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
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Distribution:

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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 vison 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:

1. To improve the health and wellbeing of people in Manchester

- Proactively support people's health by starting well, living well, ageing well and at the end of life.
- Improve both mental and physical health.
- Provide services fairly, to reduce local variation in healthy lives.

2. To strengthen the social determinants of health and promote healthy lifestyles

- Enable healthy lifestyle choices and prevent ill health.
- Support improvements in housing, jobs, education, the economy and people's social connections.

3. To ensure services are safe, equitable and of a high standard with less variation

- Coordinate health and care, ensuring safety, quality, value for money and high standards for all.

4. To enable people and communities to be active partners in their health and wellbeing

- Build on the strengths of communities, voluntary groups and social networks.
- Invest in individuals and carers, supporting them to manage their own health.

5. To achieve a sustainable system

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

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.

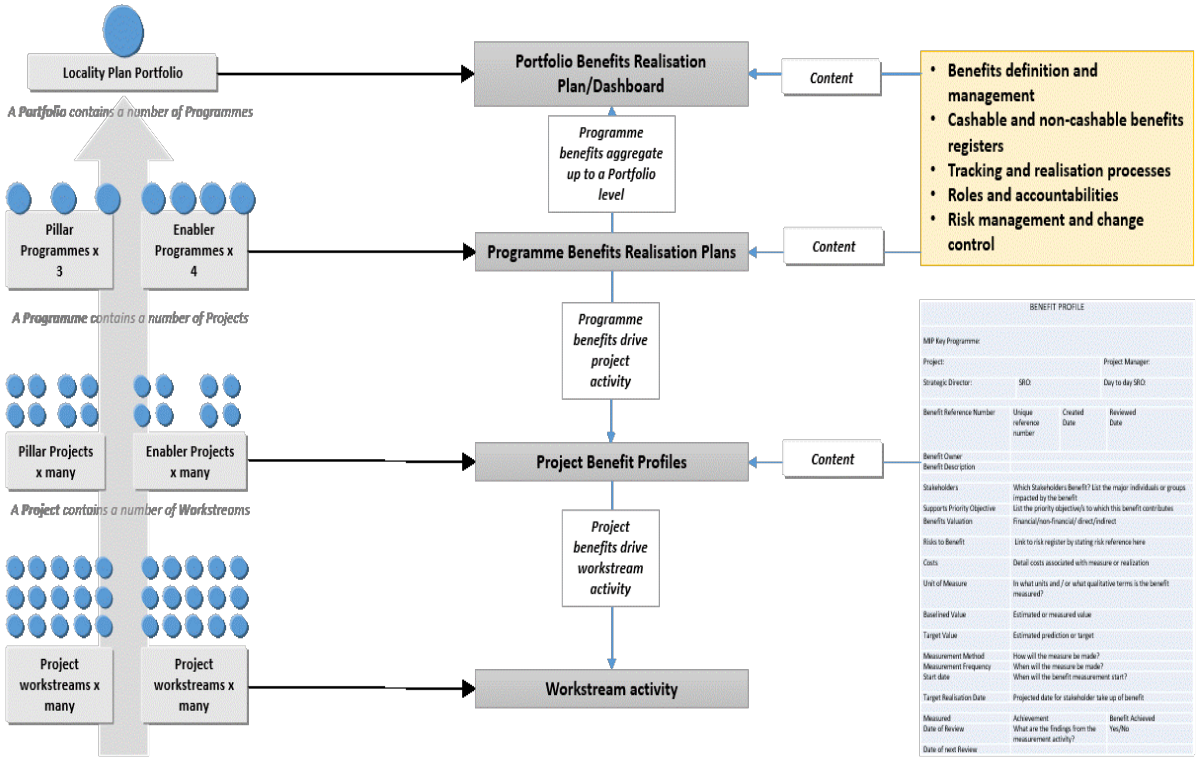
6.3 Benefits Management Tools

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.

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.

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

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

APPENDIX A – PERFORMANCE FRAMEWORK DASHBOARD

Appendix A - MA Performance Framev