regarding smoking, diet, exercise and alcohol,
- The health and care system being an exemplar of the Our Manchester approach,
- Working with others to bring opportunities for education, employment, good housing, a developing economy and social inclusion.

'Our Outcomes'

This means:

- Delivery of quality, safety and performance across the system,
- Achieving financial balance across the health and social care system in the short and medium term,
- Good levels of recruitment, retention and staff satisfaction,
- Modern buildings and technology supporting effective working.

The health and care system is currently identifying the high level milestones over the next 12 months (laying the foundation) , three years (system performing), five years (system maturing) and ten years (delivering the vision) that will need to be achieved in order to achieve the strategic aim across 'Our Services', 'Our People' and 'Our Outcomes'. A draft of the high level milestones is shown below, and further work is taking place to articulate the full milestone plan that will support delivery.

SECTION TWO – PERFORMANCE, BENEFITS & EVALUATION

4. Introduction

This section of the MA describes the approach the system will take to identifying, managing and delivering the performance, benefits and evaluation aspects of transformational system change.
The importance of these three aspects, not only in their stand-alone state but in the way they interact and support each other, cannot be overestimated. Effective identification, management and delivery of performance, benefits and evaluation will underpin system transformation.

5. Performance Framework

The MA performance framework is intended to provide a high-level view of how whole system reforms are progressing. It identifies a small number of definable indicators that can be used to track and measure progress over time. The measures

represent the changes required to the LCO, SHS, to population health, and align with broader strategic objectives in the city such as increasing social value. The measures focus in particular on quantifying the short and medium term changes required, in order to deliver longer-term financial and clinical sustainability.

The performance framework should be read alongside the sections on: benefits realisation, to understand how these measures will actually be tracked through to realising benefits; evaluation, to give confidence that it is the investments in reform that are having an impact rather than other factors; and gain and loss share, so the same performance measures are being used to determine how money will flow around the system in future.

The proposed performance framework, displayed as a series of dashboards, is attached at Appendix A.

5.1 Approach

The performance framework uses a logic model approach:

- Inputs: what are the additional inputs, e.g. new resources, investment, people?
- Outputs: what changes in activities does this lead to, e.g. increased episodes of preventative care?
- Outcomes: how do these activities reduce demand and cost in the system?
- Impacts: how does this improve population health?

The main focus in this framework is on the outputs and outcomes, as the measurable changes that will more directly result from the investments. The evaluation framework will consider how to demonstrate that the inputs and outputs are driving the outcomes.

The Health & Social Care Data Warehouse will bring together the different data required for patients (through the development of the Manchester Care Record) and at an aggregate level. Data input sources will be agreed, and a Data Quality Improvement Plan will set out the measures needed to improve data and address gaps.

5.2 Summary of Performance Measures

The four main areas that are covered in this framework are as follows.

<u>LCO Outcomes</u>

These are measures of activity reductions or financial savings related to Manchester, for example fewer non-elective admissions to hospital. To note:

- The measures included here are consistent with the GM Investment Agreement (GMIA), which reflects top-down assumptions from a dated baseline position, at a point in time in March 2017. These will subsequently be updated to form an accurate baseline position from April 2018

- The table includes revisions noted previously to the Transformation Accountability Board (TAB) on the metrics for homecare packages (one part of the cost of care packages) and North West Ambulance Service (NWAS) journeys.
- The table includes the non-cashable elements for the metrics as well as cashable reductions required to present the totality of the challenge for the system. These overall reductions need to be achieved in order for a proportion of the reductions to be cashed. Note those items considered 0% cashable are excluded.
- Acute metrics are currently shown in activity terms, whereas social care and prescribing are shown in financial terms. This is in order to be consistent with the GM IA and work with the best available data.
- Measures are after reductions for optimism bias.

Further development work will include:

- Subsequent versions of the framework will be developed in future, including:
    a) inclusion of measures being used to track the investments in the mental health improvement programme as part of GMTF investment,
    b) just the cashable element of savings, as per the GMIA,
    c) bottom-up calculation of benefits based on aggregation of individual business cases for investment submitted by the LCO,
    d) commissioner cashability assessment – which is the main measure used in MHCC financial reporting.
- Further breakdowns will also be shown such as the split across LCO priority cohort groups, and the implications for each organisation – but showing these here would make the framework much more complicated to view.
- A proxy measure still needs to be developed for GP productivity. This was 0% cashable in the GM IA but is still an important element of the overall reforms.

LCO Outputs and Activities

This section takes a small number of key quantifiable metrics for activity that the LCO needs to deliver from each of the key models of care set out in individual business cases and the overall LCO programme plan, such as Integrated Neighbourhood Teams and High Impact Primary Care. Including these here is intended to give system leaders an indication that the LCO is on track to deliver the metrics of activity that in turn should drive the longer-term reductions in demand and improvements to people's health.

SHS Outputs and Activities

The SHS performance framework seeks to provide a robust and workable performance and benefits framework based on the patient benefit cases developed as part of the merger approval process.

The SHS table included in the performance framework in appendix A shows when service transformation is scheduled to start and finish in each of the benefit areas. These will be developed further as specific patient benefits are described.

Whole-system change

This section includes a small selection of further indicators that the whole system is on track to deliver the longer-term improvements needed in population health. Examples include fewer deaths from preventable diseases and improvements in school readiness. These metrics are consistent with the targets for Manchester within the GM Population Health plan.

6 Benefits Planning, Management & Realisation

This section specifies the approach that will be adopted to ensure benefits are planned, managed and realised. The outcome measures specified in Manchester's performance framework are, effectively, benefits. Given this, and to make the process as comprehensible as possible, further benefits over and above outcome measures will not be identified at this stage.

6.1 Approach

Typically, a benefits planning, management and realisation approach follows four main steps:

- Identify – high level identification of benefits.
- Validate – benefits worked through in detail, culminating in a firm promise to deliver, based on stated assumptions (what, where, when and how).
- Enable – benefits embedded in solution delivery.
- Monitor and realise – progress tracked against operational and financial targets.

This MA builds on the work undertaken in Manchester to 'Identify' and 'Validate' benefits, and outlines how the 'Enable' and 'Monitor and realise' stages will be delivered.

Planning, managing and realising benefits on this scale, at this level of complexity, is a challenge. Therefore, the intention with this approach is to start with a manageable process that allows for the build-up of capabilities over time, informed by learning from how benefits management is working in practice.

6.2 Governance

6.2.1 Classifying benefits

In the broadest sense, benefits are either cashable or non-cashable. Cashable benefits are those that, upon achievement, result in some financial benefits. In the case of the transformation being pursued in Manchester, cashable benefits will directly contribute to the objective of achieving financially sustainable system. Once a cashable benefit is realised, the gain and loss share agreement will determine how and where the benefit is 'banked', and how it will trigger the resulting change in investment in service delivery. In Manchester's case, this should broadly result in a shift in funding flows from in-hospital to out-of-hospital services.

Non-cashable benefits are all those benefits that don't have a quantifiable financial measure, and as a result can't be 'banked'. These often include resident satisfaction measures and efficiency improvements, for example.

The two types of benefit are not mutually exclusive, and the categorisation of a benefit can sometimes be difficult. For example, a non-cashable benefit may result in cashable benefits over time, but unless the cashability of these benefits can be quantified accurately and 'banked' after a defined period, they remain non-cashable.

A financial benefit could also accrue from a non-cashable benefit in the case of benefits that result in future cost avoidance. For example, in a situation where demand is still rising, but at a lesser rate than predicted. The capacity freed up as a result of slowing the rise in demand could be used to deliver new activity, which could also have a positive financial impact beyond cost avoidance.

6.2.2 Governing performance management and benefits realisation

There are three levels of governance that play a key role in assuring delivery against performance and benefits targets:

Level 1- Portfolio level

Portfolio level responsibilities include:

- Reporting to, and liaison with, GM HSCP,
- A quarterly review of progress against performance and benefits, using the portfolio level dashboard,
- Instigation of 'root cause analysis', where the thread between the achievement of a project level benefit and the achievement of a portfolio level benefit is broken. For example, if situation occurs where all projects and programmes are reporting a positive impact on non-elective attendance rates, but the citywide headline figure isn't changing, then this would trigger a root cause analysis to understand why.
- Monitoring the extent to which benefits are being duplicated across programmes, and taking remedial action.
- Monitoring the impact of transformation performance and benefits realisation on BAU and overall system stability, whether the impact is intended or otherwise.
- Setting and re-setting priorities for portfolio resource deployment on the basis of benefits achievement and continued strategic fit.
- Banking the benefits.

The Locality Plan PMO will support and manage the various activities that make up the responsibilities outlined above. However, accountability rests with senior leaders that sit on portfolio level governance forums, notably the TAB and the Finance Executive, and from a delivery perspective with the Performance and Evaluation Programme.

Level 2 - Programme level

Programme level responsibilities include:

- Reporting benefits at risk of not being achieved on time and/or in full to the relevant portfolio level governance forum,
- Monthly review of benefits realisation through normal highlight reporting process,

- Setting and re-setting priorities for programme resource deployment on the basis of benefits achievement.
- Confirming to portfolio level that a benefits has been achieved, and can be 'banked'.

Dedicated programme teams will support and manage the various activities that make up the responsibilities outlined above. However, as at portfolio level, accountability rests with senior leaders that sit on programme boards.

Level 3 - Project level

Project level responsibilities include:

- Reporting benefits at risk of not being achieved on time and/or in full to the programme board,
- Monthly progress reporting on benefits through project highlight reporting processes.

Project managers will be responsible for these activities.

Transition to mainstream activity

Many of the outcomes and benefits specified at project and programme level will not be fully realised within the timeframe of the project or programme itself, given both are time limited by definition. Because of this, the link between project and programme delivery, the mainstreaming of a new service, and the revised or new contractual arrangements that reflect this transition, need to be strong. This will ensure the ongoing tracking and evaluation of benefits realisation will continue beyond the lifecycle of a project or programme.

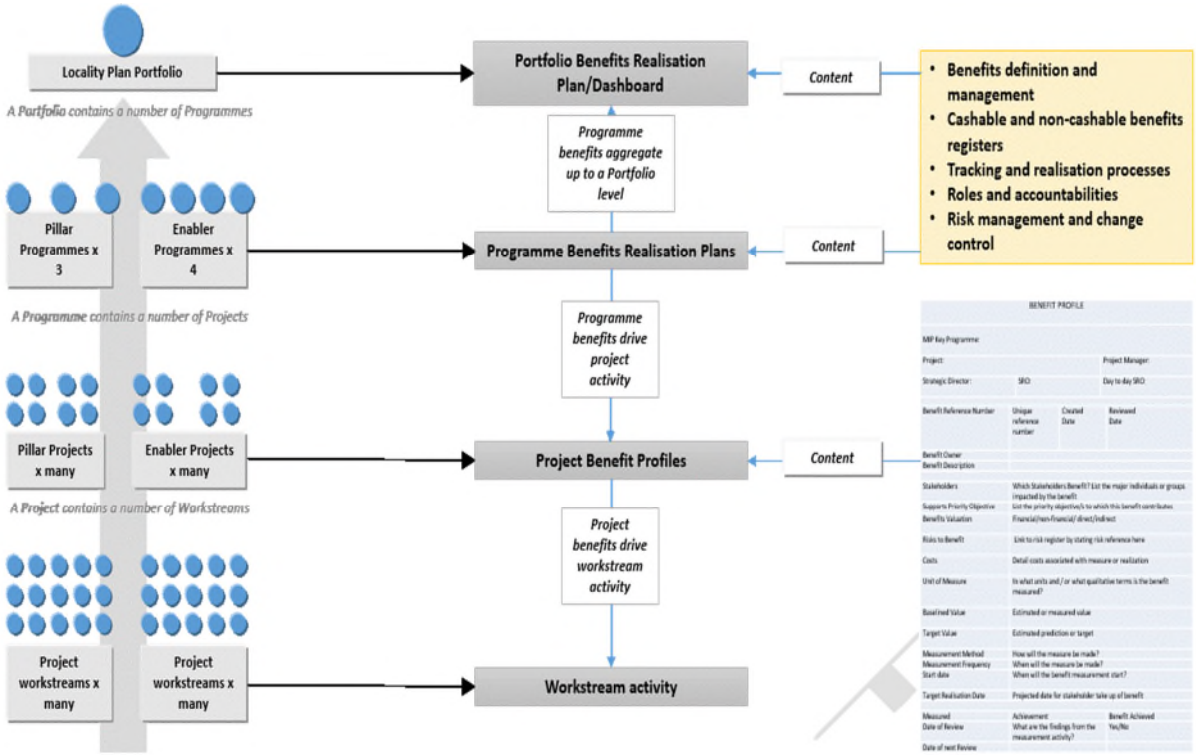
6.3 Benefits Management Tools

Standard benefits management tools will be adopted across the portfolio to ensure consistency in benefits planning, management and realisation. These tools include:

- Portfolio benefits realisation plan/dashboard
- Programme benefits realisation plan
- Project benefit profiles/register

At each level the benefits registers need to link to the highlight reporting process in place. For example, a project highlight report, delivered monthly to a project or programme board, must include a section that allows the project manager to update on the achievement of benefits.

The Locality Plan PMO is responsible for keeping the effectiveness of these tools under review. Programme Managers and Project Managers are responsible for populating and maintaining these tools.



6.4 Benefits realisation

Once a benefit is realised, the relevant programme director should confirm this with the Finance Executive and the Performance and Evaluation Programme.

The Finance Executive will then undertake the necessary accounting measures to 'bank' the benefit (if cashable), and will make any further recommendation to TAB on how system funding flows should change as a result. At this point, the decision about whether to communicate the benefit to internal and external stakeholders will also be made.

7 Evaluation

The evaluation will cover investments from the Greater Manchester Transformation Fund (GMTF) across Manchester and it will specifically cover two broad areas:

A. Projects that have had new investment from the GMTF - this will include the totality of investment where other locally matched funding is supporting GMTF investment, but will exclude wholly matched funded projects at this stage.

B. Projects impacted by existing saving plans which are running concurrently with the transformation investments – for example where transformational activities are running alongside agreed BAU service changes or decommissioning.

Whilst the evaluation will be complex and cover both process and impact elements at the system and project level, at a high level it is designed to answer five questions:

1. Are investments from the GMTF leading to expected outcomes across Health and Adult Social Care services?
2. Are the services and processes working as intended in practice?
3. Is there good evidence to suggest a causal link between GMTF investments and changes in outcomes?
4. Is there good evidence to suggest a causal link between integration of services and changes in outcomes?
5. Is there good evidence to suggest real, sustainable and positive behaviour change across the system?
6. Do the changes in outcomes outweigh the financial investments, leading to financially sustainable delivery models?

The evaluation will complement wider performance management, tracking and benefit realisation strands to provide a comprehensive picture of the implementation, performance, causality and impact of new services across an integrated health and social care system.

7.1 Approach

There will be many specific elements to evaluation work, however the recommended approach falls into four interrelated elements:

- Development of 'Theory of Change' models for both individual investments and the investment as a whole.
- An Outcomes Evaluation, establishing a series of measures which closely match the anticipated outcomes.
- A Process Evaluation, to explore what is being done differently and whether individual areas of investment are working as expected. This stage also provides the opportunity to understand the links between actions and outcomes.
- A Cost Benefit Analysis, linking activity and financial activities so that fiscal impact can be measured against investments (this updates the ex-ante CBA's with actual impacts).

The evaluation framework is intended to cover the overall scope of the areas above, however it will not be a single meta-evaluation study, given that:

- Evaluation at a scheme level will be predominately managed by commissioners.
- Evaluation of the impact of the SHS will be managed by the Trust(s) and will evolve from a focus on just transactional processes to transformational changes over time.
- Evaluation of the Mental Health Programme will be managed by GMMH, focusing specifically on the impact at a programme level.
- Evaluation of the LCO as a function will be managed by the LCO, focusing on the overall effectiveness[1].

Therefore, this proposal provides the overall framework and a way in which to align

[1] Likely to be delivered through a Research Partnership with Manchester Metropolitan University.

the various aspects, but relies on input and commitment for various parts of the system.

7.2 Timescales

It is anticipated that the Theory of Change work and the initial process evaluation elements will take place during the first 6-12 months, and a review of impacts from month 12 until the end of the programme (c.60 months). The chart below sets out the proposed timetable for the main elements of the evaluation.

Proposed Evaluation Timeline		Months																								
		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	24+
Process Evaluation	Evaluation of Investments																										
Impact Evaluation	Evaluation of Impact																										→
	Impact on wider BAU																										→
	Bi-Annual Case Audit / Evaluation of Service																										→
	Cost Benefit Analysis																										→

Whereas the overall timetable for the evaluation describes completing the Theory of Change work over the next six to 12 months, this will be completed incrementally following implementation timelines associated with individual transformation investments. This means that work around High Impact Primary Care (HIPC), which is due to start soon, will be the first area to draw down evaluation support. As this will come in advance of any commissioning of wider evaluation support, the Primary Research Team within MCC will offer short term support to enable the Theory of Change work and associated contractual requirements around data to be progressed. This will both ensure that HIPC has evaluation embedded from the start, but also act as a pilot of how the Theory of Change approach will be applied to all other transformation projects.

There are a number of crucial elements that underpin the approach, including continued access and development of the H&SC Data Warehouse[2], the creation and management of a Common Basic Dataset (CBD) to track delivery[3], development and implementation of a sampling methodology to facilitate appropriate and proportionate case reviews, engagement and review of user, staff and leader perceptions, and the development of statistical models to test and scale results to the whole system.

7.3 Governance

It is important that any evaluation is independent, has the appropriate governance, and empowers decision makers. Therefore, agreement will be required on where evaluation reports will go, how they will be used and disseminated across the system, and how the outputs are reported back into the various parts of the system to inform planning and decision making.

The Performance and Evaluation Programme, once established, will take on governance responsibilities for evaluation, and the Programme Lead will operate as the SRO for the evaluation work.

[2] Currently Managed by the MHCC Business Intelligence Team
[3] To be embedded within the Terms of Investment

SECTION THREE – RISK & GAIN SHARE

8 Introduction

The approach to financial risk and gain share is a system wide initiative due to the interdependencies of the funding flows within health and social care. Funding cannot be released in acute commissioning to invest in community based care if the Manchester acute hospital activity and associated tariff payments are not reduced against predicted demand. This is closely linked to the evaluation aspect of the MA, as the ability to monitor and evaluate new care models is fundamental to the ability to share benefits. As a result, a three faceted approach is being taken to risk and gain share within the locality:

8.1 Commissioner risk and gain share

The creation of MHCC and the aspiration to have a fully pooled budget is at the heart of the integrated commissioning arrangements. The principle of a pooled budget is to pool all resources and to utilise them to achieve the best outcomes in the city for patients and service users. In addition, by working together to create efficiencies across the Health and Social Care system (H&SC) in Manchester, benefits may arise in both health and/or social care which were influenced by investment made in the opposite sector. A risk and gain share may help distribute these benefits more equitably across the system.

However, risk and gain shares may potentially expose both partners to levels of financial risk and it is important to understand how this can be managed/mitigated by the organisations. Work is currently underway to agree an approach for 2018/19 and a paper has been drafted on potential options available to commissioners. There is also a programme of work to further develop integrated commissioning.

8.2 Acute Hospital Capacity

As previously stated, there are significant interdependencies for investment to be made in the community sector with the expenditure on acute hospital care. Work must be undertaken to initially understand the impact of the new care models, particularly on MFT, within the Manchester locality.

This modelling will inform all partners of the potential impact on activity within the city. From these discussions, consideration will be given as to how capacity may be best managed to ensure the deflections of activity are sustainable and not replaced with additional activity.

The 2018/19 contracting process with the acute hospitals should consider the above considerations including other commissioning intensions and QIPP, in particular where block contracts are agreed to manage system risk. This must be reviewed in light of the successful implementation of new care models and the proposed monitoring and evaluation.

8.3 Investment in LCO

The third element to the gain and risk share is to ensure that the benefits generated by the new care models are invested in the delivery of out of hospital care in the community. The benefits will accrue in two main areas: acute hospital activity (commissioner led budget) and residential and nursing care budgets (LCO led budget).

The contractual agreements with the LCO must consider how the investments in new care models will be made, in particular once transformation funding has been fully utilised. Including specifically how the benefits generated within secondary care, and those generated in residential and nursing will move around the system. This must be clearly linked to the evaluation process undertaken by commissioners and as part of the MA the outcome of evaluations will identify if benefits have been delivered to fund the service in future years.

In 2018/19, the expectation is that the LCO will receive the required new models of care funding, in addition to the contract baseline for existing services. It must be clear which new care models are subject to evaluation mid-year (for 2018/19 and future years), and the impacts of evaluation on funding streams. The LCO can also be incentivised utilising the Improvement Payment Scheme as a lever to ensure their engagement in the system wide changes by aligning delivery of appropriate outcome measures.

At present the LCO is made of constituent partners, and consideration is being given as to how the reinvestment of benefits works across these partner organisations.

SECTION FOUR – PARTNERSHIP COMPACT

The Manchester Agreement ('the Agreement') builds on the work undertaken by all health and care partners in Manchester over a number of years to build a strong and enduring coalition to steer the transformation of Manchester's health and care system.

The strategic direction for this transformation is set out in Manchester's Locality Plan. The Manchester Agreement now underpins the Locality Plan as it contains the detail behind how delivery will be monitored and measured, and how funding flows will change over time.

Partners are asked to sign this Compact to confirm their ongoing commitment to collaborate in order to deliver the Locality Plan, now in the context of the roles and responsibilities required of them as outlined in the Manchester Agreement. These roles and responsibilities are set out in the main body of the Agreement, and specifically relate to:

- Performance management,
- Benefits identification, management and realisation,
- Evaluation,
- Risk and gain share.

Responsibilities will be discharged through existing governance arrangements that support the delivery of the Locality Plan.

This Agreement is not legally binding. Current and emerging contractual arrangements between commissioners and providers, locally and at a GM level, provide the legal basis for delivery. These contractual arrangements are the first stage in the development by commissioners and providers of integrated health and social care services for Manchester. As the transformation set out in Manchester's Locality Plan is achieved, these contractual arrangements will need to evolve to ensure true integration in the delivery of Manchester's health and social care.

It may be the case that subsequent iterations of this Agreement resulting from an update of any one of the approaches to the areas included in the Agreement will require a review as to whether the Agreement requires a more formal legal basis. Partners will be consulted with well in advance of any future request to sign a legal document binding them to the Agreement, if developments require this course of action.

By signing this Compact, each party confirms that implementation of its obligations under this Agreement is consistent with its statutory obligations, and that it has complied with any relevant requirements imposed upon it by legislation or regulatory authority, and will continue to do so.

Signatures

Signed on behalf of **NHS MANCHESTER CLINICAL COMMISSIONING GROUP**

Name:

Role:

Signature: _____

Date:

Signed on behalf of **THE COUNCIL OF THE CITY OF MANCHESTER**

Name:

Role:

Signature: _____

Date:

Signed on behalf of **MANCHESTER UNIVERSITY HOSPITAL FOUNDATION TRUST**

Name:

Role:

Signature: _____

Date:

Signed on behalf of **PENNINE ACUTE HOSPITALS NHS TRUST**

Name:

Role:

Signature: _____

Date:

Signed on behalf of **GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST**

Name:

Role:

Signature: _____

Date

Signed on behalf of **MANCHESTER PRIMARY CARE PARTNERSHIP LIMITED**

Name:

Role:

Signature: _____

Date

Signed on behalf of **MANCHESTER PROVIDER BOARD / LCO EXECUTIVE**

Name:

Role:

Signature: _____

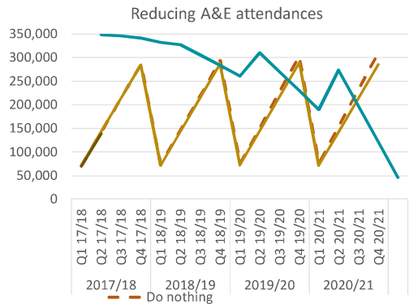
Date

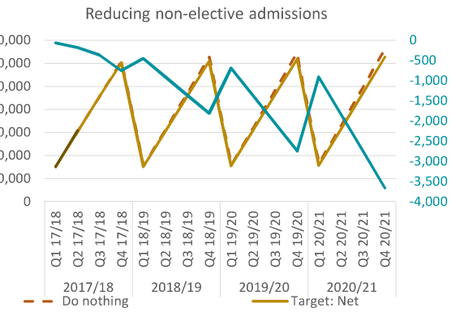
Ref	Measure	Unit	Desired performance	No previous data	Target 17/18	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q2 17/18 performance: Better than last quarter?	Better than last year?	Better than target?
1A	Reducing A&E attendances	Activity	Low	N/A	284,841	70,002	138,219	-	-	✓		✓
1B	Reducing non-elective admissions	Activity	Low	N/A	60,246	15,218	30,754	-	-	✗		✗
1C	Reducing elective admissions	Activity	Low	N/A	59,472	13,509	27,660	-	-	✗		✓
1D	Reducing outpatient attendances	Activity	Low	N/A	449,364	113,964	228,687	-	-	✗		✗
1E	Reduction in avoidable prescribing	Spend	Low	N/A	92,612	22,389	44,457	-	-	✓		✓
1F	Reduction in ambulance journeys	Activity	Low	N/A	67,849	16,637	33,356	-	-	✗		✓
1G	Reducing avoidance contacts & referrals	Spend	Low	N/A	7,902	1,734	3,489	-	-	✗		✓
1H	Reducing the cost of R&N / Homecare	Spend	Low	N/A	40,989	9,501	22,595	-	-	✗		✗
1I	SCF running costs	Spend	Low	N/A	15,328	3,691	7,125	-	-	✓		✓

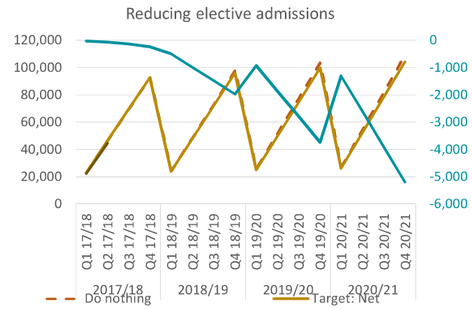
2017-18 out-turn will change as a result of further work to refine baselines as part of the budget-setting process.

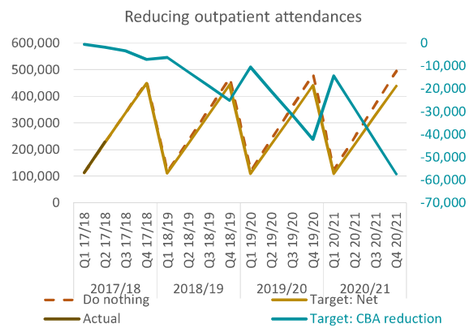
Ref	Measure	Unit	Desired performance	Year 1 2017/18 Target 17/18	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Year 2 2018/19 Target 18/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Year 3 2019/20 Target 19/20	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Year 4 2020/21 Target 20/21	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 18/19 performance: Better than last quarter?	Better than last year?	Better than target?
1A	Reducing A&E attendances	Activity	Low	284,841	70,002	138,219	-	-	286,991	-	-	-	-	289,476	-	-	-	-	285,343	-	-	-	-	⇔	↑	↑
1B	Reducing non-elective admissions	Activity	Low	60,246	15,218	30,754	-	-	60,950	-	-	-	-	61,833	-	-	-	-	62,673	-	-	-	-	⇔	↑	↑
1C	Reducing elective admissions	Activity	Low	59,472	13,509	27,660	-	-	60,261	-	-	-	-	61,202	-	-	-	-	62,111	-	-	-	-	⇔	↑	↑
1D	Reducing outpatient attendances	Activity	Low	449,364	113,964	228,687	-	-	444,624	-	-	-	-	441,146	-	-	-	-	439,002	-	-	-	-	⇔	↑	↑
1E	Reduction in avoidable prescribing	Spend	Low	92,612	22,389	44,457	-	-	96,104	-	-	-	-	99,876	-	-	-	-	104,249	-	-	-	-	⇔	↑	↑
1F	Reduction in ambulance journeys	Activity	Low	67,849	16,637	33,356	-	-	67,984	-	-	-	-	68,205	-	-	-	-	66,461	-	-	-	-	⇔	↑	↑
1G	Reducing avoidance contacts & referrals	Spend	Low	7,902	1,734	3,489	-	-	7,776	-	-	-	-	7,667	-	-	-	-	7,560	-	-	-	-	⇔	↑	↑
1H	Reducing the cost of R&N / Homecare	Spend	Low	40,989	9,501	22,595	-	-	42,105	-	-	-	-	43,541	-	-	-	-	44,272	-	-	-	-	⇔	↑	↑
1I	SCF running costs	Spend	Low	15,328	3,691	7,125	-	-	15,012	-	-	-	-	15,045	-	-	-	-	15,076	-	-	-	-	⇔	↑	↑

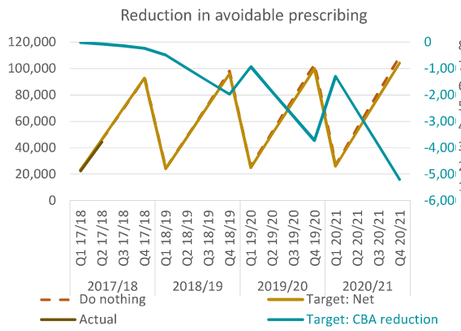
SUGGESTED CHARTS - NOT REAL ACTIVITY - WILL BE UPDATED WHEN ENOUGH TREND DATA IS AVAILABLE

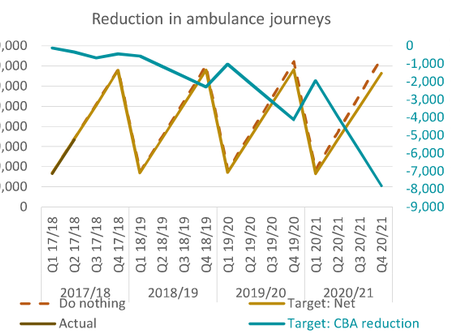


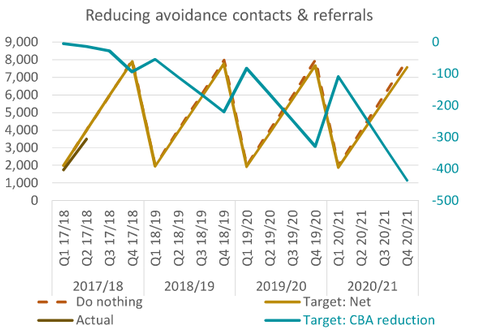


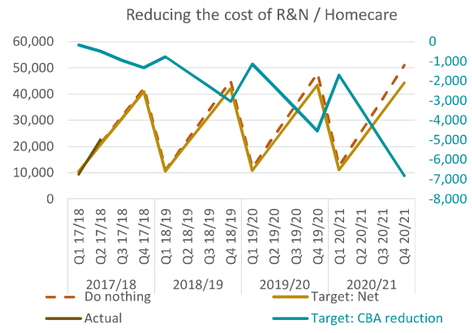


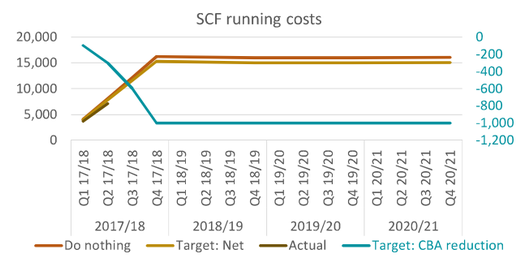












Note: Any figures in red are placeholders and should not be read or interpreted as actual figures. Any figures in black are correct.

1	2	3				4	5			6	10	14	18	22	23
								Latest		Year 1	Year 2	Year 3	Year 4	Year 5		
							Desired Performance	Period	Value	2016/17	2017/18	2018/19	2019/20	2020/21	Data Source	Frequency
GM Population Health Plan Outcomes																
	Outcome	Measure	Metric	PHOF ID	Period											
A	Improve health and well being of people in Manchester	Reduction in children in low income families (under 16s)	% of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income)	1.0ii	Calendar year	Do nothing (Forecast trend)	Low	2014		27.2%	26.0%	24.7%	23.6%	22.4%	PHE	Annual
						Target trajectory				24.9%	23.2%	21.6%	20.0%	18.5%		
						Actual			35.6%							
B	Improve health and well being of people in Manchester	Increase in proportion of children who are school ready	% of eligible children achieving a good level of development at the end of reception year	1.02i	School year	Do nothing (Forecast trend)	High	2015/16		70.9%	75.0%	78.5%	81.5%	84.1%	PHE	Annual
						Target trajectory				71.9%	76.8%	80.9%	84.4%	87.3%		
						Actual			63.7%							
C	Improve health and well being of people in Manchester	Reduction in low birth weight term babies	% of all live births with recorded birth weight and a gestational age of at least 37 complete weeks with a recorded birth weight under 2500g	2.01	Calendar year	Do nothing (Forecast trend)	Low	2015		3.1%	3.0%	2.9%	2.9%	2.8%	PHE	Annual
						Target trajectory				3.0%	2.9%	2.7%	2.6%	2.5%		
						Actual			3.3%							
D	Improve health and well being of people in Manchester	Reduction in under 75 mortality rate from cardiovascular diseases considered preventable	Age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years of age per 100,000 population	4.04ii	Calendar year (3 year rolling average)	Do nothing (Forecast trend)	Low	2014-16		69.6	66.0	62.5	59.3	56.2	PHE	Annual
						Target trajectory				68.7	63.8	59.0	54.4	49.9		
						Actual			94.9							
E	Improve health and well being of people in Manchester	Reduction in under 75 mortality rate from cancers considered preventable	Age-standardised rate of mortality considered preventable from all cancers in those aged less than 75 years of age per 100,000 population	4.05ii	Calendar year (3 year rolling average)	Do nothing (Forecast trend)	Low	2014-16		127.5	126.5	125.5	124.5	123.6	PHE	Annual
						Target trajectory				125.2	121.4	117.6	114.0	110.5		
						Actual			128.6							
F	Improve health and well being of people in Manchester	Reduction in under 75 mortality rate from respiratory disease considered preventable	Age-standardised rate of mortality considered preventable from respiratory disease in those aged less than 75 years of age per 100,000 population	4.07ii	Calendar year (3 year rolling average)	Do nothing (Forecast trend)	Low	2014-16		46.8	47.5	48.1	48.8	49.5	PHE	Annual
						Target trajectory				45.9	45.2	44.6	44.1	43.6		
						Actual			46.7							
G	Reduction in avoidable non elective activity in secondary care	Reduction in emergency hospital admissions due to falls in people aged 65 and over (Persons)	Age standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population	2.24i	Financial year	Do nothing (Forecast trend)	Low	2015/16		2955.4	2994.6	3034.4	3074.7	3115.6	PHE	Annual
						Target trajectory				2801.0	2721.6	2642.1	2564.7	2488.1		
						Actual			2,624.0							

NOTE: Hospital admissions for dental caries in children aged 0-4 will be added into future iterations of the framework.

				Desired Performance	Year 1 2017/18 Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Year 2 2018/19 Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Year 3 2019/20 Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Year 4 2020/21 Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Data Source	Frequency
1. LCO CBA Activity reductions: Outcomes (from GM Investment Agreement)																						
1A	Reducing A&E attendances	~ Includes cashable and non-cashable ~ Units of activity	Do nothing	Low	71,589	143,178	214,766	286,355	73,663	147,325	220,988	294,651	75,797	151,593	227,390	303,187	77,846	155,692	233,538	311,384	SUS	Quarterly
			Target: CBA reduction		-121	-363	-727	-1,514	-1,915	-3,830	-5,745	-7,660	-3,428	-6,855	-10,283	-13,711	-6,510	-13,021	-19,531	-26,041		
			Target: Net		71,468	142,814	214,040	284,841	71,748	143,495	215,243	286,991	72,369	144,738	217,107	289,476	71,336	142,671	214,007	285,343		
			Actual		70,002	138,219																
1B	Reducing non-elective admissions	~ Includes cashable and non-cashable ~ units of activity	Do nothing	Low	15,250	30,499	45,749	60,998	15,691	31,383	47,074	62,765	16,146	32,292	48,438	64,584	16,582	33,165	49,747	66,330	SUS	Quarterly
			Target: CBA reduction		-60	-181	-361	-752	-454	-908	-1,361	-1,815	-688	-1,375	-2,063	-2,751	-914	-1,828	-2,742	-3,656		
			Target: Net		15,189	30,319	45,387	60,246	15,238	30,475	45,713	60,950	15,458	30,916	46,375	61,833	15,668	31,337	47,005	62,673		
			Actual		15,218	30,754																
1C	Reducing elective admissions	Reducing Elective admissions - includes cashable and non-cashable - units of activity	Do nothing	Low	15,024	30,048	45,073	60,097	15,459	30,919	46,378	61,838	15,907	31,815	47,722	63,629	16,337	32,675	49,012	65,350	SUS	Quarterly
			Target: CBA reduction		-50	-150	-300	-625	-394	-789	-1,183	-1,577	-607	-1,214	-1,820	-2,427	-810	-1,619	-2,429	-3,238		
			Target: Net		14,974	29,899	44,773	59,472	15,065	30,130	45,195	60,261	15,300	30,601	45,901	61,202	15,528	31,056	46,583	62,111		
			Actual		13,509	27,660																
1D	Reducing outpatient attendances	~ Includes cashable and non-cashable ~ units of activity	Do nothing	Low	114,111	228,223	342,334	456,446	117,417	234,834	352,252	469,669	120,819	241,637	362,456	483,275	124,085	248,171	372,256	496,341	SUS	Quarterly
			Target: CBA reduction		-567	-1,700	-3,399	-7,081	-6,261	-12,522	-18,783	-25,045	-10,532	-21,064	-31,597	-42,129	-14,335	-28,670	-43,005	-57,339		
			Target: Net		113,545	226,523	338,935	449,364	111,156	222,312	333,468	444,624	110,286	220,573	330,859	441,146	109,750	219,501	329,251	439,002		
			Actual		113,964	228,687																
1E	Reduction in avoidable prescribing	~ Includes cashable and non-cashable ~ Financial savings (spend £000)	Do nothing	Low	23,213	46,425	69,638	92,850	24,520	49,041	73,561	98,082	25,902	51,804	77,706	103,608	27,361	54,723	82,084	109,446	EPACT	Quarterly
			Target: CBA reduction		-22	-67	-134	-238	-494	-989	-1,483	-1,977	-933	-1,866	-2,799	-3,732	-1,299	-2,598	-3,898	-5,197		
			Target: Net		23,190	46,358	69,503	92,612	24,026	48,052	72,078	96,104	24,969	49,938	74,907	99,876	26,062	52,124	78,186	104,249		
			Actual		22,389	44,457																
1F	Reduction in ambulance journeys	~ Includes cashable and non-cashable ~ Units of activity	Do nothing	Low	17,076	34,152	51,228	68,304	17,571	35,141	52,712	70,282	18,080	36,159	54,239	72,318	18,568	37,137	55,705	74,274	NWAS Portal	Quarterly
			Target: CBA reduction		-114	-341	-681	-454	-575	-1,149	-1,724	-2,298	-1,028	-2,057	-3,085	-4,113	-1,953	-3,906	-5,859	-7,812		
			Target: Net		16,962	33,811	50,547	67,849	16,996	33,992	50,988	67,984	17,051	34,103	51,154	68,205	16,615	33,231	49,846	66,461		
			Actual		16,637	33,356																
1G	Reducing avoidance contacts & referrals	~ Includes cashable and non-cashable ~ Financial savings (spend £000)	Do nothing	Low	1,999	3,998	5,997	7,996	1,999	3,998	5,997	7,996	1,999	3,998	5,997	7,996	1,999	3,998	5,997	7,996	MiCare	Quarterly
			Target: CBA reduction		-5	-14	-28	-94	-55	-110	-165	-220	-82	-165	-247	-329	-109	-218	-327	-436		
			Target: Net		1,994	3,984	5,969	7,902	1,944	3,888	5,832	7,776	1,917	3,833	5,750	7,667	1,890	3,780	5,670	7,560		
			Actual		1,734	3,489																
1H	Reducing the cost of R&N / Homecare	~ Adjusted from GMIA ~ Includes cashable and non-cashable - financial savings (spend £000)	Do nothing	Low	10,577	21,154	31,731	42,308	11,286	22,572	33,858	45,144	12,018	24,035	36,053	48,071	12,774	25,547	38,321	51,094	MiCare	Quarterly
			Target: CBA reduction		-160	-480	-959	-1,319	-760	-1,520	-2,279	-3,039	-1,132	-2,265	-3,397	-4,530	-1,706	-3,411	-5,117	-6,822		
			Target: Net		10,417	20,675	30,772	40,989	10,526	21,052	31,579	42,105	10,885	21,770	32,656	43,541	11,068	22,136	33,204	44,272		
			Actual		9,501	22,595																
1I	SCF running costs	(spend £000)	Do nothing	Low	4,057	8,114	12,171	16,228				16,012				16,045				16,076	GL	Quarterly
			Target: CBA reduction		-100	-300	-600	-1,000				-1,000				-1,000				-1,000		
			Target: Net		3,957	7,814	11,571	15,328				15,012				15,045				15,076		
			Actual		3,691	7,125																

2. LCO Outputs: key deliverable activities from programme plan and business cases

3A	High Impact Primary Care	1200 people supported by 3 HIPC teams /		HIgh	By Sept 2018																		
		Total 4400 HIPC patient hours		HIgh	By Sept 2018																		
3B	Integrated Neighbourhood Teams	Increase in the proportion of Older People who are still at home 91 days after hospital discharge into Reablement/Rehabilitation		HIgh																			
		Manager recruited for each INT		HIgh				70%	100%														
		Teams co-located		HIgh						By Sept 2018													
		Signed-off delegation of authority in place for managers and leads		HIgh				By March 2018															
		Percentage of people with complex needs with a support plan following referral to MDT		HIgh						70%		90%											
		Percentage of people with complex needs with a key worker allocated following referral to MDT		HIgh					75%	100%													
3C	Mental health transformation	X increase in IAPT referrals seen in 6/18 weeks (nat std)		HIgh																			
		GP referrals - number forwarded in 1 day / seen in 21 days		HIgh																			
		X Home Based Treatment numbers		HIgh																			
3D	Integrated Front Door	Increase from 35% of contacts resolved at front door to 70%		HIgh					0%			45%				55%				70%			
		Increased self-assessment of carers (c. 5,000 in total)		HIgh					500			1000				1,500				2,000			
3E	Prevention	Increased use of community activities by cohort group																					
		X number of adults ready for work																					
3F	Primary Care	16,000 hours of additional PC appointments per year						16,000				32,000				48,000				64,000			
		X% of practices covered by Federation led Population coverage for LCS and Primary Care Standards																					
3G	Frail Older People	Business Case not yet approved																					
3H	Carers' Support	TBC																					
3I	Extra Care	% of citizens staying in a NA satisfied with the experience Score of 3 or more out of 5)		High	N/A	100%	N/A																
		Monthly number of Neighbourhood Apartments ready for use (total 20)		High	9	11																	
3J	Reablement	Number citizens supported per month		High																			
		Number of staff recruited to per quarter		High																			
		Number of citizens supported by complex reablement		High																			

		Number of staff recruited to per quarter		High																	
3K	Home from Hospital	TBC																			

NOTE: non cashable GP productivity savings measures will be included in future iterations of this framework.

Note: Any figures in red are placeholders and should not be read or interpreted as actual figures. Any figures in black are correct.

Assistive Technology

Mental Health

Early Help

Reablement

		Year 1 2017/18			Year 2 2018/19				Year 3 2019/20				Year 4 2020/21				#REF!	
		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Better than last quarter?	Better than last year?
4. SHS: Integration Plan																			
Workstream	Projects																		
Gynaecology	•Single service across city																		
	•Gynae ambulatory care in North Manchester and Withington																		
Obstetrics	•Single community midwifery workforce																		
	•Obstetric rotas reviewed																		
Neonates	•Neonates clinical management by St Mary's																		
Urology	•Reconfigure cancer and benign surgery																		
Vascular	•Single vascular centre																		
Head & neck	•H&N / Oral / max fax single site																		
Pharmacy	•Information system																		
Pathology	•Mortuary integrated service																		
Decontamination	•Sterile services rationalisation																		
Medical Engineering	·Integrated service model																		
Frailty	•Standardised frailty pathway																		
Stroke	•Extra Saturday TIA clinic																		
	•Integrated stroke service																		
Respiratory	•Single clinical team																		
Cardiac	•Heart rhythm 7 day service																		
	•ACS pathway																		
	•Acute aortic surgery single service																		
T&O	•#NOF centre																		
	•Elective centre																		
Paediatrics	•Single service																		
Gastro	•Gastro single team																		
	•Endoscopy capacity																		

Mental Health - Benefits and Outcomes Tracker

Status at: 09/01/2018
Version: 10.30

Reference	Transformation Area	Benefit Description	Benefit Measure	Data Source	Numerator	Denominator	Baseline Measure	Baseline Date	Baseline Period	Target	Target Date
ATS 1	**Access to Services (SPOC)**	Routine GP referrals to be forwarded to appropriate services within 1 working day	Feedback to GP within 1 working day on destination where referral has gone	Amigos Data	Number of Gateway Referral Outcomes where there is an outcome of response to GP ("Feedback to Referrer") recorded within 24 hours.	Number of GP referrals received by Manchester Integrated Care Gateway (Recorded as Gateway Referral Outcome on Amigos).	89%	Mar-17	Month	75%	31/03/2018
CMHT 1	**Enhanced 7-day CMHT**	Routine GP referrals seen within 21 days from referral	% of routine Manchester CCG patients seen within 21 days of referral	Amigos Data	Number of referrals coded as 'routine' in the reporting period seen within 21 days of referral	Total number of referrals coded as 'routine' seen in reporting period	74%	Mar-17	Month	60%	31/03/2018
CMHT 2		Urgent referrals seen within 72 hours from referral	% of urgent Manchester CCG patients seen within 72 hours of referral	Amigos Data	Number of referrals coded as 'Urgent' in the reporting period seen within 72 hours of referral	Total number of referrals coded as 'Urgent' seen in reporting period	0%	Mar-17	Month	95%	31/03/2019
CMHT 3		Emergency referrals seen within 24 hours from referral	% of emergency Manchester CCG patients seen within 24 hours of referral	Amigos Data	Number of emergency Mental Health Act assessments in the reporting period seen within 24 hours from referral	Total number of emergency Mental Health Act assessments in the reporting period	98%	Mar-17	Month	95%	31/03/2019
CMHT 4		Clinically appropriate LOS in the CMHTs	Average LoS for Manchester CCG patients in CMHTs, per month	Amigos Data	For all people who have been open to CMHT during the reporting period: Sum of (Discharge date(reporting period end date, if not discharged) - Referral accepted date)	Total number of people open to CMHT at any point during the reporting period	533 days	Mar-17	Month	N/A	31/03/2019
CMHT 8		Reduction in attendees at A&E	Total number of A&E attendances for same cohort of patients (Sept-Aug 16/17 and Sept-Aug 17/18)	Amigos Data	Number of A&E attendances during the reporting period for the same group of people seen during first period	N/A	701	Sept-16 to Aug-17	Year	<700	31/03/2019
HBT 1	**24/7 Home Based Treatment (HBT)**	Provision of a 24/7 HBT - A true alternative to inpatient care and least restrictive environment	Increase in patients being seen out of hours	Amigos Data	Number of people being seen out of hours (after 5pm and before 8am) by HBT team during the reporting period	N/A	34	Mar-17	Month	65	31/03/2019
HBT 2		Optimum length of stay	% of Manchester CCG patients receiving HBT care for 6-8 weeks	Amigos Data	Number of people discharged from HBT during the reporting period with a length of stay between 42 and 56 days	Total number of people discharged from HBT during the reporting period	8%	Mar-17	Month	90%	31/03/2019
HBT 3		Appropriate care and treatment in the least restrictive environment	The number of patients receiving 2 to 3 visits per day	Amigos Data	Number of people within the reporting period where 2 or 3 direct contacts have been recorded on each day their referral has been open.	N/A	76	Mar-17	Month		31/03/2019
HBT 4		Referrals seen within 24 hours	Average number of HBT team contacts to Manchester CCG patients within 24 hours of referral	Amigos Data	Number of referrals opened during the reporting period with a HBT team contact recorded within 24 hours of referral received date	Total number of referral opened within the reporting period	85%	Mar-17	Month	90%	31/03/2019
Rehab 1	**Rehabilitation Pathway**	Reduction in the number of people being placed out of area	Total number of rehab Manchester CCG patients being placed out of area per month	TBC	Number of out of area placements during the reporting period (Rehab)	N/A					
Comm 1	**Community Engagement**	Increase in number of hours delivered by volunteers	Total number of volunteer hours delivered in commissioned projects/schemes on a monthly basis	Local Service Data	Number of hours delivered by volunteers during the reporting period	N/A	119	May-17	Month		
Comm 2		Increase in number of hours that service users and carers engage in activities funded by the trust	Total number of hours spent undertaking activity by participants of the commissioned projects/schemes on a monthly basis	Local Service Data	Number of hours of service user and carer engagement in trust funded activities during the reporting period	N/A	35	May-17	Month		
Comm 3		Increase in number of training hours received by volunteers	Total number hours spent training by volunteers in commissioned projects/schemes on a monthly basis	Local Service Data	Number of hours training received by volunteers during the reporting period	N/A	50	May-17	Month		
S136 1	**Section 136 Suite**	Reduction in the number of Section 136 Manchester CCG patient presentations at A&E.	Reduction in the number of Section 136 presentations in A&E of Manchester CCG patients.	Amigos	Number of s136 presentations at A&E during the reporting period	N/A	24	Mar-17	Month	12	31/03/2019
S136 2		The number of Section 136 seen at the dedicated Section 136 Suite	Number of Section 136 Manchester CCG patients being seen in the dedicated suite.	Amigos Data	Number of s136 being seen at Section 136 suites during the reporting period	N/A	0	Mar-17	Month	12	31/03/2019
S136 3		Reduction in Section 136 presentations to Manchester A&E Depts	The number of Section 136 presentations at Manchester A&E Departments	Amigos Data	Number of s136 presentations at A&E during the reporting period	N/A	31	Mar-17	Month	15	31/03/2019