Greater Manchester Health and Social Care Partnership Executive Board

Date: 29 July 2021

Subject: Proposed Greater Manchester Governance

Report of: Sarah Price, Interim Chief Officer, GMHSC Partnership

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PURPOSE OF REPORT

The purpose of this paper is to set out the emerging proposals for the governance model and architecture of the new Greater Manchester health and care system.

These proposals have been developed by the governance task and finish group, supported by Mike Farrar who has been working with GM as we move towards the establishment of the GM Integrated Care System (ICS). Wider system engagement through workshops held during June have also played an important part in developing the proposals.

REQUESTS OF PEB

The GMHSC Health and Care Board is asked to:

- Approve and adopt the proposals for Governance set out in the report
- Support the ambition to establish these arrangements in shadow form from 1 October 2021

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GMICS Emerging Governance Proposals

July 2021

Purpose

The purpose of this paper is to set out the emerging proposals for the governance model and architecture of the new GM health and care system. These proposals have been developed by the governance task and finish group and informed by a paper produced by Sir Richard Leese that was submitted to the Partnership Executive Board in June.

Design Principles and Requirements

The proposed approach is designed to enable GM to meet its strategic objectives (tackling inequality, guaranteeing constitutional healthcare standards, innovation at pace and scale and creating a comprehensive sustainable system). In doing so, it also meets five essential requirements -

1) GM health and care system proposed governance **must offer the continuity of purpose, ethos and culture that have underpinned the GMS devolution deal** in the previous five years of its ten year journey

2) GM health and care system is required **to meet the national policy requirements and priorities** of the forthcoming legislation on integrated care; and **the principles of good governance**

3) GM health and care system governance must be designed to **enable the oversight and delivery of the aims and intentions of the new GM operating model** (recognising its architecture and its incentives)

4) the proposed governance arrangements should further develop the commitment in the operating model ***to a shared approach to its key functions**** by establishing **the crucial principle of shared governance.** This will serve to create the necessary commitment of constituent organisations to taking responsibility for delivery of the system's aims and avoid the GM ICS (Boards and Executive functions) being seen and felt as a separate entity (there is a strong desire to avoid an 'us and them' culture)

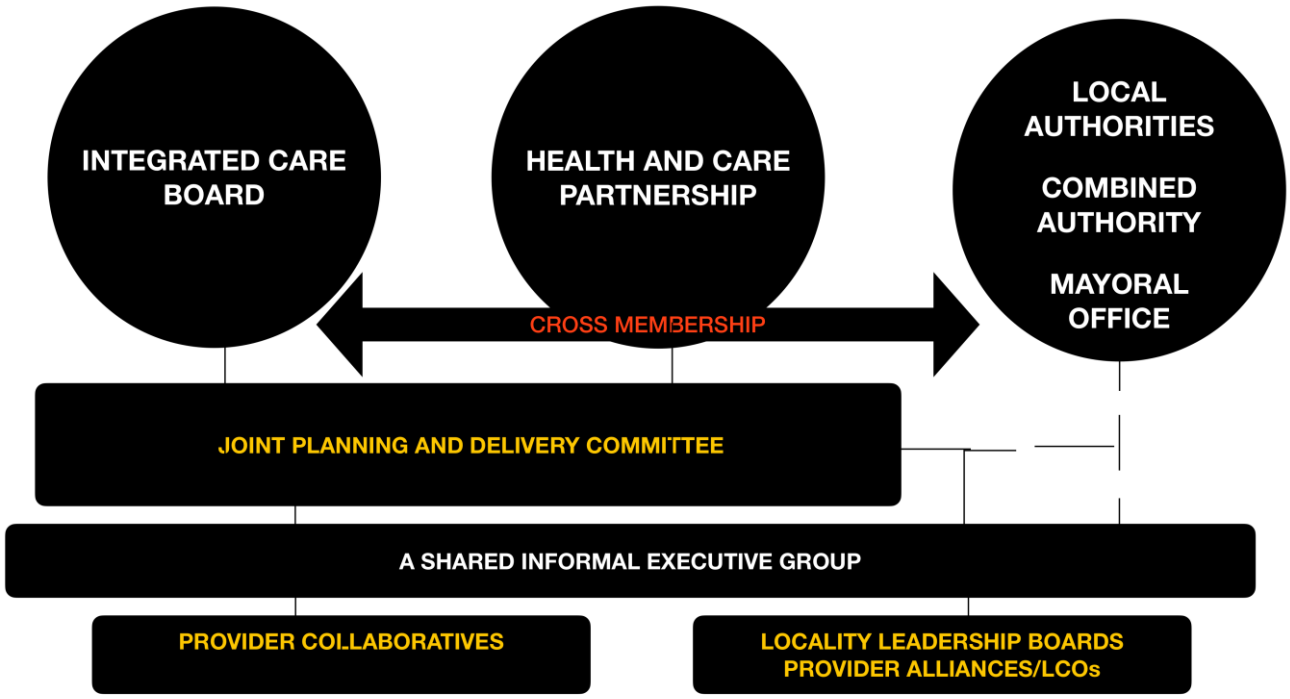
5) the proposed arrangements are built to respond to the challenge issued at the design workshops of **keeping it simple and reducing bureaucracy**. Hence meetings are dovetailed and designed to be coherent in terms of inter-connectedness and will operate with delegated powers and clarity of roles and functions. (See the meeting schedule section later)

As these principles are informing a new set of arrangements it is proposed to keep them under review as the new system beds in, with a more formal review set up to take stock prior to the ICS becoming a legal statutory entity on April 1st 2022 (subject to legislation).

Proposals

The new arrangements are designed to meet the principles above by

- Creating **a new Health and Care Partnership (HCP) which is central** to setting priorities and preserving the culture and ambitions of GM devolution. This replaces the current Partnership Board
- Establishing **an Integrated Care Board (ICB) to deliver the legal national requirements and functions** including allocation of, and accounting for NHS resource; and fulfilling primary care and specialised commissioning functions
- Creating **a Joint Planning and Delivery Committee (JPDC) that replaces PEB and JCB** and ensures/oversees joined up service planning and delivery between the GM enabling programmes, locality programmes (LA and health), Collaborative programmes and adjacent programmes (eg Mayoral office, Health Innovation Manchester, Marmot City Region etc)
- Establishing **a shared executive group (SEG) that meets weekly to coordinate executive delivery** on an ongoing basis and support the work of the three structures above
- Building on **the key delivery vehicles of Locality Boards/Alliances working through their constituent neighbourhoods** and **Provider Collaboratives** taking responsibility for programmes requiring a wider GM footprint to achieve their objectives
- Being **consistently underpinned by expert clinical and care professional advice** through lead professionals, advisory groups and forums, and adoption of a clinically and professionally empowering culture to enable service transformation and population health improvement. These mechanisms are not listed here but will be present in practice to support all the governance arrangements



Detailed Governance Functions

The GM governance model encompasses these **key collaborative governance mechanisms** with the stated intention of them operating coherently to oversee the planning and delivery of services and programmes.

The structures are part of a governance system organised in such a manner not to duplicate but to undertake the collective roles and functions of priority setting, pooling and alignment of budgets, stewardship of budgets, delivery of services and the accountability for achieving objectives.

The proposal would be **to establish the following in shadow form as of October 2021 with a review** and any adjustments made prior to formal adoption from April 2022.

1) Integrated Care Board

Function

- Fulfil all the NHS statutory functions for the ICB as set out in the 2021 Health and Care Bill including setting strategy to achieve national priorities (as set out by DHSC/NHSE in Planning and Priorities Guidance) and GM priorities (as proposed by the GM HCP and built on Locality and Provider Collaborative priorities) , allocation of NHS resources to support this strategy, oversee the commissioning or primary and specialised care, ensuring the component programmes and organisations fulfil their collective and individual responsibilities for delivering their contribution to the GM aims as agreed in the planning process.

Membership (12 members)

- 1 x Independent Chair
- 2 x Independent NEDs
- 1 x Chief Accountable Officer
- 1 x Medical Director
- 1 x Nursing Director
- 1 x Chief Finance Officer
- 3 x Partner Directors as specified (1 x LA; 1 x Primary Care; 1 x NHS Provider)
- 1 x VCSE Representative
- 1 x Chair of HCP (ex-officio)

Board of 12 Directors with ability to have observers in attendance (eg GMCA CEO)

Ability to delegate any, or all, functions
- priority setting to HCP
- planning and delivery to Joint PDC

Ability to establish joint committees (eg with Localities and Provider Collaboratives)

Ability to establish functional committees (eg Audit, Remuneration, Finance etc)

Meets 8 times per year (see meeting schedule in section below)

2) **Health and Care Partnership**

Function

- fulfil all, if any, statutory functions for the HCP as set out in the Health and Care Bill 2021; takes responsibility for setting priorities, informing and being informed by national and local priorities; provides a forum for wide engagement

- liaises, where appropriate, with Local Health and Well Being Boards on understanding locality needs, priorities and strategies

- has the power to establish wider working parties or engagement mechanisms (eg BAME forum, Inequality assembly, Younger People's Forum etc)

- With the ICB, replaces HSC Partnership Board

Membership (numbers tbd)

- Chaired by GMCA Health and Care Portfolio Holder
- Representatives from all constituent parties (eg Trusts, LAs, VCSE, local Primary Care forums/boards, academics, private sector, etc)

- Mixture of elected members, NED, lay members with executive directors, officers and lead clinical and care professionals
- Healthwatch and patient groups

- Meets 4 times per year, aligned with business planning and priority setting process (see meeting schedule in section below)

3) Joint Planning and Delivery Committee

Function

- operates with delegated responsibility to oversee the detailed **joint planning and delivery** process which will ensure that Locality programmes, Provider Collaborative programmes and GM enabling programmes work coherently. The process will coordinate the spatial levels for delivery of the programmes and the consequent financial flows set out in the GM operating model
- **strong focus on delivery of national and locally determined standards and outcomes**
- considers, determines and resolves operational issues associated with the delivery of the GM strategy
- has informal routes through Chair to political leadership
- advises ICB and HCP on potential priorities
- reports into ICB for formal decisions that have not otherwise been delegated
- liaises directly with LAs, GMCA, and Mayoral Office to align operational planning and delivery across the £7bn health & care spend with £15bn non health and care spend
- aligns the direct commissioning functions transferred from the CCG or NHSE/I (eg spec com, primary care etc) to ensure alignment of these budgets/programmes with other key programmes
- **replaces PEB and JCB**

Membership (23 members)

- 1 x Chair is GMCA health and care portfolio holder
- 1 x ICB Chair
- 3 x Provider CEOs (PFB Chair, MH Lead CEO, LCO Lead CEO)
- 1 x PCB Chair
- 10 x Locality Representatives (individuals to be determined by each locality but could potentially be the Chair of the Locality Boards as a default option)
- 4 x ICS officers (CAO, CFO, MD, ND)
- 1 x CEO GMCA
- 1 x VCSE Representative
- 1 x CEO Health Innovation Manchester

In attendance - specific attendees with distinct backgrounds, if not covered through locality representatives; and clinicians by invitation for key items

4) Shared Executive Group

Function

Brings together the key executive leaders on a weekly basis under the chairing of the ICS CAO. **Not a formal decision making group, but one that can fulfil the key role of ensuring coherence in the implementation of strategy**. The group will help steer the implementation process and serve to fix elements or programmes that are under performing. Sets agenda for Board, Partnership and Committee meetings and commissions papers.

Produces an action note rather than formal minute.

Membership

- to be determined by ICS AO, but not a formal membership list, much more about a fluid group depending on the nature of the work in hand.

5) Locality Leadership Boards

Function

- Responsible for setting local priorities, pooling and aligning NHS and social care spending, allocating budgets to local providers or local provider alliances, ensuring delivery of key programmes set out in the GM Operating Mode, liaison with GM enabling programmes and Provider Collaboratives.
- working closely with local HWBs on priorities and strategy
- subject to local scrutiny
- supporting, developing and embracing neighbourhood working as a key element of their strategy and integrated programme delivery
- aligning non health and care spend to deliver a health and care dividend
- can operate as a joint committee with ICS to allow for pooled budget

Membership

- to be determined locally but may be helpful to mirror the model options set out in the GM operating model
- will need an appointed ICS place based lead

6) Provider Collaboratives

Function

- take responsibility for leading (predominantly urgent care and elective care programmes) and partnering in the delivery of key programmes on behalf of the GM

ICS. In particular, to help GM achieve progress towards the national constitutional standards and priorities (including in cancer, mental health and physical health care)

- signals appropriate resource allocation to each Trust to deliver their collective clinical strategy
- liaison with locality boards and GM enabling programmes
- undertake programmes to standardise care, optimise workforce and sites; deliver technical efficiency and productivity improvement for existing quantum of resources spent
- has the ability to convene wider provider groupings where relevant to the GM aims (eg health and criminal justice issues etc)

Membership

- PCB - As now but may be reviewed as the system and responsibilities develop
- PFB - Executive Group - membership and structure as per recent agreements
- PFB - Chairs Group - meets quarterly
- PFB - All decisions made and accountable via individual Trust Boards steered by PFB Executive Group and Chairs to ensure visibility, and public/partner scrutiny

Schedule of Meetings

	Jan	Feb	Marc	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
ICB	X	Devel	X	X	X	Devel	X		X	Devel	X	X
HCP		X			X				X			X
JPDC	X	X	X	X	X	X	X	X	X	X	X	X
SEG	xxxx	xxxx	xxxxx	xxxx	xxxx	xxxxx	xxxx	xxxx	xxxxx	xxxx	xxxx	xxxxx

Notes

ICB (Integrated Care Board)

- Meets 8 time per year formally at the beginning of each month
- Has 3 Optional Development Sessions a year (strategic session with no expected papers for decision) - can invite wider attendance
- Meets nationally prescribed membership (with GM additional membership, as set out above)
- REPLACES the GM Partnership Board

HCP (Health and Care Partnership)

- Meets 4 times formally per year, at the beginning of the month in question, and dovetailed with the NHS ICS Board
- Has larger membership drawn from the full range of stakeholders

JPDC (Joint Planning and Delivery Committee)

- Meets monthly in the middle of each month dovetailed with ICS Board and HCP
- Takes direction, informs and statutorily reports into NHS ICB
- Minutes also go to CA
- Has a standing membership drawn from ICSB, HCPB, LA and Mayoral Office
- REPLACES Partnership Executive Board and JCB

SEG (Shared Executive Group)

- Meets weekly
- Is an informal meeting but with action notes taken
- Has a small core membership but with ability to bring in additional input on a fluid basis

RECOMMENDATION - Taken together these proposals are recommended for adoption by the GM Health and Care Partnership Board