Future commissioning arrangements in Southampton

April 2021

1. Background

1.1. Our immediate priority remains ensuring our local system can deliver essential services and treat people with COVID-19 in hospitals, and many more in primary, community and mental health care. The COVID-19 vaccination programme is progressing well in Southampton, with hospitalisation rates declining. National data indicates this is also having a significant impact on transmission rates. In Southampton, for many years our priority has been to tackle health inequalities. Nationally, the pandemic has highlighted more clearly the need to address inequalities in access, experience and outcomes.

1.2. Since the pandemic began, there has been a huge acceleration in system working and collaboration. We are now starting to look at how we can build on the existing partnership working to improve outcomes for patients as we move to a new phase in our response to the pandemic. While much of this work was in train prior to the pandemic, such as plans to merge CCGs, the last year has shown we must move at pace to implement the changes needed to improve services for local people.

1.3. This report provides an update on these changes. On 1 April 2021, CCGs merged to form a single commissioning organisation: NHS Hampshire, Southampton and Isle of Wight Clinical Commissioning Group (CCG).

1.4. Building on existing close working arrangements, NHS Hampshire, Southampton and Isle of Wight CCG brings together Southampton City CCG, West Hampshire CCG and Hampshire and Isle of Wight Partnership of CCGs (which has been a mechanism for closer joint working between South Eastern Hampshire, Fareham and Gosport, the Isle of Wight and North Hampshire CCGs over the last three years).

1.5. Portsmouth CCG remains a statutory body and will work closely with the newly formed CCG. Portsmouth CCG appointed Maggie MacIsaac as its Accountable Officer on 1 April 2021, which means both CCGs have the same executive lead.

1.6. The process of merging CCGs follows the development of detailed proposals, in-line with national policy and local plans for health and care, which also saw Hampshire and the Isle of Wight designated as an Integrated Care System (ICS) in November 2020. Arrangements for the new CCG continue to be developed in parallel with the design and development of the ICS.

1.7. Place-based working is at the heart of the new CCG. In the new CCG, Southampton has retained its own local area team, led by Dr Sarah Young as

Clinical Director and Stephanie Ramsey as Managing Director, which will work to implement the Five Year Health and Care Strategy (2020-2025) for the city.

1.8. In February 2021 the Government released its White Paper, 'working together to improve health and social care for all'. Many of the structural changes we have made in recent months were designed to pre-empt future legislation and, as such, our existing plans mean we are well placed to adopt the changes likely to be put to parliament this year.

2. Local context: operating as part of the Hampshire and Isle of Wight Integrated Care System

2.1. We remain committed to supporting our communities to stay as healthy as possible and ensuring local residents have access to high quality healthcare when they need it. Coming together as one CCG for Hampshire, Southampton and the Isle of Wight enables us to build on our successful collaborative approach to planning and delivery, maintaining local, clinically-led decision making focused on the needs of local people, while also realising the benefits of working at scale across the area to achieve the best possible outcomes.

2.2. Our experience during the COVID-19 pandemic has further highlighted the benefits of closer joint working. Coming together as one organisation also enables us to build a more efficient and effective operating model, make better use of our resources avoid duplication and achieve economies of scale for the benefit of local residents.

2.3. The CCG has created five local teams to help to meet the needs of the local population. These teams are North and Mid Hampshire, Isle of Wight, South West Hampshire, South East Hampshire, and Southampton City.

2.4. A single CCG/ICS executive team and CCG governing body have been formed. The governing body is chaired by Margaret Scott as an independent chair and Dr Nicola Decker as Clinical Lead for Hampshire, Southampton and Isle of Wight. A clinical director representing each 'place' area also sits on the governing body, which includes Dr Sarah Young representing Southampton City. The governing body also has additional support from a secondary care clinician and three non-executive directors. This is in line with statutory requirements. The full membership of the CCG governing body is:

- Margaret Scott – Independent Chair
- Maggie MacIsaac – Chief Executive
- Dr Nicola Decker – Clinical Lead
- Edward Palfrey OBE – Secondary Care Clinician (Non Executive)
- Judy Gillow MBE – Non Executive Director (Patient and public involvement)
- Matt Stevens – Non Executive Director (Primary care commissioning)

- Simon Garlick – Non Executive Director (Governance)
- Julie Dawes – Chief Nursing Officer (Julie commences her role in May 2021 and until that point the statutory role of Chief Nurse will be covered by Stephanie Ramsey)
- Roshan Patel – Chief Finance Officer
- Dr Sarah Young – Clinical Director, Southampton
- Dr Michele Legg – Clinical Director, Isle of Wight
- Dr Charlotte Hutchings – Clinical Director, North and Mid Hampshire
- Dr Zaid Hirmiz – Clinical Director, South East Hampshire
- Dr Karl Graham – Clinical Director, South West Hampshire

2.5. The executive team is led by Maggie MacIsaac as Chief Executive, supported by:

- Derek Sandeman - Chief Medical Officer
- Roshan Patel - Chief Finance Officer
- Helen Ives - Executive Director of Workforce
- Julie Dawes - Chief Nursing Officer (due to start in May 2021 on part time secondment from Hampshire Hospital NHS Foundation Trust)
- Tessa Harvey - Executive Director of Performance
- Paul Gray - Executive Director of Strategy
- Richard Samuel - Director of Transition and Development
- Fiona Howarth - Chief of Staff
- Emma McKinney - Director of Communications and Engagement

2.6. In order to better support the planning and delivery of improvements in health outcomes for local people and service performance, the CCG will aim to:

- Increase the support we provide to primary care and to the development of primary care networks. General practice is the cornerstone of the NHS and the first port of call for most people who seek health advice or treatment. We are committed to supporting general practice and Primary Care Networks (PCNs), which are at the heart of integrated care.

- Pursue deeper integration of health and care with local council partners, building on existing relationships at local place across Hampshire, Southampton and the Isle of Wight. Strengthening collaborative arrangements with local authorities, including parish, district and borough councils in addition to upper tier authorities, at local place and maintaining the focus on local communities and the places where people live and work is fundamental. This provides the best opportunity to use our collective resources to make a genuine impact on preventing ill health, reducing inequalities, joining up health and care delivery, and improving people's independence, experience and quality of life.

- Better support providers to redesign and transform service delivery. Providers, CCGs and local authorities are working increasingly closely together to redesign service delivery, co-ordinating and improving the delivery of services for the population they serve. For some services it makes most sense to build delivery alliances to plan, transform and co-ordinate service delivery in geographies based around acute hospital footprints. For other services it makes sense to plan and deliver transformation together at the scale of Hampshire and Isle of Wight, and beyond. Alongside our work to integrate health and care with local authorities, we will also align CCG teams and resources with each delivery alliance, supporting them to redesign pathways and develop services.

- Create a single strategic commissioning function for the Hampshire and Isle of Wight ICS to support and enable the ICS, accelerating simplification of planning, transformation and infrastructure at a Hampshire and Isle of Wight level.

3. National context: the publication of the government's White Paper 'Working together to improve health and social care for all'

3.1. In December 2020 NHS England and NHS Improvement (NHSEI) proposed options for legislation in Parliament, to support the development of Integrated Care Systems. In February 2021 the Government has published a White Paper outlining which proposals it plans to take forward to Parliament to become law.

3.2. In Hampshire and Isle of Wight, in December last year our Sustainability and Transformation Partnership (STP) was given approval to become an Integrated Care System (ICS) from 1 April 2021. At the moment, in legislative terms, both Sustainability and Transformation Partnerships and Integrated Care Systems are voluntary partnerships of commissioners, providers and local authorities, with no legal powers.

3.3. The proposals outlined in the government's White Paper are summarised as below:

3.3.1. **Legislate for every part of England to be covered by an integrated care system (ICS).** This is in line with NHS England's recommendation last year and would formally bring together NHS organisations, local government and wider partners at a system level. The White Paper suggests an ICS will be coterminous with the boundaries of the local authorities within its geography. An ICS will be comprised of two entities:

- **An ICS Health and Care Partnership.** There will be a broad duty for organisations to collaborate and deliver better care for all patients, better

health and wellbeing for everyone, and maintain a sustainable use of NHS resources.

- **An ICS NHS Body.** This part will be the organisation responsible for the day to day running of the ICS. This body will be responsible for developing plans to meet the health needs of the population within their defined geography, developing a capital plan for NHS providers and securing the provision of health services to meet the needs of the system population.

3.3.2. **Merge the functions currently being performed by non-statutory STPs/ICSs with the functions of a CCG.** This effectively means CCGs would merge to become the local ICS NHS Body. Each ICS NHS body will have a board, and this will be directly accountable for NHS spend and performance within the system, with its Chief Executive becoming the Accounting Officer for the NHS money allocated to the NHS ICS Body. At present ICSs do not receive money directly because they are not statutory bodies.

3.3.3. Implement NHS England's recommendations to **remove barriers to integration through joint committees, collaborative commissioning approaches and joint appointments**, as well as their recommendation to preserve and strengthen the right to choice within systems.

3.3.4. **Formally bring NHS England and NHS Improvement into one organisation.** At present both organisations technically have non-shareable functions but in effect work together as one. The new NHS England will have operational independence but the Secretary of State will have intervention powers.

3.3.5. **Give the Secretary of State for Health and Social Care new powers** to set the objectives of NHS England, intervene in service reconfiguration changes where required, have the ability to make direct payments to social care providers, and take on specific public health functions such as the implementation of fluoride in water.

3.3.6. **Enable NHS England to delegate or jointly commission some of its responsibilities to ICSs**, such as screening and immunisation services and specialist services. This could also involve commissioning functions with more than one ICS Board, covering larger populations.

3.3.7. **Allow for the creation of new trusts to provide integrated care.** However the White Paper also makes clear that there are no plans to significantly alter the provider landscape. New legislation will allow for ICSs to apply to the Secretary of State to create a new trust.

3.3.8. Ensure **more effective data use** across the health and care system. A soon to be published Data Strategy for Health and Care will set out a range of proposals to address cultural, behavioural and legislative barriers to data sharing.

3.3.9. Ensure its proposals would also, in line with the approach set out by NHS England, **allow for ICSs to delegate significantly to place level and to provider collaboratives**. This means these proposals are as much about making sure the right decisions are made locally as they are about making sure the right decisions are made centrally by an ICS, NHS England or the Secretary of State.

3.3.10. **Legislate for the NHS to be free to make decisions on how it organises itself without the involvement of the Competition and Markets Authority** (CMA). This also means reforming the procurement process we currently use for NHS services and create a bespoke health services provider selection regime that will give commissioners greater flexibility in how they arrange services than at present.

3.3.11. **Enhance integration of health and care by placing a social care element in the ICS structure**, a new standalone legal basis for the Better Care Fund and allowing 'Discharge to Assess' models to be followed.

3.3.12. Amend previous legislation on social care **to provide a new duty for the Care Quality Commission to assess Local Authorities' delivery of their adult social care duties**, alongside powers for the Secretary of State to intervene and provide support where there is a risk of local authorities' failing to meet these duties.

3.4. These are some of the recommendations outlined in the White Paper. Broader reforms around public health functions and social care are not outlined in this White Paper and we expect more details on those areas to be announced in the future.

3.5. We await the publication of a Bill to Parliament this year. NHSEI expects ICSs to take steps in their development during 2021/22 to ensure they are able to deliver the four core purposes described above. ICSs are asked to set out how they will organise themselves to support this, including through preparing for moving to a statutory footing from April 2022, subject to legislation.

4. Place-based development in Southampton City

4.1. There is a strong history of joint working between health and care partners in Southampton City. Our challenge today is retain strong joint leadership and

governance arrangements in light of the changing policy and organisational landscape.

4.2. The CCG and Council have moved from limited joint planning and separate use of health and care resources to joint working across a wide range of areas to improve outcomes for vulnerable adults, children and families. There are established joint roles and joint decision-making forums, with a pooled budget totalling c.£135m. The Southampton City Health and Care strategy (2020-2025) is supported by all stakeholders and is felt to set the vision and ambition for the place-based partnership over the coming five years. Integration with providers has also been developing with joint delivery teams now in place for services such as rehabilitation and reablement.

4.3. As part of the CCG merger, a Southampton City local area place team, as identified above, has already been put in place. This team largely inherits the staff from the previous CCG teams, ensuring continuity. The team is led by Stephanie Ramsey on an interim basis as Managing Director.

4.4. The CCG is allocated its budget nationally and this is set by the size of the patient population. Whereas the budget will now be allocated to a larger geographical area, Southampton City's share will remain the same. Therefore the commissioning budget for Southampton City for 2021/22 is as it would have been prior to the merger.

4.5. In light of existing and upcoming vacancies in senior roles in both the CCG and the Council, we have urgently considered options around leadership and governance. To support this, external support from Carnall Farrar was commissioned by the CCG and Southampton City Council to review existing arrangements and propose next steps.

4.6. It is planned that the current scope of joint working should be maintained, with the CCG delegating decision-making to the place-based arrangements in Southampton City. A senior management team and clinical leadership team are in place for Southampton to take on delegated powers.

4.7. It is also proposed to revisit the governance arrangements in the city, to ensure both a strategic and operational boards are in place.

4.8. As an interim step, there will be no change in the existing leadership structure, although personnel in specific posts may change. This will be maintained as design work is carried out prior to a longer term aim to explore future leadership roles and integrated management teams. Prior to finalising the leadership arrangements for the health and care place-based partnership, a further exploration of options is needed with providers in the context of the new legislative framework to consider whether more ambitious integration is feasible.

4.9. A task and finish group has been established to develop options on both future local governance and leadership options. This will require consideration and agreement by all organisations. Local developments will mirror the timescales of the overall ICS development, itself likely to move to shadow form by February 2022.