Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 17 January 2018

Subject: Our Healthier Manchester – update report

Report of: Dr Philip Burns, Chair, Manchester Health and Care Commissioning

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Summary:

This report updates the Health and Wellbeing Board with regard to the Manchester Locality Plan 'Our Healthier Manchester'. It includes:-

- A general update regarding the refresh of the strategy
- A progress update and the development of implementation plans for 2018/19
- Further arrangements for development of MHCC including a single Operational and financial plan, including a single budget arrangement.
- The Manchester Agreement, for approval.

Recommendations:

The Health and Wellbeing Board is asked to:-

1. Note the progress made.
2. Support the direction of travel for the strategy refresh and plans for 2018/2019.
3. Approve the Manchester Agreement.

Board priorities addressed:

Health and Wellbeing Board Priority	Summary of contribution to strategy
Getting the youngest people in our communities off to the best start	The Our Healthier Manchester Strategy includes the full scope of reform for Health and Social Care. It also has a broader scope connecting to the wider determinants of health and the broader Our Manchester strategy.
Improving people's mental health and wellbeing	
Brining people into employment and ensuring good work for all	
Enabling people to live well and live independently when they grow older	
Turning round the lives of troubled families as part of the Confident and Achieving Manchester Programme	
One health and care system - right care, right place, right time.	
Self-care	

Lead Board member:

Dr Philip Burns – Chair MHCC

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Background documents (available for public inspection).

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

1.0 Introduction

This report updates the Health and Wellbeing Board with regard to the Manchester Locality Plan 'Our Healthier Manchester'. It includes:-

- A general update regarding the refresh of the strategy
- A progress update and the development of implementation plans for 2018/2019
- Further arrangements for development of MHCC including a single operational and financial plan, including a single budget arrangement.
- The Manchester Agreement, for approval.

2.0 Our Healthier Manchester refreshed strategy

The Board agreed the high level refresh of the Manchester Locality plan (see figure 1) and associated governance. Since this point the Transformation Accountability Board (TAB) and the Locality Plan Delivery Group (LPDG) have been established.

Figure one – draft Our Healthier Manchester strategy on a page

The TAB has focussed upon the high level strategic issues regarding implementation of the Our Healthier Manchester strategy including the progress of implementation of the Local Care Organisation (LCO) and the

initiation of the process to transfer North Manchester General Hospital (NMGH) into Manchester University Foundation Trust (MFT).

The LPDG has focussed upon developing the detail beneath the high level strategy for Our Healthier Manchester including plans for hospital, out of hospital, population health as well as enabling workstreams such as estates, IM&T and workforce.

A number of leadership workshops have been held to inform this, including sessions focussed upon alignment to the Our Manchester strategy and also creating stronger policy linkages with the wider determinants of health including leisure; work and skills etc.

This plan, with a delivery plan for 2018/2019, will be brought to the March Health and Wellbeing Board for approval.

The implementation of the strategy is increasingly becoming part of the business as usual activities of partner organisations. It is essential that implementation becomes work which is beyond a series of projects and becomes a fundamental change to how our system operates.

Julie Taylor has been appointed to a newly established post of Programme Director for Our Healthier Manchester.

3.0 Progress report 2017/18

Key achievements since the November Board are as follows:-

- A number of new delivery models have become operational including high impact primary care and home from hospital
- Development of the Manchester agreement (see section 6.0).
- Continuation of the post transaction implementation plan to ensure safe and effective services following the merger.
- Initiation of the process for the NMGH to transfer to MFT.
- The LCO continues to progress with the three work streams; Organisational Set Up, Service Strategy and Transaction in order to establish the LCO and become operational from April 2018. Specific key achievements include;
- The year 1 Target Operating Model and Mobilisation Plan for the LCO have been produced through a co-designed approach between the LCO and MHCC;
- The new models of care continue to be mobilised and have started to become operational i.e. High Impact Primary Care (HIPC); and
- All partners are progressing with the development of a Partnering Agreement which will ensure the LCO becomes operational in April 2018, which is expected to be completed in February 2018.
- Manchester received £1m NHS capital for digital to implement Electronic Patient Records (EPR) in South Manchester community services and expansion of the Manchester Care Record (MCR).

- Posts supported by the Transformation Fund investment, including estates and communications are now in place.

We anticipate the formal agreement with the Greater Manchester Health and Social Care Partnership to be signed during January. All outstanding issues have now been resolved.

4.0 Priorities for 2018/19

Delivery plans are being developed across the Our services, Our people, Our outcomes themes within the locality plan. 2018/2019 is the year where there is a shift from building foundations toward the new system increasingly realising benefits against strategic aims. 2018/2019 will still need to see completion of the organisational changes for the LCO and single hospital service vision. A full delivery plan will be brought to the March Board meeting. However, an indication of priorities is below. It is important to note that the development of the refreshed strategy had strong involvement from the community and voluntary sector. There is continued work with the sector to agree the priorities in this regard.

4.1 Our services

Key priorities for 2018/19 will include:-

- Continuation of the single hospital services programme which will include implementation of benefits plans for the USHM and CMFT merger to create MFT. Impacts next year will include; reduced waits for emergency gynaecology surgery; reduction in waiting times at Manchester Royal Infirmary for lithotripsy; and in increased number of choices of location for treatment across the two sites. In addition it is planned that the Healthier Together changes for general surgery, A&E and Acute Medicine will be implemented during the course of the year. (See separate SHS report).

- We expect the majority of the transaction process to be complete within 2018/2019 with a target transfer date of North Manchester General Hospital from April 2019 although the timeline has yet to be agreed.

- Development of clear strategies for enabling work programmes including Information Management and Technology; Workforce and Organisational Development; Estates; Communications and engagement; and Performance and Evaluation.

- The LCO will become operational from April 2018. The LCO is expected to evolve and grow as an organisation throughout the year with further services to be transferred to the management of the LCO over a further 2-year period. The LCO is also expected to change services on the ground, including the delivery of the new models of care across health and social care as well as starting to create the basis of neighbourhood working in mainstream services. Key work that will be undertaken in order to realise the ambition of this includes but is not limited to:

- Realising the 100-day plan to ensure for a safe transition of services and continued roll out of the new models of care;
- Progress with the development of the Integrated Neighbourhood Teams (INT's) including leadership and model; and
- Undertake due diligence for services transferring to the management of the LCO from 2019/2020 onwards to construct a business case and long term financial model.

4.2 Our people

Key priorities for 2018/2019 will include:-

- Completion of the population health plan for Manchester and associated priorities for the first year (scheduled for March Health and Wellbeing Board).
- Agreed priorities regarding workforce health and wellbeing

4.3 Our Outcomes

Key priorities for 2018/2019 will include:-

- Financial balance across health and social care
- Operational stability in areas of quality and performance challenge e.g. urgent care
- Financial and non-financial outcome measures within Manchester agreement

5. Commissioning operational plan (incorporating budget plan) for 2018/19 and 2019/20

Single planning, delivery and assurance approach

5.1 Building upon the establishment in April 2017 MHCC will operate a single planning, delivery and assurance process from April 2018. This will oversee all commissioning responsibilities for health, adult social care and public health and will include single budget arrangements.

5.2 This will generate the following benefits:-

- Joined up commissioning of health, social care and public health enabling more proactive and joined up care.
- More co-ordinated transformation; oversight of quality and performance; and financial management.
- More effective and efficient spending
- Clear commissioning voice within and for the Manchester health and care system

Governance

5.3 These arrangements will sit within the governance of MHCC and led through its Executive committee, reporting to the Board. Reporting will be provided to MCC Senior Management Team for information and for assurance purposes to the CCG Governing Body and MCC Executive.

Planning and assurance

5.4 MHCC will have a single Operational Plan which will encompass all of its work programmes for each year. This will set out the means by which it will achieve operational responsibilities as well as progressing towards its strategic aims. As well as being an annual plan it will have a forward view of plans for future years.

5.5 Within the Operational Plan will be the Financial Sustainability Plan which will set out the steps it will take to achieve financial balance in the current and future years. The following sections focus upon the Financial Sustainability Plan (FSP) as we approach budget setting for 2018/19.

Single budget

5.6 Manchester City Council and NHS Manchester CCG have an agreed intent for a single commissioning budget for health, adult social care (ASC) and public health. This is planned to take effect from April 2018. This will be through a section 75 agreement, to be developed by the end of February, within a broader partnership agreement which sets out the governance arrangements for MHCC. The budget is intended to include the totality of the CCG allocation and the agreed budget for ASC and public health.

Financial Pressures

5.7 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. A key principle of change within the Locality Plan is to achieve a sustainable system by costs being reduced through better co-ordinated proactive care which keeps people well enough not to need acute or long term care. This will be achieved by:

- Transforming the health and care system, moving our focus from hospital to the community.
- Reinvesting the savings we make into better care.
- Balancing our finances now and in future years.
- Developing our workforce so we have committed, healthy, skilled, people where and when they are needed.

5.8 Earlier in 2017/18 the overall locality health and social care gap for Manchester was reassessed as part for application for Transformation Funding. The projected do nothing Council pressure by 2019/20 was projected to be £31.878m and for the CCG the 2019/20 gap was projected to be £34.5m. These pressures are a result of the nationally recognised pressures on health and social care including: Local Government financial settlement not adequately recognising the pressures for social care, increase in demographic

pressures, increase in demand, price and tariff inflation and other local developments. Significant work has been undertaken to begin to address those pressures, and in respect of MHCC a more detailed understanding of the combined commissioner pressures has been developed.

Mitigations

5.9 As part of the City Council budget for 2017-20 additional resource for Adult Social Care of £35m was allocated to close part of the locality plan gap. This left a remaining gap of £9.676m for 2017/18 rising to £12.750m by 2018/19 and £16.814m by 2019/20 which was to have been achieved via the implementation of the new care models and a jointly agreed programme of savings. The CCG's resource allocation was confirmed from NHS England, and no additional recurrent allocation has been received.

5.10 The residual financial gap for the single commissioning budget is to be addressed by:

1. In the short term non recurrent resources have been allocated by both organisations to mitigate the pressures. This includes carry forward of CCG 17/18 non recurrent surplus, utilisation of the adult social care grant announced in March 2017; business rules reserves from the CCG, and additional resources from Council reserves.
2. Investment in new care models. These are funded through GMTF, ASC grant and recurrent health budgets. 2017/18 marked the start of these initiatives and have been implemented at a slower pace than anticipated. The main focus of these new care models is to move care out of hospital where appropriate, in to a community setting. In 2018/19 savings of £17.7m have been identified from investments made from the transformational fund.
3. Savings initiatives. Both the CCG and the Council have ambitious savings plans developed, of which some have been successfully implemented in 2017/18 with clear reductions in spend.

Forecast budget position 2018 – 19

5.11 Through the use of non-recurrent resources and the achievement of planned savings, MHCC have a projected breakeven position for 2018/19.

Social Care

5.12 The Council's budget position for Adult Social Care (ASC) 2017/18 at the end of October 2017 is an overspend of £0.9m. This position is after taking account of use of non-recurrent ASC Grant of £10m and CCG funding of £4.750m to mitigate underlying pressures.

5.13 The proposed funding for Adult Social Care in 2018/19 is £179.5m. This includes budget growth to meet pressures, savings and draft allocations for demography, costs of implementing the National Living Wage and inflation available to be drawn down during 2018/19. It was agreed with the CCG in

December 2017 that as part of the pooled budget arrangements for 2018/19, an uncommitted contingency of £4m will be created to mitigate pressures, this has been included in the Council's 2018/19 draft budget position. The Council is proposing, as part of its draft budget subject to Executive and Council approval, to fund £5.8m from non-recurrent resources in 2018/19.

5.14 This brings the total additional funding for 2018/19 to £28.250m of which £13.7m is non-recurrent, inclusive of £4m from CCG contingency, £5.8m of non-recurrent funding from the Council and £3.9m of Adult Social Care grant. The total savings required in 2018/19 is £10.558m. The forecast expenditure for 2018/19 is £179.5m, resulting in a projected breakeven position for social care if the savings proposals are delivered.

5.15 The table breaks down the proposed increased budget allocation. This budget is subject to approval by the Council's Executive on 7 February 2018 and full Council in March 2018.

Adult Social Care Draft 2018/19 Budget Allocation (excluding Homelessness)	**2018/19 £000**
Opening Budget 2017/18	**160,044**
Savings for 2018/19 approved in 2017/18 budget	**-4,814**
New Proposed Savings (pending Executive approval)	-5,744
New Funded Pressures (pending Executive approval)	15,503
CCG risk share contribution (non-recurrent)	-4,000
Proposed budget changes 2018/19	**5,759**
2018/19 Opening Control Total	**160,989**
Pay and Non Pay Inflation	4,189
National Living Wage (NLW)	4,258
Demographics	2,400
Total draft allocations (pending Executive approval)	**10,847**
Adult Social Care Grant Recurrent	3,775
Adult Social Care Grant Non-Recurrent	3,869
Adult Social Care Grant	**7,644**
Adult Social Care Resource 2018/19	**179,480**

Health

5.16 In 2017/18 the CCG is projected to deliver against its resource limit. The projected do nothing position for health is £33.4m for 2018/19, with anticipated savings (assuming 100% of new care model delivery) of £19.5m (including impact of 2017/18 prescribing savings). In addition, £13.91m of non-recurrent resource is also being utilised in year.

	2018/19 £000's
Allocation	913,823
Forecast Cost (net of income)	947,235
Total Pressures	**(33,412)**
Assessment of Planned Savings	
GMTF CBA Savings	11,271
QIPP	8,244
Subtotal Planned Savings	**19,515**
Unmitigated Pressures	**(13,897)**
Mitigations	
1. Carry Forward Surplus	6,000
2. 0.5% non-recurrent reserve	4,069
Subtotal Existing Mitigations	**10,069**
Additional Mitigations	3,827
Revised Unmitigated Pressure	**(0)**

Risk

5.17 Whilst the sections above describe a balanced position for the pooled budget for 2018/19, there is a significant level of risk associated with this position. The level of savings required is significant and plans will need to be robustly monitored to ensure delivery. In addition the position is underpinned by significant level of non-recurrent resource

5.18 MHCC has agreed to manage CCG and MCC budgets within portfolios held by Directors. These will give accountabilities to Directors for both health and care budgets collectively within single budget responsibilities.

Future years

5.19 The 2018/19 pooled budget includes a significant level of non-recurrent resources. Work is required to identify further efficiency plans to ensure that a balanced budget can be set for 2019/20 and beyond, and commissioning partners have agreed to commit to developing plans to support this as a matter of high priority.

6.0 Manchester Agreement

The Manchester Agreement (appendix one) is an agreement which will formalise the joint commitment of organisations' to the Our Healthier Manchester strategy and to create some governance mechanisms to enable effective implementation. The agreement is not legally binding but acts as a commitment to a joint vision, strategy and collective ways of working which will enable more effective implementation. The agreement consists of the following:-

1. A clear outline of the vision and strategy for the system.

2. A clear approach to performance (outputs of new care models); benefits (the intended outcomes of the new care models); and evaluation (the causal link between the two). The initial performance framework (appendix two) links to the investments through the Greater Manchester Transformation Fund.
3. The principles of risk and gainshare within the system.
4. The partnership Compact which is the commitment made between organisations.

This is a starting point for more formal system governance and supporting working arrangements. It is anticipated that this will evolve and grow in both scope and maturity of the working arrangements.

The agreement has been supported by the Transformation Accountability Board and has/will be agreed at organisations' Boards.

The Health and Wellbeing Board is asked to support this agreement.

7.0 Recommendations

The Health and Wellbeing Board is asked to:-

1. Note progress.

2. Support the direction of travel for the strategy refresh and plans for 2018/2019.

3. Approve the Manchester Agreement.

THE MANCHESTER AGREEMENT

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

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.

LCO Outcomes

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.

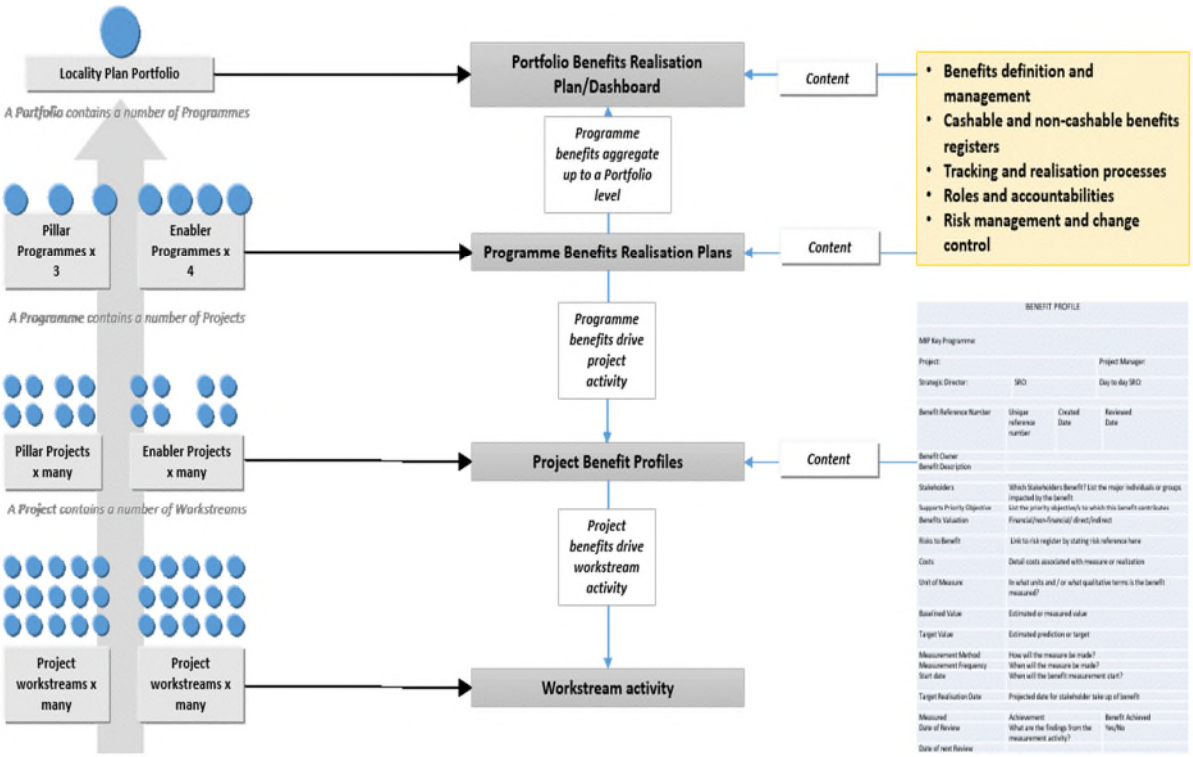
6.3 Benefits Management Tools

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

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

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: _____

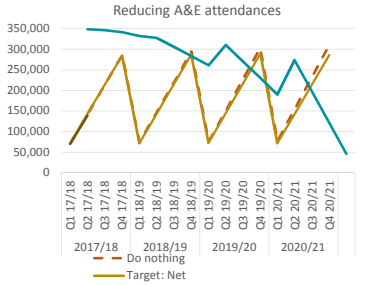
Date

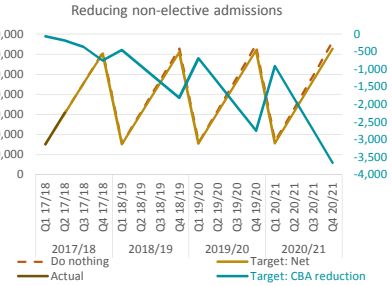
Ref	Measure	Unit	Desired performance	No previous data	Target 17/18	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q2 17/18 performance: Better than last quarter?	Better than last year?	Better than target?
1A	Reducing A&E attendances	Activity	Low	N/A	284,841	70,002	138,219	-	-	✓		✓
1B	Reducing non-elective admissions	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	-	-	✓		✓

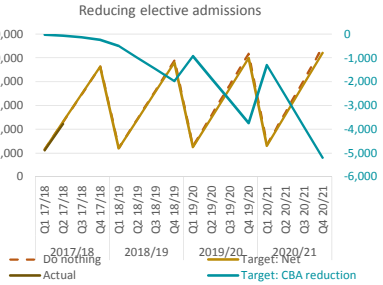
2017-18 out-turn will change as a result of further work to refine baselines as part of the budget-setting process.

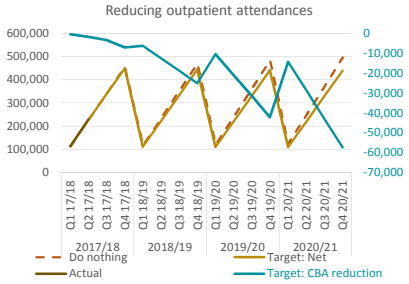
Ref	Measure	Unit	Desired performance	Year 1 2017/18 Target 17/18	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Year 2 2018/19 Target 18/19	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Year 3 2019/20 Target 19/20	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Year 4 2020/21 Target 20/21	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 18/19 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	-	-	-	-	⇔	↑	↑

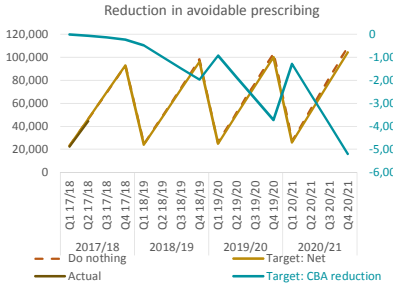
SUGGESTED CHARTS - NOT REAL ACTIVITY - WILL BE UPDATED WHEN ENOUGH TREND DATA IS AVAILABLE

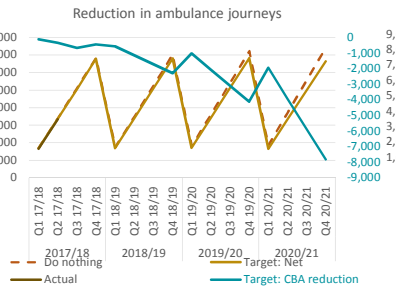


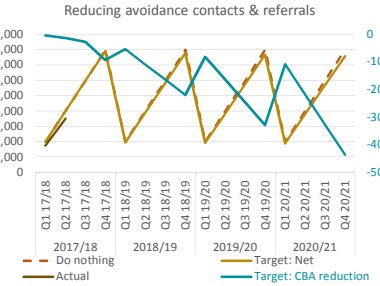


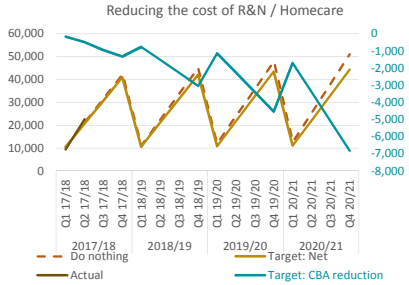


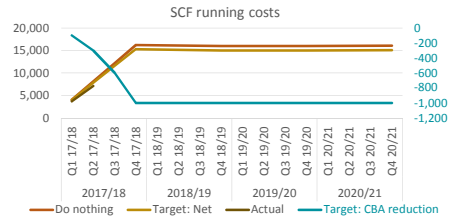












Note: Any figures in red are placeholders and should not be read or interpreted as actual figures. Any figures in black are correct.

1	2	3				4	5			6	10	14	18	22	23
							Desired Performance	Latest Period	Latest Value	Year 1 2016/17	Year 2 2017/18	Year 3 2018/19	Year 4 2019/20	Year 5 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