Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 22nd October, 2020
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Virtual meeting

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor White (Vice-Chair)
Councillor Laurent
Councillor Professor Margetts
Councillor Noon
Councillor Payne
Councillor Vaughan

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PUBLIC INFORMATION

ROLE OF HEALTH OVERVIEW SCRUTINY PANEL (TERMS OF REFERENCE)

The Health Overview and Scrutiny Panel's responsibilities and terms of reference are set out within Part 3 of the Council's Constitution: Responsibility for Functions

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

MOBILE TELEPHONES: - Please switch your mobile telephones to silent whilst in the meeting.

USE OF SOCIAL MEDIA: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council's Guidance on the recording of meetings is available on the Council's website.

PUBLIC REPRESENTATIONS
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

SMOKING POLICY – the Council operates a no-smoking policy in all civic buildings.

Southampton: Corporate Plan 2020-2025 sets out the four key outcomes:

- Communities, culture & homes - Celebrating the diversity of cultures within Southampton; enhancing our cultural and historical offer and using these to help transform our communities.
- Green City - Providing a sustainable, clean, healthy and safe environment for everyone. Nurturing green spaces and embracing our waterfront.
- Place shaping - Delivering a city for future generations. Using data, insight and vision to meet the current and future needs of the city.
- Wellbeing - Start well, live well, age well, die well; working with other partners and other services to make sure that customers get the right help at the right time

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

RULES OF PROCEDURE
The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

(a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or

(b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

OTHER INTERESTS

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

- Any body to which they have been appointed or nominated by Southampton City Council
- Any public authority or body exercising functions of a public nature
- Any body directed to charitable purposes
- Any body whose principal purpose includes the influence of public opinion or policy

PRINCIPLES OF DECISION MAKING

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the “rationality” or “taking leave of your senses” principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, ‘live now, pay later’ and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

DATES OF MEETINGS: MUNICIPAL YEAR 2020/21

2020	2021
2 July	4 March
3 September	22 April
22 October	
17 December	

AGENDA

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)
(Pages 1 - 4)

To approve and sign as a correct record the minutes of the meeting held on 3rd September, 2020 and to deal with any matters arising, attached.

7 HAMPSHIRE TOGETHER: MODERNISING OUR HOSPITALS AND HEALTH SERVICES (Pages 5 - 38)

Report of the Managing Director, North and Mid Hampshire – Hampshire and Isle of Wight Partnership of CCGs, West Hampshire CCG and the Chief Executive of Hampshire Hospitals NHS Foundation Trust providing an overview of the Hampshire Together: Modernising our Hospitals and Health Services programme.

8 COVID-19 PLANNING (Pages 39 - 40)

Report of the Chair of the Panel requesting that the Panel consider a verbal update from the Interim Director of Public Health on Covid-19 planning in Southampton.

9 **NHS FINANCIAL REGIME FOR 2020/21** (Pages 41 - 68)

Report of the Managing Director, NHS Southampton City CCG, outlining the financial regime for the NHS in 2020/21.

10 **CCG REFORM IN HAMPSHIRE AND ISLE OF WIGHT** (Pages 69 - 80)

Report of the Clinical Chair, NHS Southampton City CCG, on CCG reforms in Hampshire and the Isle of Wight.

Wednesday, 14 October 2020 Service Director – Legal and Business Operations

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 3 SEPTEMBER 2020

Present: Councillors Bogle (Chair), White (Vice-Chair), Laurent, Professor Margetts, Noon, Payne and Vaughan

5. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes for the Panel meeting on 2nd July 2020 be approved and signed as a correct record.

6. **COVID-19: RECOVERY PLAN OVERVIEW**

The Panel considered and noted the report providing an overview of the recovery and restoration activity underway in the Southampton and South West Hampshire system following the COVID-19 outbreak.

Stephanie Ramsey - Director of Quality and Integration, Integrated Commissioning Unit (ICU); David Noyes - Chief Operating Officer, Solent NHS Trust; Joe Teape – Chief Operating Officer, University Hospital Southampton NHS Foundation Trust; Dr Adam Cox - Divisional Clinical Director, Southern Health NHS Foundation Trust and Jane Hayward – Hampshire and Isle of Wight Care System were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- How the health care providers are recovering from the peak of the Covid-19 pandemic and the risks, pressures on their services;
- Workforce resilience;
- The effect of the pandemic on numbers of patients:
    - awaiting routine appointments;
    - needing early help and assistance to prevent the need for more intensive care;
    - public willingness to attend medical settings. The Panel sought to understand whether reluctance to attend clinical settings during the pandemic had led to an increase in urgent / crisis referrals;
- Sustainability of funding;
- How Covid-19 appears to have been a catalyst to deliver changes that were already identified as being required such as:
    - the increased co-operation with service providers;
    - a greater emphasis on treatment outside of the emergency department, in community settings; and
    - the better use of technology.

  The Panel questioned the extent to which the system would revert back to the previous operating methods once the pandemic is over as individual Trust's focus on their priorities.
- System resilience with regards to the expected Wave 2 Covid-19 and winter pressures, given workforce concerns; and
- The long term impacts of the Covid-19 pandemic on the local health system.

7. **SOUTHERN HEALTH NHS FOUNDATION TRUST - WILLOW WARD PROPOSAL AND CQC UPDATE**

The Panel considered the report of the Chair of the Panel requesting that HOSP consider proposals to close Willow Ward, and the Trust's CQC inspection update.

Celia Scott-Molloy – Head of Operations, Learning and Disability Service- Southern Health NHS Foundation Trust and Ron Shields, Chief Executive - Southern Health NHS Foundation Trust were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- The number of patients now on Willow Ward;
- What the new community based provision would look like;
- The impact on service users that the delay in service from the proposed closure of Willow Ward to the new service being established would have; and
- Whether the creation of the new service would help to reduce the number of patients that require treatment outside of the region over time;

The Panel welcomed Ron Shields to the meeting congratulating the Trust on its recent CQC rating and commenting on the improvement shown by the Trust.

RESOLVED That an update is provided to the Panel, in advance of the 22 October meeting of the Panel, that would set out any progress on establishing the proposed Enhanced Intensive Support Service.

8. **THE EMERGING PICTURE - COVID 19 AND HEALTH INEQUALITIES IN SOUTHAMPTON**

The Panel considered and noted the report the Interim Director of Public Health enabling the Panel to discuss the emerging picture with regards to Covid-19 and health inequalities in Southampton.

Dr Debbie Chase - Interim Director of Public Health, Southampton City Council and Kate Lees - Consultant in Public Health, Southampton City Council were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- Resources available to the Interim Director of Public Health to support action to tackle health inequalities in the City;
- When more robust evidence is anticipated that would enable a base level being established that would help to direct approaches;
- Whether the Council was listening to the views and evidence provided by Public Health in establishing policy locally; and
- What implications were there to the City with the forthcoming abolition of Public Health England.

9. **CCG REFORM IN HAMPSHIRE AND ISLE OF WIGHT**

The Panel considered the report of the Chair of the Panel recommending that the Panel consider developing a response to the proposals to reform Clinical Commissioning Groups (CCG) in Hampshire and the Isle of Wight.

Dr Mark Kelsey – Clinical Chair, NHS Southampton City CCG and James Rimmer – Managing Director, NHS Southampton City CCG were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel noted that this item would be returning to the 22 October 2020 meeting for a fuller discussion. It was explained that the item would be presented to the Board of the CCG prior to this date.

The Panel raised a number of points including:

- The Panel's concerns that needs of Southampton residents would be side-lined as part of the reform. The Panel expressed apprehension that the joining together of the areas CCGs would result in a reduction in focus on the health matters within the City;
- The need for a place- based approach to health care as much as possible based on the needs of Southampton's population;
- A need for an explanation on governance arrangements and more detail on how the proposed reforms would work;
- The Panel briefly explored why Portsmouth CCG had not engaged in the merger and sought clarification on the benefits of any proposed changes.

RESOLVED that

(i) the Panel delegated responsibility to the Scrutiny Manager, in consultation with the Chair, to draft a response on behalf of the Panel setting out the Panel's comments in regard the proposed reforms in advance of the joint meeting of regional CCGs on 24 September; and

(ii) the 22 October meeting of the Panel includes a more detailed item on CCG reforms in Hampshire and the Isle of Wight.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		HAMPSHIRE TOGETHER: MODERNISING OUR HOSPITALS AND HEALTH SERVICES		
DATE OF DECISION:		22 OCTOBER 2020		
REPORT OF:		HAMPSHIRE TOGETHER: MODERNISING OUR HOSPITALS AND HEALTH SERVICES PROGRAMME		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Ruth Colburn-Jackson** (Managing Director, North and Mid Hampshire – Hampshire and Isle of Wight Partnership of CCGs, West Hampshire CCG), **Alex Whitfield** (Chief Executive – Hampshire Hospitals NHS Foundation Trust)	**Tel:**	**01256 852615**
Director	**Name:**	Ruth Colburn-Jackson Alex Whitfield	**Tel:**	**01256 852615**

STATEMENT OF CONFIDENTIALITY
Not Applicable

BRIEF SUMMARY

This report provides an overview of the *Hampshire Together: Modernising our Hospitals and Health Services* programme and the progress we are making as we prepare a business case and proposals for consultation in early 2021.

In addition to this report, a brief presentation will be provided for members of the committee as part of the meeting.

RECOMMENDATIONS:

	(i)	To note the report.
	(ii)	To consider and decide whether the proposed changes constitute a substantial change/variation in service.
	(iii)	If so, to recommend to full council that Southampton City Council takes part in a Joint Overview and Scrutiny Committee with neighbouring local authorities to consider and be consulted formally on the proposed changes.

REASONS FOR REPORT RECOMMENDATIONS

1.	To inform understanding of the Hampshire Together Programme.
2.	To ensure that Southampton City Council is consulted on the proposed changes they consider a substantial variation.
3.	To enable the formation of a Joint Overview and Scrutiny Committee, if required.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

4.	• Not to recommend to full council Southampton City Council takes part

	in a Joint Overview and Scrutiny Committee to consider the matter. This option has been rejected on the grounds that other local authorities have indicated to the NHS in mid and north Hampshire that the outline proposals constitute substantial variation and therefore, if Southampton City Council agrees with regard to its own population, a Joint Overview and Scrutiny Committee would need to be established to consider and be formally consulted on the proposed changes.
DETAIL (Including consultation carried out)	
5.	**Background** Hampshire Together is a programme that involves all NHS and social care services across north and mid Hampshire (Alton, Andover, Basingstoke, Eastleigh, Winchester and the surrounding areas). It is being led by Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups and West Hampshire Clinical Commissioning Group, in partnership with Hampshire Hospitals NHS Foundation Trust. It involves all organisations providing health and social care across the Alton, Andover, Basingstoke, Eastleigh and Winchester area working together to develop a health, wellbeing and care service so that everyone in north and mid Hampshire can access high-quality, timely and sustainable health care as close to home as possible. The programme is looking at the best way to organise services to meet the population's changing health needs and to adapt the way some services are delivered so they can continue to meet best practice and clinical quality guidelines, and are sustainable for the long-term. To meet these challenges the local NHS has been exploring the possibility of centralising some of the most specialist hospital services for the sickest people on one site, rather than spread across two main sites (Basingstoke and Winchester) as they currently are. Consolidating the most specialist services in one place would mean a better use of senior clinicians, who are currently spread too thinly across hospital sites. It would also mean clinical teams treat more patients with particular conditions and illnesses, helping to better maintain their specialist expertise. The programme also includes the potential for the construction of a brand new hospital as part of the Government's Health Infrastructure Plan. Hampshire Hospitals was last year named as one of the trusts chosen to receive capital funding as part of this Department of Health and Social Care's plan, which is designed to support 40 hospital building projects across the country between 2025 and 2030. **Public Engagement** Initial public engagement activity was held between 1 June and 7 August 2020, based on a listening document (see Appendix 1) that set out the challenges facing our health and care system, the opportunities provided by the Hampshire Together programme and the decisions that will need to be taken in order to maintain safe, high quality, sustainable services for the long-term. Feedback received during engagement was independently analysed and a summary, including a breakdown of the key themes identified, can be found at Appendix 2. **Options Development** A process of options development began in late August 2020. Doctors,

nurses and other clinicians from north and mid Hampshire held a series of conversations and virtual workshops to look at how health and care services could be designed for the future.

More than 100 people, including current patients with experience of using hospital services, clinicians from across the health and care system, and representatives of various groups from the community took part. They initially developed eight options, or clinical models, for the way services could be provided in the future.

The eight options (see Appendix 3) were then considered by doctors, nurses, and other clinicians and evaluated against pre-agreed criteria to decide whether they should be discounted or taken forward and investigated further. Two options were discounted during this process. One because it involved continuing to run services as they are currently set up (named Option A), and another because it involved moving all services to a new hospital, with no facilities elsewhere (Option H).

Further work is now being undertaken to review and evaluate each option in detail. Options will be assessed with regards to clinical quality, patient experience and outcomes as well as the impact on staffing levels, the amount each option would cost and affordability, accessibility and deliverability, to inform the development of a shortlist.

Clinical options currently being explored

Five of the six options currently being explored involve the construction of a new hospital. Four of the six options involve the development of a main satellite hospital and all options have some health care services provided elsewhere, working together as a network to serve the people of north and mid Hampshire. Work is ongoing to identify proposed locations for these services.

The six options currently being explored are:

- Option B – Investment would be made to sustain hospital services at the Basingstoke and Winchester sites for the long-term. Services including emergency care, consultant-led maternity care and intensive care would be centralised at one of the hospitals. Centralisation will help to ensure delivery of the clinical quality standards required for these services, so they can continue to be provided in north and mid Hampshire.
- Option C – Emergency care, consultant-led maternity care and intensive care would be centralised in a new hospital, as would a new outpatient centre which would enable patients to undergo scans, have tests carried out and have an appointment with their consultant in the same visit. A centre for surgery planned in advance would be provided from a main satellite hospital, which would also benefit from additional investment. Outpatient consultations and a range of other hospital services would be provided at additional satellite locations across north and mid Hampshire.
- Option D - Emergency care, consultant-led maternity care and intensive care would be centralised in a new hospital, as would a centre for surgery planned in advance and a new outpatient centre which would enable patients to undergo scans, have tests carried out and have an appointment with their consultant in the same visit. Outpatient consultations and a range of other hospital services would be provided at satellite locations across north and mid Hampshire,

with some additional investment.

- Option E – Emergency care, consultant-led maternity care and intensive care would be centralised in a new hospital, as would a centre for surgery planned in advance and a new outpatient centre which would enable patients to undergo scans, have tests carried out and have an appointment with their consultant in the same visit. An outpatient centre, offering the same services described above, would also be provided from a main satellite hospital, which would also benefit from additional investment. In addition, outpatient consultations and a range of other hospital services would be provided at additional satellite locations across north and mid Hampshire.
- Option F – Emergency care, consultant-led maternity care and intensive care would be centralised in a new hospital, as would a new outpatient centre, which would enable patients to undergo scans, have tests carried out and have an appointment with their consultant in the same visit. A centre for surgery planned in advance and an outpatient centre offering the same services described above would be provided from a main satellite hospital, which would also benefit from additional investment. In addition, outpatient consultations and a range of other hospital services would be provided at additional satellite locations across north and mid Hampshire.
- Option G – Emergency care, consultant-led maternity care and intensive care would be centralised in a new hospital, as would a centre for surgery planned in advance. An outpatient centre which would enable patients to undergo scans, have tests carried out and have an appointment with their consultant in the same visit would be provided from a main satellite hospital, which would also benefit from additional investment. In addition, outpatient consultations and a range of other hospital services would be provided at additional satellite locations across north and mid Hampshire.

The main satellite hospital would contain, as a minimum, an urgent treatment centre, step down inpatient care for patients requiring services such as physiotherapy, midwife-led maternity care, and diagnostic tests such as MRI scans and blood tests.

Next steps

An options development group, including clinicians and patients is currently meeting on a weekly basis to discuss the clinical options and, through a clear process of evaluation against a set of agreed criteria, finalise which of them should be carried through for inclusion in a Pre-Consultation Business Case (PCBC).

The PCBC will go through Stage Two assurance with our regulator, NHS England/Improvement, towards the end of the year (date tbc), before being finalised and published.

Public consultation is currently planned for early 2021. A consultation plan will be shared with the committee for comment at a later date.

Impact of the proposals

As an indicator of the possible impact on the public and health services that Southampton City Council is responsible for, patient flow data is detailed in Appendix 4 (flow of patients from north and mid Hampshire to acute providers over the last three years) and Appendix 5 (patients who have

	accessed Hampshire Hospitals services over the last three years by local authority area).
RESOURCE IMPLICATIONS	
Capital/Revenue	
6.	There are no financial implications for Southampton City Council from the report, which is an information report only.
Property/Other	
7.	This report is an information report only.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
8.	The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS commissioners to consult local authorities on proposed substantial variations to health services; requiring each CCG to notify its local authority partners when it has such proposals under consideration.
9.	Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires local authorities to appoint "mandatory" joint committees where a relevant NHS body or health service provider consults more than one local authority's health scrutiny function about "substantial reconfiguration" proposals. In such circumstances, Regulation 30 sets out the following requirements: • Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately) • Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal • Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service.
Other Legal Implications:	
10.	No significant legal implications to bring to the committee's attention at this point
RISK MANAGEMENT IMPLICATIONS	
11.	Not Applicable
POLICY FRAMEWORK IMPLICATIONS	
12.	Not Applicable to any Southampton City Council policy frameworks, but the Hampshire Together programme and the proposals being developed by the NHS in north and mid Hampshire are within the context and policy framework of the *NHS Long Term Plan* and the government's *Health Infrastructure Plan*.

KEY DECISION?	**YES**
WARDS/COMMUNITIES AFFECTED:	All wards and communities have the potential to be affected if service change impacts University Hospitals

	Southampton NHS Foundation Trust
SUPPORTING DOCUMENTATION	
Appendices	
1.	Hampshire Together: Modernising our Hospitals and Health Services Listening Document
2.	Engagement Report Summary
3.	Clinical Options Chart
4.	Flow of patients from north and mid Hampshire to acute providers 2017-2020
5.	Patients who have accessed Hampshire Hospitals services by local authority area 2017-2020

Documents In Members' Rooms

1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?	**Yes**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	**No**
Other Background Documents **Other Background documents available for inspection at:**	

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	**N/A**	

Hampshire Together
Modernising our Hospitals and Health Services

Hampshire Together: Modernising our Hospitals and Health Services

Listening document

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FOREWORD

The NHS constitution starts with the words:

> **"The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill, and when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need when care and compassion matter most."**

To deliver on this promise we need to provide our staff with the tools and support they need.

We have been given an amazing opportunity to enhance our local NHS services, for decades to come. We are part of the government's new programme to replace hospital buildings across the country. Our ambition is to use this opportunity to support the NHS purpose, to improve the health and wellbeing of the population of north and mid Hampshire, now and in the future.

It is no secret that some of our buildings – while much loved – are now approaching the end of their usable lives. This programme will enable us to build a new hospital – complementing existing services and allowing us to embrace new ideas and innovations; all with our patients at the heart of our thinking.

But our ambition is to go even further.

This project will include our whole local NHS – from GPs to mental health services, community care to acute hospital provision; as well as our colleagues in social care and the wider voluntary sector. As such, we are working together as one, with the aim of delivering fully joined-up care; from hospital to home and everything in between.

Taking advantage of this opportunity will require both significant change and some hard choices - and we want your views on the best way forward. We are also aware that the lessons learned from the COVID-19 outbreak will need to be incorporated into any plans we develop.

In this paper and on our website we aim to present as much information and data as we can so that you can see exactly what is informing our current thought processes and how you can best help us reach better, more informed decisions.

It is important to note that at this stage no decisions have been taken and no options generated. This is a real chance for you to have your say from the very start. Just as critically, this is just the start of our conversation with you; a conversation we expect to last for more than a year and grow as we develop our proposals and consult the public appropriately.

Thank you for taking the time to read this and we really look forward to your feedback.

Kind Regards,

Alex Whitfield, Chief Executive, Hampshire Hospitals NHS Foundation Trust

Maggie MacIsaac, Chief Executive, Hampshire and Isle of Wight Integrated Care System; Southampton City, West Hampshire and Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups

Ruth Colburn-Jackson, Managing Director - North and Mid Hampshire Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups

OUR CLINICAL VISION

We want to improve the health and wellbeing of all our population, throughout their life journey, from before conception to after death. This project, combined with our experiences of rapid change and service development during the COVID-19 pandemic, have helped us realise that we have a unique opportunity to adapt to ensure that we are able to meet the needs of our population - both now and for future generations.

Our vision is for our health and social care services to provide outstanding care for all our people within north and mid Hampshire:

- All health and social care services will work together to deliver the best care for our people
- People will have easy, timely access to the help and support they need
- Services will be designed to meet their requirements
- Services will be sustainable, efficient and high quality; with a focus on delivering the best clinical outcomes possible
- Where practical, care will be provided in people's homes or as close to them as possible
- People will be empowered to self-manage wherever they can, with the information and support required to do so; including access to diagnostic tests and specialist advice when needed
- Where necessary, services will be centralised to ensure the best possible care and outcomes
- We will be able to live within the money allocated to our area; reducing duplication and inefficiency
- We will ensure our healthcare facilities are accessible, fit for purpose and improve a sense of wellbeing for those using them and working there
- Our services will attract the best staff, being renowned for high quality, innovation, research and training support

We will ensure that our people have continuity between their primary care and community teams; supported by quick access to specialists when this is required. Our specialists and primary care teams will work closer together to improve the care we can provide, often with linked specialist and GP networks.

We will use digital advances in communication so that consultations within the primary care setting or with specialist services will only require travel when absolutely necessary. We will maximise the use of innovation and technology to bring care as close to home as possible, reduce repetition and duplication and proactively manage people's care. This will allow many of our services to be available seven days a week.

When people need care in a hospital setting, we will ensure this is delivered in state of the art buildings, designed for modern health care, with facilities to diagnose and treat their condition rapidly. These facilities will have the option to adapt to changing pressures and that protect people from infections. Working together, we will ensure that when our people no longer need acute hospital care, they can leave hospital and receive on-going care at or near to their homes, straight away. Only people who need to be cared for in a hospital will be there.

With your help and guidance, we know we can design these services and buildings to deliver the outstanding care you and your families deserve now and in the future.

Dr Lara Alloway, Chief Medical Officer, Hampshire Hospitals NHS Foundation Trust

Dr Nicola Decker, Clinical Chair - North Hampshire, Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups

THE CHALLENGES

The NHS is ever-changing – and so are the challenges it faces! At present there are four main issues which need to be tackled by this project:

Clinical sustainability

It is critical that our clinical services not only deliver outstanding patient care but that they are sustainable. This means that we need to be sure we can provide them consistently and predictably so that people know they can trust and rely on them. It also means that services are able evolve to take advantage of new technology or adapt to a new challenge.

However, to achieve this some very difficult decisions will need to be made about what services we provide and where.

For instance: Hampshire Hospitals often struggles to fully staff two relatively small Emergency Departments at both Royal Hampshire County Hospital (RHCH) and Basingstoke and North Hampshire Hospital (BNHH). It also has issues delivering maternity and paediatric care across multiple sites and risks losing neo-natal services altogether unless the service is placed on a more long-term sustainable footing.

How can this project ensure that these services are delivered reliably and efficiently?

Our changing population

Our population is growing in two ways. Estimates show that the population served by Hampshire Hospitals NHS Foundation Trust could increase by 9.6% over the next decade and by 23% between 2018 and 2050.

But our population is also aging rapidly. The predicted growth in the over 75s in Hampshire between 2017 and 2024 is 35%. And it is well documented that older people require more healthcare. For example, an 85-year-old man requires, on average, seven times more NHS care than a man in his late 30s. This trend is particularly noticeable in Basingstoke as the town expanded rapidly in the 1960s and 1970s and the young families who moved there, then, are now reaching older age.

Financial resilence

It is obvious from every public survey and the outpouring of appreciation during the COVID-19 crisis that the NHS is one of the most valued, if not the most valued, aspects of British society. However, the way we currently deliver care and treatment costs more every year and will continue to do so as we try to keep up with technological advances, population growth and the fact that medical advances and lifestyle changes mean that more of us will live much longer than our grandparents had expected to. This final point is clearly something to celebrate, but it does mean that there are a larger number of frail, elderly people requiring our help than our health system was designed for.

For instance: The local health system struggled financially in 2019/20, with Hampshire Hospitals in particular ending the year in a

How can the financial position be addressed so we can continue to deliver the care that is rightly expected?

The condition of the buildings operated by Hampshire Hospitals

All of the trust's hospitals require a significant amount of urgent maintenance. The current estimate of the cost to make the improvements needed to bring the buildings up to the standard required to support services as they are delivered at the moment is £73 million; more than three times the national average.

Moreover, it would require more than £700m in maintenance spend to keep the buildings functioning over the course of the next 30 years.

This is simply unaffordable.

The trust is committed to both reducing its carbon footprint and expanding its use of digital technology. Unfortunately the age, condition and design of the current buildings often stops such projects in their tracks or means they deliver less than was intended.

Finally, it is vital that all the different strands of care – community services, mental health, primary care etc – are able to be as joined up as possible. The current estate is a barrier to this becoming a reality due to its design, condition and structure.

For instance: The inherent inflexibility of the estate has been exposed during the COVID-19 crisis. The trust has struggled to increase the number of beds available for patients and the ability to adapt wards and areas to treat different kinds of patients has been limited.

Much of this is driven by the fact that the area has changed significantly in recent years – and is set to do so again in the coming decades; with new housing roughly equivalent to a city the size of Salisbury planned in the Basingstoke area alone!

THE FACTS AND FIGURES

Estimated increase of population served by Hampshire Hospitals NHS Foundation Trust over the next decade

£73 MILLION

X3 THE NATIONAL AVERAGE

The estimate of the cost to make the improvements needed to bring the buildings up to the standard

1,600

People took part in our initial online survey

The initial survey told us that the following results were top priorities for the public who took part:

Capacity to care for more patients

Access to a wide range of health services

Transport

WHAT IS HAMPSHIRE TOGETHER: MODERNISING OUR HOSPITALS AND HEALTH SERVICES?

Hampshire Together is part of the government's plan to modernise NHS hospitals and will deliver a new hospital to serve the people of north and mid Hampshire – and the whole local NHS is determined to make the most of this opportunity. The location and clinical make-up of this future hospital have not yet been decided – and your views on both would be very welcome!

Thankfully, we are not starting from scratch.

Direct services

The health and care system across north and mid Hampshire has – in conjunction with other key partners – been working towards an ambition for the next five years and beyond to support patients, their families and their carers to access **the right care, in the right place, at the right time in order to keep them healthy.** A new hospital supports this ambition, though it is far from the only component.

Currently, Hampshire Hospitals operates (primarily) from three sites: Basingstoke and North Hampshire Hospital, Royal Hampshire County Hospital, in Winchester, and Andover War Memorial Hospital.

In recent years Hampshire Hospitals has undertaken a number of public engagement exercises on potential changes to clinical models and infrastructure for the delivery of acute health services in north and mid-Hampshire. This included the development of a full business case for a Critical Treatment Hospital in 2016 and an associated pre-consultation research exercise conducted in May 2017.

We are building on all of the previous work – but this is a new project.

After viewing the wheel of potential services, are there any health services you think are missing?

THE OPPORTUNITIES

This presents a phenomenal opportunity for the people of north and mid Hampshire. The opportunities can be described in three ways:

An economic opportunity for the population

A building programme like this provides jobs and attracts further investment to our area.

In addition, the new build will attract more high quality healthcare staff to come and work in the area.

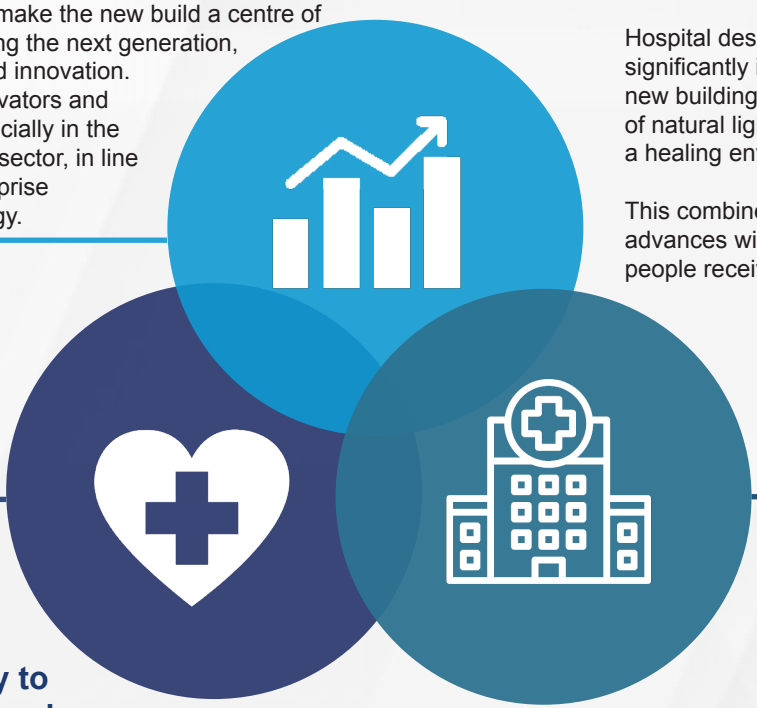
Our aspiration is to make the new build a centre of excellence for training the next generation, and for research and innovation. This will attract innovators and entrepreneurs, especially in the medical technology sector, in line with the Local Enterprise Partnership's strategy.

State of the art buildings, technology and equipment

The investment in new buildings is an opportunity to bring the latest in healthcare design and thinking to our people.

Hospital design has progressed significantly in the last 50 years, and new buildings bring in all the benefits of natural light, ergonomic designs and a healing environment.

This combined with digital advances will ensure that our local people receive outstanding care.



An opportunity to join up health and care for our people

This is a fantastic opportunity to join up the health and care system in our area, which we have been striving to do for a number of years.

A project of this magnitude gives us a real opportunity to bring mental and physical healthcare closer together; ensure that we connect GPs and hospital doctors using digital technology; and incorporate the voluntary and social care sectors into our design principles from the beginning.

This is much more than just a hospital – it is an investment in the people of north and mid Hampshire.

MAKING CHOICES:

WHAT NEEDS TO BE DECIDED AND ON WHAT BASIS?

To get the most out of this project, some very hard choices will need to be made, from where to locate a potential new hospital to what services are delivered and from where.

Given the scale of the project, it will benefit the entire community, though the impact it has on individuals will of course vary depending on a number of factors, for instance how frequently a person requires care.

We want you to tell us what you think about the problems being faced by our health system and to consider how we might go about solving them.

When doing this, it's important that you bear the following factors in mind. Please note that there may be other factors that are important to you, but we have put this list together as a guide for your feedback:

CLINICAL NEEDS

The communities served by the NHS in Hampshire are diverse, large and a mix of rural and urban. Any solution proposed must be firmly rooted in the needs of the population.

As such, as well as our clinical vision set out on pages four and five of this document, it is important to take account of the Hampshire Hospitals clinical strategy, the clinical strategies of the Hampshire & Isle of Wight Partnership of CCGs and West Hampshire CCG, the plans of the Hampshire and Isle of Wight Sustainability Transformation Partnership, the priorities of the Hampshire Health and Wellbeing Board and the North and Mid Hampshire Integrated Care Partnership objectives.

PATIENT EXPERIENCE

Patient experience – how a person feels about the way they receive care – is recognised as a significant factor in the outcome of the care itself.

Factors which impact this include timely appointments, ease of travel, the environment (light, design, green spaces etc) and good communication between everyone involved.

LESSONS OF COVID-19

It would be impossible to undertake any project like this without keeping in mind the hard won lessons of the COVID-19 outbreak.

Lessons such as how the centralising of key services meant they were more resilient and could adapt to rapidly changing needs or the critical importance of single person rooms.

Equally, the need for advanced laboratory space at a local level has been firmly underlined and adopting new technology early shown to be essential.

What services are needed and when? And with this in mind, where should they be provided from?

FLEXIBILITY

The NHS is ever changing – as is society – and so future hospitals must be flexible and able to adapt to radically different ways of working and technology.

Equally, they must be able to reflect changing demands; such as a greater emphasis on mental health services.

STAFF EXPERIENCE

Very much linked to patient experience is the equally important issue of staff experience.

Factors such as on-site changing areas, a pleasant working environment and ease of access (transport etc) play a significant role in boosting staff morale and aid in both recruitment and retention.

A rise in positive staff experience will also lead to expanded take up of new roles and opportunities such as becoming a physician or nursing associate.

SUSTAINBILITY

It is important that the programme promotes sustainability in three ways. Firstly, it is to aid the development of healthy, thriving and equal communities; supporting public health initiatives.

Secondly, it should be environmentally sustainable, not just in terms of construction but operationally; including factors like transport.

Finally, it must be financially sustainable – delivering value for money.

ACCESSIBILITY

Ensuring that services are accessible to all who need them is a priority. This means that services must be within reasonable reach of people who rely on them. This includes distance, travel, opening hours, appointment systems and other factors that allow people to make use of the services when they need them.

RESPONSES TO DATE

Earlier in the year we launched an initial survey to determine what your priorities for healthcare where. This information is already being used to help shape our thinking – a report on it can be found online at www.hampshiretogether.nhs.uk

EQUALITY

One of the NHS's founding principles is that it is essential for any change be consistent with the provision of a personal, fair and diverse health and care system; a system in which everyone counts equally and is treated with respect, compassion and dignity.

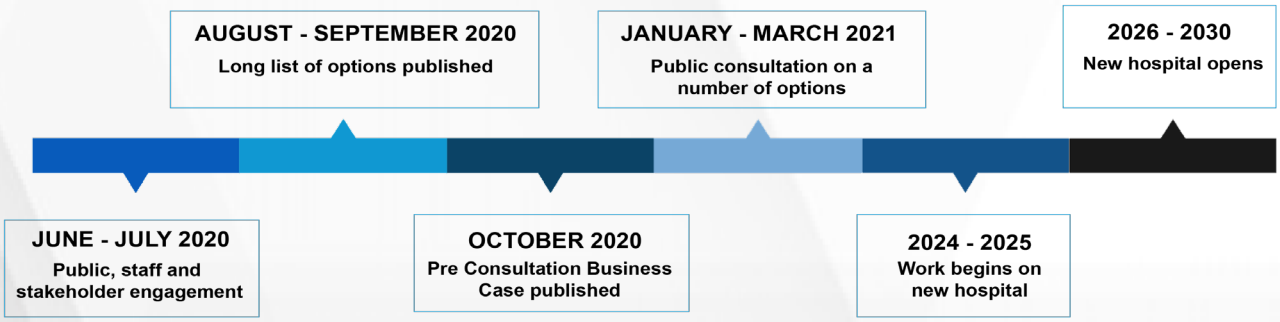
Equally, it is very important that care is adapted as far as possible to meet patients personal needs and circumstances.

DELIVERABLE

Any scheme must be deliverable – to time and to budget – be practical to implement and be both safe and clinically sustainable.

NEXT STEPS - THE JOURNEY FROM HERE

POTENTIAL TIMELINE



Over the course of the summer we will be engaging with the public, our staff and stakeholders to gather views on everything included here and more. This feedback will then be fed into the decision-making process where it will directly affect our thinking.

From that point we aim to be able to release a summary of our findings before Christmas, with formal public consultation on a number of options following in 2021. This will include a preferred way forward which we think is the best of them. After this process has been concluded and fully assessed we will announce our decision as soon as possible.

MAP OF HOSPITALS IN HAMPSHIRE

Do you have any suggestions for sites where a new hospital could be built?

BETTER TOGETHER: **WE NEED YOUR HELP**

While it is right that we will be seeking views, ideas and evidence from clinicians, staff and management from across the Hampshire and Isle of Wight NHS system, it is also important that we do the same for the public we serve. We will be collaborating – working with communities and patients in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.

Over the coming months we will have lots of ways for you to get involved and opportunities for you to give your views. The easiest way to stay up to date is to follow us on Twitter @HampshireMOHHS and sign up for our regular update bulletins by visiting www.hampshiretogether.nhs.uk.

Our dedicated programme website, www.hampshiretogether.nhs.uk has all of the most up-to-date information documents and further reading. It will also host links to surveys and event registration when they become available.

Alternatively you can write to us at:

FREEPOST
Hampshire Together

GET IN TOUCH

www.hampshiretogether.nhs.uk

/HampshireTogether

@HampshireMOHHS

FREEPOST Hampshire Together

Summary of listening exercise independent analysis report

Prepared for MoHHS Options Development Group and Steering Group

Introduction

This paper summarises a draft version of a report prepared by ASV, a research and analysis company, on the recent listening phase activity of the Hampshire Together Modernising our Hospital and Health Services (MoHHS) programme.

The ASV report is still in development, and a final version is expected shortly. The purpose of this paper is to give the MoHHS Options Development Group and the Programme Steering Group an overview of the listening phase activity and the key themes that have emerged. This is so they can start to take on board the public and stakeholder feedback emerging from the listening exercise as they continue to deliberate and work on the design of proposals and options for change.

It is important to note that the draft report currently contains very little analysis on what proportion of participants from the listening phase events expressed a particular view, which makes it difficult to judge the strength of feeling around the key themes identified. That said, the themes that emerge in the report are, in our experience, fairly common when discussing proposed changes to health services with staff, stakeholders, patients, carers, and local communities.

Overview of the listening phase methodology

The listening phase ran from June 2020 through to the first week in August 2020. The MoHHS team engaged with local people, staff, and stakeholders. The exercise was designed as an opportunity for all to provide their opinions on a very broad discussion of the challenges, opportunities and the choices faced by the healthcare system in Hampshire.

Because of the Covid-19 pandemic, the listening phase events had to use a range of no-contact methods of engagement. These included:

- contact forms available on the Hampshire Together website and in hard copy for postal return
- virtual deliberative events and focus groups with the public, staff, and stakeholders
- direct contact with stakeholders (email, letter, phone calls).

In total **1,718** people or organisations participated during the listening period. A summary of the numbers participating is set out in the table below.

Response method	Number of responses/participants
Contact forms (Hampshire Together website and hard copy)	539
Virtual deliberative events and focus groups with the public, staff, and stakeholders.	1,137
Direct contact with stakeholders (email, letter, phone calls).	42
Total responses	**1,718**

The full current draft ASV report provides a detailed breakdown of the responses by demographic characteristics.

Responders to the contact form, and the stakeholders contacted directly, were asked to respond to the following questions:

- What are your views on the challenges faced by the local health system?
- What are your views on the opportunities that Hampshire Together offers for the area?
- What are your views on how we should go about meeting the challenges and making the most of the opportunities?
- Is there anything else you would like to tell us in relation to the programme?

The virtual deliberative events were also structured around these questions.

Key themes emerging from the listening phase

The draft report from ASV presents the key themes from each of the three types of engagement activities separately, however, as all the activities generated very similar themes they are presented together in this paper. It is important to note that the deliberative events, unsurprisingly, generated comments on a wider range of issues than the more structured forms and contact with stakeholders, although these can still be categorised within the broad themes.

A summary of the key themes is set out below.

Population challenges – including an ageing and growing population and health inequalities

Responders from all the activities acknowledged the challenges for health and care of the growing and changing population across north and mid Hampshire, and that these population changes mean health services need to change to provide different types of care. The most commonly raised issues included:

- As well as considering the increase in older people and general growth in the population, the NHS needs to factor in the growing number of young families and students (both of these particularly in Winchester) in the design of new services
- The importance of public health and prevention services in the context of population growth and an ageing population
- The need to do more to reduce health inequalities and to ensure any service changes take inequalities and deprivation into account.

The need for integration across health (including mental health), public health and prevention, social care, third and voluntary sector services

This theme came across very strongly from all the listening phase activities, with a clear acknowledgement of the need for better join up not only between health, social care and voluntary or third sector organisations, but also between different parts of the NHS in Hampshire (and neighbouring systems). Key points included:

- A clear recognition of the value of integration and the benefits it will bring for staff and patients
- Some scepticism that integration is achievable and criticism of current disjointed services

- The need for better integration of mental health services, and a need for more resources and improvements in mental health services
- The need for better, and more joined up social care. Respondents commented on how the social care system is under-resourced (which can have an impact on the NHS) and is confusing to navigate.

Support for more local and community care, including enhanced services in community hospitals

Linked to the integration theme, comments about improving both local (out of hospital) care and community services – including community hospital provision – came across strongly in the feedback. Some of the most common points included:

- An understanding of how increasing and improving services provided by local/primary care and community care could offer better patient experience and reduce the pressure on acute hospitals
- An openness to services traditionally provided in hospital being provided more locally (there was some mention of the role Covid-19 has played in making this more acceptable)
- A clear recognition of the important role that community services play and a desire for more services to be provided in community hospitals, closer to where people live
- Those living in Andover and Alton are concerned for the future of their community hospitals and want these services to be protected and enhanced
- The need for greater inpatient community hospital provision. This was described a few times as providing places for people to 'convalesce'.

A desire to make the most of this opportunity to improve care and services (and some scepticism)

Although there were specific concerns raised, many participants saw the MoHHS programme as a positive opportunity. Key points from the feedback included:

- There are many positive opportunities ranging from 'starting from scratch' with service design, improving patient pathways and designing services that truly meet patients' needs rather than organisational needs, through to specific opportunities such as better access to diagnostics, reduced waiting times and better working environments for staff leading to improved morale etc.
- A new build offers the opportunity to deliver care and services in line with modern standards
- Any new buildings should make the most of opportunities presented by new technology to improve patient care and experience, and the sharing of information, as well as using green technology to reduce the environmental impact of a new hospital
- The Covid-19 pandemic has demonstrated that the NHS can work in new and innovative ways, and that patients can access services in different ways. This positive attitude should be retained by the NHS, along with any changes that have been successful (e.g. video consultations etc)
- There was some scepticism about whether the changes can be delivered, with some participants referencing previous programmes of work that have not come to fruition and

some being unconvinced that the NHS can achieve the right culture of integration and joined up working.

General support for a new hospital in Basingstoke…

Unsurprisingly, participants from Basingstoke were very supportive of a potential new hospital in the area:

- There was acknowledgement that a new hospital would have better facilities, in line with modern standards
- Some people mentioned the centralisation of services, but this does not come across very strongly in the feedback. Where it is mentioned, it is not necessarily seen as positive (see Winchester summary feedback below)
- There were some concerns about accessing a potential new site on public transport, but also there were some responses in support of a central location for a new hospital in the area and some people specifically mentioned J7 of the M3 as a good location.

…But also strong support for retaining services in Winchester

There was very clear concern from Winchester residents about the potential loss of services, in particular A&E and maternity, from Winchester, with many comments asking for services to remain in the city, including:

- Concerns about traveling to Basingstoke, especially in an emergency, but also concerns about the cost and complexity of journeys by car and public transport for patients and visitors
- The growth of the population in Winchester needs to be taken into account, particularly of families with young children. This is seen as a reason to maintain A&E and maternity services at the hospital there
- Access to the hospital by public transport is perceived as better in Winchester (although others commented that it is not as accessible as Basingstoke).

Concerns and suggestions about travel and access

Concerns about travel and access to services, both existing and future, came across strongly in the feedback. Key points included:

- People are concerned about public transport links to a potential new site in Basingstoke and there is a clear call for any new build to be accessible by reliable, affordable public transport
- Car parking issues are mentioned frequently, with people worried about the availability and cost of parking
- As mentioned above, people are worried about traveling to Basingstoke from Winchester should services move
- The need to ensure people from more deprived populations, and those with additional needs or disabilities, are able to access services easily
- The importance of having green and ethical transport to hospital sites.

Concerns and suggestions about staffing

Respondents clearly recognised that there are current challenges with staffing across the two acute hospital sites, with lots of comments about there not being enough staff, and staff being overworked. Specific themes in the feedback included:

- There will still need to be the same number of staff as (it was perceived) services will have to be retained on two sites
- A new hospital will not necessarily attract new staff to the area, and some staff could be put off by moving to a new site
- Improving the working environment and offering better on-site facilities (for example staff gym, childcare, free parking etc) would attract people to work in the area
- Improving the working environment would improve staff morale.

Comments about specific services, including mental health, cancer, maternity and paediatric care

There were some general comments about specific services in the full report. In particular participants commented on:

- The desire to see a dedicated cancer centre in the area – some people mentioned this has previously been considered but not come to fruition
- The need to improve mental health care services in the community in general, in particular finding an alternative to A&E for people in crisis
- In addition to a desire to retain maternity services in Winchester, people spoke of a need to improve maternity provision in communities so pregnant women do not have to travel to hospital for routine care
- Some participants called for a separate paediatric hospital and/or a dedicated paediatric A&E.

An acknowledgement of estate challenges

While most of the feedback focused on issues around the way services are organised and delivered, participants did generally recognise that the current estate in both Winchester and Basingstoke is not able to meet the needs of the local population, nor enable the NHS to deliver care in line with modern standards.

Ask for ongoing engagement and collaborative working

There was a clear ask in the feedback for ongoing engagement and collaborative working with local people, patients, staff, and stakeholders as the plans develop:

- Some participants were positive about the engagement so far and want to ensure lines of communication remain open
- Some others referred to the listening phase as the consultation, and felt the engagement was not sufficient and it was not sensible to be 'consulting' during the pandemic.

Conclusion

As referenced in the introduction to this summary paper, the current draft ASV report does not give a sense of the strength of feeling on the themes identified, beyond the number of comments on a specific topic included in the report. However, the themes that do emerge are, in our experience, commonly heard in change programmes of this nature. Acknowledgement of the challenges faced by the NHS are weighed understandably against concerns about what changes could mean for individuals and their families.

It is evident, however, that there is a clear willingness and desire from local people, staff, and stakeholders to be involved in the MoHHS programme as it develops.

This summary report has been commissioned from and authored by Hood & Woolf to act as an 'executive summary' for MoHHS programme colleagues. It has been drawn from information in the much longer draft ASV report which pulls together feedback from a range of engagement exercises with local people in north and mid Hampshire during the summer of 2020.

25 September 2020

Option	Retain all current hospital sites	Essential backlog maintenance	Essential backlog maintenance and additional investment in hospital sites	Reconfiguration of at risk services	Centralised services delivered in new hospital	Range of services delivered in satellite locations	Planned surgery centre at new hospital	Planned surgery centre at main satellite location	Complex outpatient centre at new hospital	Complex outpatient centre at main satellite location	Outpatient consultations delivered at satellite locations
A Business as usual	+	+									
B Essential Service Reconfiguration	+		+	+							
C Configuration 1 New hospital and satellite			+	+	+	+		+	+		+
D Configuration 2 New hospital and satellite			+	+	+	+	+		+		+
E Configuration 3 New hospital and satellite			+	+	+	+	+		+	+	+
F Configuration 4 New hospital and satellite			+	+	+	+		+	+	+	+
G Configuration 5 New hospital and satelite			+	+	+	+	+			+	+
H All services in a new location				+	+		+		+		

Chart key Option discounted Option carried forward

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Hospital Activity for North and Mid-Hampshire Patients from 2017/18 to 2019/20

Data source: CSU SUS Self-service tool
Patients included: North and Mid-Hampshire (as defined by the 33 practices in the area - all of North Hampshire CCG and the practices in the WINCAR and Andover locality of West Hampshire CCG.
Maternity admissions have been defined by Admissions Methods 31 and 32.
Prepared by Jon Rumsey (jon.rumsey@nhs.net)

All Inpatient Activity

Provider	2017/2018	2018/2019	2019/2020	Total	2017/2018	2018/2019	2019/2020	Total
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	92,023	95,953	99,344	287,320	82.6%	82.0%	82.1%	82.2%
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	5,275	5,848	5,834	16,957	4.7%	5.0%	4.8%	4.9%
PORTSMOUTH HOSPITALS NHS TRUST	2,689	3,102	3,283	9,074	2.4%	2.6%	2.7%	2.6%
FRIMLEY HEALTH NHS FOUNDATION TRUST	2,128	2,333	2,425	6,886	1.9%	2.0%	2.0%	2.0%
SALISBURY NHS FOUNDATION TRUST	1,210	1,203	1,237	3,650	1.1%	1.0%	1.0%	1.0%
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	564	600	591	1,755	0.5%	0.5%	0.5%	0.5%
ROYAL BERKSHIRE NHS FOUNDATION TRUST	336	396	598	1,330	0.3%	0.3%	0.5%	0.4%
SOUTHAMPTON NHS TREATMENT CENTRE	137	180	188	505	0.1%	0.2%	0.2%	0.1%
ST MARY'S NHS TREATMENT CENTRE	86	80	65	231	0.1%	0.1%	0.1%	0.1%
ISLE OF WIGHT NHS TRUST	19	12	9	40	0.0%	0.0%	0.0%	0.0%
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	2	3	1	6	0.0%	0.0%	0.0%	0.0%
Other Providers	6,939	7,347	7,471	21,757	6.2%	6.3%	6.2%	6.2%
Total	**111,408**	**117,057**	**121,046**	**349,511**	**100%**	**100%**	**100%**	**100%**

All Outpatient Activity

Provider	2017/2018	2018/2019	2019/2020	Total	2017/2018	2018/2019	2019/2020	Total
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	462,977	470,277	464,142	1,397,396	70.7%	70.4%	68.5%	69.9%
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	31,166	32,345	38,468	101,979	4.8%	4.8%	5.7%	5.1%
FRIMLEY HEALTH NHS FOUNDATION TRUST	19,304	21,769	23,453	64,526	2.9%	3.3%	3.5%	3.2%
PORTSMOUTH HOSPITALS NHS TRUST	18,216	17,016	17,283	52,515	2.8%	2.5%	2.6%	2.6%
SALISBURY NHS FOUNDATION TRUST	5,238	5,600	5,712	16,550	0.8%	0.8%	0.8%	0.8%
ROYAL BERKSHIRE NHS FOUNDATION TRUST	2,184	2,535	2,283	7,002	0.3%	0.4%	0.3%	0.4%
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	2,164	2,192	2,363	6,719	0.3%	0.3%	0.3%	0.3%
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	744	720	801	2,265	0.1%	0.1%	0.1%	0.1%
SOUTHAMPTON NHS TREATMENT CENTRE	339	591	752	1,682	0.1%	0.1%	0.1%	0.1%
ST MARY'S NHS TREATMENT CENTRE	178	156	160	494	0.0%	0.0%	0.0%	0.0%
ISLE OF WIGHT NHS TRUST	22	22	20	64	0.0%	0.0%	0.0%	0.0%
Other Providers	112,246	114,943	122,142	349,331	17.1%	17.2%	18.0%	17.5%
Total	**654,778**	**668,166**	**677,579**	**2,000,523**	**100%**	**100%**	**100%**	**100%**

All A&E Activity

Provider	2017/2018	2018/2019	2019/2020	Total	2017/2018	2018/2019	2019/2020	Total
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	94,308	95,761	101,350	291,419	80.2%	79.1%	80.5%	79.9%
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	5,539	6,098	5,903	17,540	4.7%	5.0%	4.7%	4.8%
PORTSMOUTH HOSPITALS NHS TRUST	3,136	3,202	3,415	9,753	2.7%	2.6%	2.7%	2.7%
FRIMLEY HEALTH NHS FOUNDATION TRUST	2,578	2,895	3,012	8,485	2.2%	2.4%	2.4%	2.3%
SOUTHAMPTON NHS TREATMENT CENTRE	1,584	1,689	1,798	5,071	1.3%	1.4%	1.4%	1.4%
SALISBURY NHS FOUNDATION TRUST	1,082	1,164	1,254	3,500	0.9%	1.0%	1.0%	1.0%
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	664	783	738	2,185	0.6%	0.6%	0.6%	0.6%
ROYAL BERKSHIRE NHS FOUNDATION TRUST	568	672	651	1,891	0.5%	0.6%	0.5%	0.5%
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	683	747	57	1,487	0.6%	0.6%	0.0%	0.4%
ST MARY'S NHS TREATMENT CENTRE	382	349	424	1,155	0.3%	0.3%	0.3%	0.3%
ISLE OF WIGHT NHS TRUST	107	114	88	309	0.1%	0.1%	0.1%	0.1%
Other Providers	6,984	7,625	7,141	21,750	5.9%	6.3%	5.7%	6.0%
Total	**117,615**	**121,099**	**125,831**	**364,545**	**100%**	**100%**	**100%**	**100%**

Inpatient Activity (Maternity Only)

Provider	2017/2018	2018/2019	2019/2020	Total	2017/2018	2018/2019	2019/2020	Total
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	4,799	4,747	4,657	14,203	88.0%	87.2%	87.5%	87.6%
FRIMLEY HEALTH NHS FOUNDATION TRUST	220	218	206	644	4.0%	4.0%	3.9%	4.0%
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	132	151	159	442	2.4%	2.8%	3.0%	2.7%
PORTSMOUTH HOSPITALS NHS TRUST	115	106	118	339	2.1%	1.9%	2.2%	2.1%
SALISBURY NHS FOUNDATION TRUST	57	78	52	187	1.0%	1.4%	1.0%	1.2%
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	48	51	39	138	0.9%	0.9%	0.7%	0.9%
ROYAL BERKSHIRE NHS FOUNDATION TRUST	22	35	29	86	0.4%	0.6%	0.5%	0.5%
BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	0	0	0	0	0.0%	0.0%	0.0%	0.0%
ISLE OF WIGHT NHS TRUST	0	0	0	0	0.0%	0.0%	0.0%	0.0%
SOUTHAMPTON NHS TREATMENT CENTRE	0	0	0	0	0.0%	0.0%	0.0%	0.0%
ST MARY'S NHS TREATMENT CENTRE	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Other Providers	61	59	60	180	1.1%	1.1%	1.1%	1.1%
Total	**5,454**	**5,445**	**5,320**	**16,219**	**100%**	**100%**	**100%**	**100%**

Any numbers in the maternity table lower than 6 have been replaced with a zero

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HHFT Hospital Activity by Local Authority from 2017/18 to 2019/20

Data source: HHFT Data Warehouse

Patients included: All activity at HHFT. There is currently an issue in that no Portsmouth patient LSOAs have been identified, so Portsmouth CCG activity has been used for Portsmouth.
The maternity activity is based on CCG activity counts.

Prepared by Jon Rumsey (jon.rumsey@nhs.net) and Zoe Cameron (zoe.Cameron@hhft.nhs.uk)

All Inpatient Activity

County or Unitary Authority	2017/2018	2018/2019	2019/2020	Total	2017/2018	2018/2019	2019/2020	Total
Hampshire	112,485	117,843	120,313	350,641	92.0%	91.7%	90.8%	91.5%
West Berkshire	4,435	4,961	5,451	14,847	3.6%	3.9%	4.1%	3.9%
Wiltshire	371	355	348	1,074	0.3%	0.3%	0.3%	0.3%
Southampton	442	463	493	1,398	0.4%	0.4%	0.4%	0.4%
Surrey	149	153	196	498	0.1%	0.1%	0.1%	0.1%
Isle of Wight	38	37	31	106	0.0%	0.0%	0.0%	0.0%
Portsmouth	70	65	80	215	0.1%	0.1%	0.1%	0.1%
Other or Unknown	4,337	4,634	5,538	14,509	3.5%	3.6%	4.2%	3.8%
Total	**122,327**	**128,511**	**132,450**	**383,288**	**100%**	**100%**	**100%**	**100%**

All Outpatient Activity

County or Unitary Authority	2017/2018	2018/2019	2019/2020	Total	2017/2018	2018/2019	2019/2020	Total
Hampshire	565,927	577,580	566,736	1,710,243	94.4%	93.9%	93.1%	93.8%
West Berkshire	12,325	14,114	15,018	41,457	2.1%	2.3%	2.5%	2.3%
Wiltshire	2,649	2,580	2,485	7,714	0.4%	0.4%	0.4%	0.4%
Southampton	1,789	1,931	1,963	5,683	0.3%	0.3%	0.3%	0.3%
Surrey	863	823	836	2,522	0.1%	0.1%	0.1%	0.1%
Isle of Wight	106	126	139	371	0.0%	0.0%	0.0%	0.0%
Portsmouth	344	354	355	1,053	0.1%	0.1%	0.1%	0.1%
Other or Unknown	15,755	17,900	20,892	54,547	2.6%	2.9%	3.4%	3.0%
Total	**599,758**	**615,408**	**608,424**	**1,823,590**	**100%**	**100%**	**100%**	**100%**

All A&E Activity

County or Unitary Authority	2017/2018	2018/2019	2019/2020	Total	2017/2018	2018/2019	2019/2020	Total
Hampshire	110,904	112,831	118,957	342,692	88.8%	88.4%	87.8%	88.3%
West Berkshire	4,309	4,650	5,241	14,200	3.4%	3.6%	3.9%	3.7%
Wiltshire	858	760	767	2,385	0.7%	0.6%	0.6%	0.6%
Southampton	721	852	794	2,367	0.6%	0.7%	0.6%	0.6%
Surrey	232	248	284	764	0.2%	0.2%	0.2%	0.2%
Isle of Wight	49	50	37	136	0.0%	0.0%	0.0%	0.0%
Portsmouth	169	197	228	594	0.1%	0.2%	0.2%	0.2%
Other or Unknown	7,703	7,988	9,162	24,853	6.2%	6.3%	6.8%	6.4%
Total	**124,945**	**127,576**	**135,470**	**387,991**	**100%**	**100%**	**100%**	**100%**

Maternity Admissions Activity

County or Unitary Authority	2017/2018	2018/2019	2019/2020	Total	2017/2018	2018/2019	2019/2020	Total
Hampshire	5,788	5,648	5,444	16,880	88.7%	89.7%	89.9%	89.4%
West Berkshire	503	520	452	1,475	7.7%	8.3%	7.5%	7.8%
Wiltshire	38	30	38	106	0.6%	0.5%	0.6%	0.6%
Southampton	61	41	39	141	0.9%	0.7%	0.6%	0.7%
Surrey	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Isle of Wight	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Portsmouth	0	0	0	0	0.0%	0.0%	0.0%	0.0%
Other or Unknown	135	56	82	273	2.1%	0.9%	1.4%	1.4%
Total	**6,525**	**6,295**	**6,055**	**18,875**	**100%**	**100%**	**100%**	**100%**

Any numbers in the maternity table lower than 6 have been replaced with a zero

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		COVID-19 PLANNING		
DATE OF DECISION:		22 OCTOBER 2020		
REPORT OF:		CHAIR OF THE HEALTH OVERVIEW AND SCRUTINY PANEL		
CONTACT DETAILS				
AUTHOR:	**Title:**	**Scrutiny Manager**	**Tel:**	**023 8083 3886**
	Name:	**Mark Pirnie**		
	E-mail	**Mark.pirnie@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
In light of rising infection rates, at the request of the Chair, the Interim Director of Public Health has been requested to provide the Panel with a verbal update on Covid-19 planning in Southampton, including a brief overview of the work of the Local Outbreak Engagement Board, the Health Protection Board and the Southampton Covid-19 Outbreak Control Plan.		
RECOMMENDATIONS:		
	(i)	That the Panel consider the verbal update from the Interim Director of Public Health on Covid-19 planning in Southampton.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To enable the Panel to scrutinise Covid-19 planning in Southampton.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	No alternative options have been considered.	
DETAIL (Including consultation carried out)		
3.	As infection rates for Covid-19 increase nationally, and in Southampton, the Chair has requested that the Interim Director of Public Health provides the Panel with a verbal update on Covid-19 developments in Southampton, including the work of the recently established Local Outbreak Engagement Board, the Health Protection Board and the delivery of the Outbreak Control Plan.	
4.	To provide context to the discussion a coronavirus infographic report is published weekly to help inform members of the public of the current coronavirus situation in Southampton. This report can be found at: https://data.southampton.gov.uk/health/disease-disability/covid-19/covid-19-updates/ (scroll down to visualisation and click download for the infographics)	
RESOURCE IMPLICATIONS		
Capital/Revenue		
5.	Not applicable	

Property/Other	
6.	Not applicable.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
7.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
8.	None
RISK MANAGEMENT IMPLICATIONS	
9.	The management of risk as it relates to Covid-19 is a key consideration of the Health Protection Board.
POLICY FRAMEWORK IMPLICATIONS	
10.	None.

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	**ALL**
SUPPORTING DOCUMENTATION	
Appendices	
1.	None

Documents In Members' Rooms

1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?	**No**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	**No**
Other Background Documents **Other Background documents available for inspection at:**	

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	**N/A**	

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	NHS FINANCIAL REGIME FOR 2020/21
DATE OF DECISION:	22 OCTOBER 2020
REPORT OF:	MANAGING DIRECTOR, NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP

CONTACT DETAILS				
Executive Director	**Title**	**Managing Director and Chief Financial Officer**		
	Name:	**James Rimmer**	**Tel:**	**023 8029 6075**
Author:	**Title**	**Managing Director and Chief Financial Officer**		
	Name:	**James Rimmer**	**Tel:**	**023 8029 6075**

STATEMENT OF CONFIDENTIALITY		
N/A		
BRIEF SUMMARY		
As the Covid-19 emergency period took effect in mid-March, the NHS saw major changes to how services and financial flows work. This report outlines the financial regime for the NHS in 2020/2021.		
RECOMMENDATIONS:		
	(i)	That the Panel notes the report.
REASONS FOR REPORT RECOMMENDATIONS		
1.	Following a request at the previous HOSP meeting, the report enables the panel to consider the NHS financial regime in light of the Covid-19 emergency.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None.	
DETAIL (Including consultation carried out)		
3.	The Covid emergency financial framework put in place by the government and NHSE/I at the beginning of the financial year continues until the end of September (M6). For the first half of the financial year, the financial regime is based upon block payments centrally calculated for all NHS providers, with an ability to claim top ups to ensure a breakeven position. Providers and commissioners can claim retrospectively for the additional Covid 19 costs on a monthly basis.	
4.	The CCG is currently forecasting an overspend to the end of September of £4,088k, £3,595k of which relates to Covid expenditure and £494k to underlying services. This will be covered by a retrospective allocation adjustment to achieve a break-even position. Retrospective allocations have already been received for April to July.	
RESOURCE IMPLICATIONS		

Capital/Revenue	
5.	The attached report outlines the current financial regime for the NHS.
Property/Other	
6.	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
7.	N/A
Other Legal Implications:	
8.	None.
RISK MANAGEMENT IMPLICATIONS	
9.	None.
POLICY FRAMEWORK IMPLICATIONS	
10.	None.

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	ALL
SUPPORTING DOCUMENTATION	
Appendices	
1.	NHS Financial Regime 2020/2021
2.	Letter from Simon Stevens to CCG Accountable Officers: THIRD PHASE OF NHS RESPONSE TO COVID-19 (31 July 2020)

Documents In Members' Rooms

1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?	**No**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	**No**
Other Background Documents **Other Background documents available for inspection at:**	

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.		

NHS Financial Regime for 2020/21

1. Context

1.1. As the Covid-19 emergency period took effect in mid-March, the NHS saw major changes to how services and financial flows work. In their letter dated 17 March 2020, Sir Simon Stevens and Amanda Pritchard made a number of clear statements for the NHS, in relation to finances including the statement below:

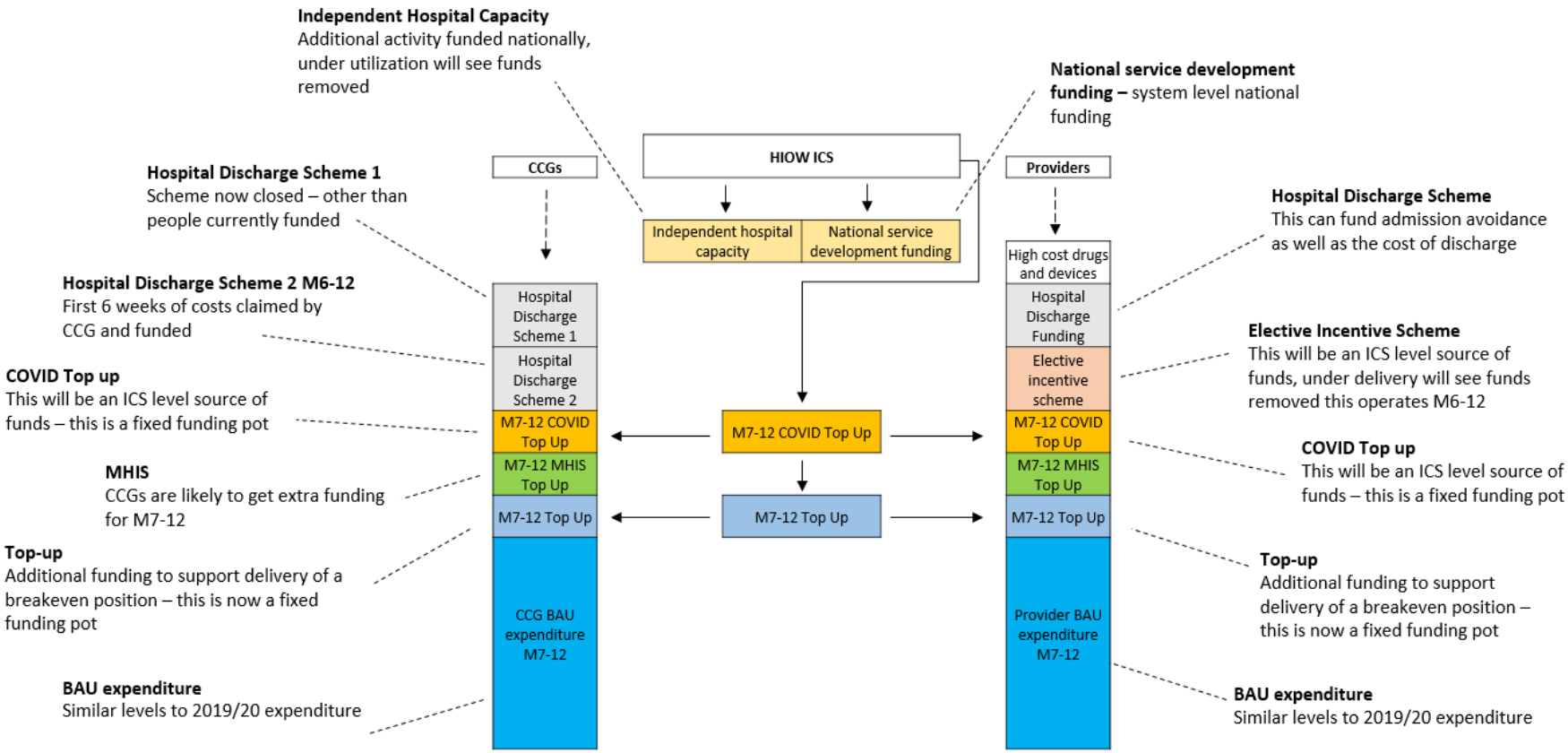
1.2. The Chancellor of the Exchequer committed in Parliament that "Whatever extra resources our NHS needs to cope with coronavirus – it will get." Therefore financial constraints must not and will not stand in the way of taking immediate and necessary action - whether in terms of staffing, facilities adaptation, equipment, patient discharge packages, staff training, elective care, or any other relevant category.

1.3. NHS organisations have just submitted draft financial plans on a system basis to NHS England, which align to the submissions made late September around the restoration and recovery of services. Final submissions are due end October 2020.

1.4. As yet we do not know what the financial regime will be for 2021/22. This is likely to become clear at the publication of the spending review.

2. What can HIOW spend before allocations for the rest of the year are finalised?

The following sections look at the known funding for the remainder of the year for the NHS. Please note the size of boxes are not to the scale of funding.



3. Months 1-6 Financial Regime

3.1. The Covid emergency financial framework put in place by the government and NHSE/I at the beginning of the financial year continues until the end of September (M6). For the first half of the financial year, the financial regime is based upon block payments centrally calculated for all NHS providers, with an ability to claim top ups to ensure a breakeven position. Providers and commissioners can claim retrospectively for the additional Covid 19 costs on a monthly basis.

3.2. The CCG is currently forecasting an overspend to the end of September of £4,088k, £3,595k of which relates to Covid expenditure and £494k to underlying services. This will be covered by a retrospective allocation adjustment to achieve a break-even position. Retrospective allocations have already been received for April to July.

3.3. This is a very different regime to normal operating, which is driven by payment for activity.

3.4. The CCG's funding is based upon last year's funding.

3.5. Sources of Revenue funding for first half of 2020/21:

- CCG and provider baseline funding based upon last year
- Hospital Discharge Service Tranche 1 (those people funded between April and September through this scheme)
- Independent hospital capacity
- Retrospective non-recurrent Covid allocation
- Retrospective top ups – to break even

4. Months 7-12 Financial Regime

4.1. The financial framework for October to the end of the financial year has now been confirmed. As expected, this sees us move to prospective allocations. This funding is now more contained, with funding given to the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP) centrally for a fair share of Covid funding and some additional monies to support recovery and restoration. The requirement for months 7-12 is not to solve all of the long-term health issues related to Covid; that is likely to form the basis of the NHS' request for future years additional funding in line with the current spending review that is being undertaken by Government.

4.2. The starting point for financial plans for the second half of the year should be a similar funding envelope to the first half of the year, the chart in this document helps outline all of the funding types.

4.3. In July 2020 Simon Stevens, NHS Chief Executive, and Amanda Pritchard, NHS Chief Operating Officer, issued the Third Phase of NHS Response to Covid-19 guidance, which is available on NHS England's website, setting out the following three priorities for the rest of 2020/21 which the month 7-12 funding will be expected to cover:

A. **Accelerating the return to near-normal levels of non-Covid health services**, making full use of the capacity available in the 'window of opportunity' between now and winter:
- Restore full operation of all cancer services
- Recover the maximum elective activity possible between now and winter
- Restore service delivery in primary care and community services
- Expand and improve mental health services and services for people with learning disabilities and/or autism.

B. **Preparation for winter demand pressures**, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally:
- Continue to follow good Covid-related practice to enable patients to access services safely and protect staff

C. Prepare for winter.
Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

4.4. Our progress to date on meeting each of the three priorities includes:

3.4.1. Accelerating the return to near-normal levels of non-Covid health services

Restore full operation of all cancer services
- Two-week wait cancer referrals and treatment activity returning to pre-Covid-19 levels
- Cancer screening capacity being rapidly increased whilst taking into account Covid-19 infection control requirements with routine

invitation letters being sent for bowel, breast and cervical screening.

Recover the maximum elective activity possible between now and winter

We have worked with the Trusts across HIOW to develop opportunities to restore inpatient/day case activity to 87% by October, improving month on month to 93% by January. We have also made progress in reducing the number of people waiting over 52 weeks to be no more than 6,325 in March 2021. We are doing this by:

- Continuing to clinically validate waiting lists
- Contacting all patients whose care has been disrupted
- Reopening wards to support restoring theatre capacity
- Recruiting additional theatre staff and supporting shielding staff to return
- Reviewing session times, reducing on-the-day cancellations and late starts, and improving scheduling and pre-assessments
- Commissioning additional theatre capacity
- Increasing Advice and Guidance Services to support GPs when considering making a referral
- Restoring use of NHS commissioned capacity within the independent sector and exploring potential additional capacity.

In outpatients, we are on track to deliver 101% of baseline activity, including Advice and Guidance by October. We are doing this by:

- Restoring outpatient clinic space that was used by other services during the Covid-19 response
- Reducing the number of patients who do not attend (DNA) outpatient appointments
- Increasing productivity through the continued use of virtual and telephone appointments
- Restoring endoscopy to full capacity by reopening all units and extending working hours
- Restoring CT and MRI to full capacity by improving DNA rates, extending working hours and increasing productivity
- All provider Trusts using the e-Referral service with all being fully open to primary care referrals.

Restore service delivery in primary care and community services

- Primary care restoring services to pre-Covid-19 levels
- Community services returning to pre-Covid-19 levels
- Developing a community care model with enhanced services to support people at home as clinically appropriate to reduce

avoidable hospital admissions and increase supported hospital discharges.

Expand and improve mental health services and services for people with learning disabilities and/or autism

- 24/7 crisis lines continuing to be maintained
- Increasing access to Child and Adolescent Mental Health Services (CAMHS) and Improving Access to Psychological Therapies (IAPT) to pre-Covid-19 levels and now focussing on tackling waiting lists and responding to Covid-19 demand
- Increasing perinatal mental health access
- Increasing the number of annual physical heath checks undertaken for those with serious mental illness
- Increasing the number of annual health checks undertaken for those with learning disabilities
- Planning the replacement of our remaining mental health dormitory wards
- Restarting work to support GP practices to achieve Learning Disability friendly status.

3.4.2. Preparation for winter demand pressures

- Starting the annual flu vaccination programme with the expanded priority groups
- Developing local escalation plans with common thresholds for the implementation of pre-agreed actions
- Agreeing mutual aid plans and protocols
- Establishing virtual wards with remote monitoring to support avoidable hospital admissions and enable step down care
- Implementing 111 First across HIOW, building on the learning from Portsmouth and South East Hampshire
- Operationalising Community Urgent Response Teams across HIOW
- Community, primary care and social care providers continuing to work together to provide out of hospital services
- Implementing an approach to pro-actively target groups who are at risk of poor Covid-19 outcomes
- Each HIOW Trust developing and implementing plans to improve Emergency Department performance in preparation for winter
- Supporting primary care winter resilience by establishing dedicated ‘hot sites’ across HIOW where patients with suspected Covid-19 will be seen if clinically required.

3.4.3. Support for our staff and action on inequalities and prevention

- Mapping the workforce capacity required to enable our acute recovery
- Trusts across HIOW regularly collaborate regarding their recruitment and incentive plans
- We continue to provide support to our staff in a number of ways with mental health and wellbeing programmes and bespoke support is in place for all staff groups.

4. **Sources of Revenue funding for second half of 2020/21** (all of which are described in more detail in the next section)
    - Hospital Discharge Service Tranche 1 & 2 (DH&SC specifically funded)
    - Elective incentive scheme (marginal rate for over delivery and under delivery)
    - Independent hospital capacity
    - Mental Health Investment Standard Monies
    - Prospective Covid funding
    - Prospective Top up funding
    - Month 7-12 baseline
    - Covid-19 related services such as testing and centrally purchased PPE
    - National service development funding (SDF)

5. Hospital Discharge Service

4.5. The guidance was published on 21 August 2020. The Government has agreed to fund, via the NHS:

- The cost of post-discharge recovery and support services, such as rehabilitation and reablement (in addition to what was provided prior to admission) for up to a maximum of six weeks to help people return to the quality of life they had prior to their most recent admission.
- To support urgent community response services for people who would otherwise be admitted into hospital. These will typically provide urgent support within two hours and for a limited time (typically 48 hours) and, if required, transition into other ongoing care and support pathways.

4.6. Under the provisions of this scheme, additional costs of post-discharge recovery and support services will be funded until the person's long-term care needs are assessed, or for up to the first six weeks if the assessment is not completed by that time. It is expected that an assessment for ongoing health and care needs takes place within six weeks of discharge and that a decision is made about how this care will be funded by this date. CCGs will not be able to draw down funding from the discharge

support arrangements after the end of the sixth week to fund any care package beyond this date.

4.7. For people discharged from hospital or assigned a package of short-term care to avoid admission into hospital from 1 September 2020, this funding arrangement will apply, replacing the previous arrangements introduced on 19 March 2020 as part of the COVID-19 Discharge Guidance.

4.8. Where a person was in receipt of a care package prior to admission to hospital and is discharged with a package of short-term reablement, this funding will pay for those additional costs (where these are over and above the activity that is ordinarily commissioned by CCGs and local authorities). This would apply regardless of whether or not the person was still being cared for by the same care provider.

4.9. Where the enhanced care services are most appropriately commissioned directly by NHS commissioners, these should be placed under existing contractual arrangements with providers but invoiced separately to ensure that enhanced discharge support funding is identifiable. This care should be paid for from the additional funding set out in this section.

4.10. The additional funding will not pay for:

- Long-term care needs following completion of a Care Act and/or NHS Continuing Healthcare (CHC) assessment.
- Social care or NHS CHC packages that are restarted following discharge from hospital at the same level as that already delivered prior to admission to hospital.
- Pre-existing (planned) local authority or CCG expenditure on discharge services.

4.11. People funded though the COVID-19 Discharge Guidance funding arrangements, which commenced on 19 March 2020, who enter a care package between 19 March and 31 August 2020, will continue to be funded through those arrangements. Relevant assessments should be completed for these individuals as soon as is practical to ensure transition to normal funding arrangements.

4.12. For the purposes of definition, the arrangements prior to 1 September 2020 (detailed in the 19 March 2020 hospital discharge guidance) will be termed ‘scheme 1’ and the arrangements from 1 September 2020 will be defined as ‘scheme 2’. The scheme funding arrangements will apply up until 31 March 2021.

5. Elective incentive scheme

5.1. In August 2020 more detail was given about how block payments will flex to reflect expected elective activity levels.

5.2. The following financial arrangements will apply from 1 September 2020:

- A notional baseline of month 6 to month 12 2019/20 activity for ordinary electives and day cases, outpatient procedures and outpatient first and follow-up attendances undertaken by NHS providers will be calculated for each system.
- Where aggregate in-scope activity delivered in the period M6-M12 is below the expected value, 25% (for elective and outpatient procedure activity) and 20% (for outpatient attendance activity) of the shortfall will be deducted from the nationally determined funding envelopes.
- Where in-scope activity delivered in this period exceeds the expected value, 75% (for elective and outpatient procedure activity) and 70% (for outpatient attendance activity) of the difference will be added to nationally determined funding envelopes.

5.3. The scheme will apply in September 2020, which is the final month of the retrospective top-up, during which NHS providers are supported to achieve a breakeven position against reasonable expenditure. As such, this scheme and the associated activity payments will support organisations to recover performance as soon as possible.

5.4. Funding for independent sector activity is being provided either via the national contracting arrangements, or through the nationally determined funding envelopes, which will include an allowance for local independent sector commissioning. In addition, where actual independent sector usage exceeds/falls below levels seen in the same period of the prior year, 10% of the difference in value will be added to / deducted from nationally determined funding envelopes.

6. Independent hospital capacity

6.1. In August 2020, NHS England and NHS Improvement (NHSE/I), in collaboration with the Independent Healthcare Providers Network (IHPN) and independent sector providers, have now agreed modifications to the contract terms to ensure access to independent hospital capacity until the longer-term arrangements for the additional capacity the NHS needs, outlined in the phase 3 letter, are procured by October/November. The national contract notice has a closing date of 27 August 2020 with a

contract start date of 30 November 2020 with an end date of 1 December 2020. These longer-term arrangements will be commissioned by call-off contracts at a local level under a national framework agreement.

6.2. The expectation of the revised contract is for the NHS to use a designated proportion of capacity in every independent sector site. For clarity, patients referred directly to the independent sector providers via the e-Referrals Service, transferred from waiting lists to be treated by the independent sector and those treated by NHS teams deployed into IS sites are all defined as NHS patients within this capacity allocation. This will release a defined amount of capacity for private patient activity and enable private patients who have been waiting to receive care and independent sector providers to offer the NHS a guaranteed minimum private patient cost offset.

6.3. NHS England and NHS Improvement may trigger a return to 'peak surge', securing access to 100% of available IS capacity, staff and facilities to facilitate an expansion of the NHS Covid-19 capacity if required.

7. CCG Mental Health Investment Standard

7.1. To support the ambitions within the NHS Long Term Plan, the NHS made a renewed commitment that mental health services will grow faster than the overall NHS budget, creating a new ring-fenced local investment fund worth at least £2.3 billion a year by 2023/24.

7.2. In consecutive years the NHS in England has met its commitment that the increase in local funding for mental health (excluding learning disabilities and dementia) is at least in line with the overall increase in the money available to CCGs. This is called the mental health investment standard (MHIS). From 2019/20 onwards, as part of the NHS Long Term Plan, the MHIS also includes a further commitment that local funding for mental health will grow by an additional percentage increment to reflect additional mental health funding being made available to CCGs.

7.3. As per the guidance issued in August 2020, the NHS priority for Mental Health in 2020/21 is the rapid expansion of services. It is likely that the Covid-19 pandemic is likely to lead to a longer-term increase in mental health needs, in addition to the existing treatment gap. Ambitions previously stated in the NHS Long Term Plan for Mental Health still stand and are now even more critical to deliver as part of the response to Covid-19. All systems should thus strive to achieve 2020/21 LTP ambitions and drive recruitment, whilst locking-in beneficial changes and adapting plans in response to Covid-19.

7.4. ICSs/STPs will lead a review of the ICSs/STPs five year Long Term Plan planning submission for 2020/21. This review will support systems to integrate activity and financial planning and ensure that there is system understanding across ICSs/STPs, CCGs and providers, of delivery across all 2020/21 LTP deliverables.

7.5. ICSs/STPs will also have an opportunity to outline any additional pressures services are facing in 2020/21, that are currently unfunded. Whilst additional funding has not been confirmed, the information you provide will inform consideration at a national level of potential additional funding requirements.

7.6. The intention of the revised financial regime from month 7 (October) is that funding to meet the remaining MHIS requirement for the period will be included within system funding envelopes.

7.7. Systems will be able to determine the appropriate deployment to delivery partners, either through uplifts to NHS provider block payment arrangements for continuation of services funded through the retrospective top-up and to fund new commitments, or contracting with non-NHS providers

8. Non-recurrent Covid funding

8.1. Non-recurrent Covid funding was retrospectively funded to fund the additional cost of Covid as below. For months 7-12 a fixed funding pot has been given. If this is overspent, NHS bodies will not be funded for this.

8.2. For months 1-6 reasonable costs claimed included:

a) Evidenced increases in staffing costs compared to the baseline period associated with dealing with increased total activity.

b) Increases in temporary staffing to cover increased levels of sickness absence or to deal with other caring responsibilities (e.g. to look after other family members).

c) Payments for bank or sub-contractor staff to ensure all sickness absence is covered consistent with Government's announced policy and public health advice which are not otherwise covered under normal practice; and

d) Additional costs of dealing with COVID-19 activity. For example: the costs of running NHS111 assessment pods; increases in the volumes required or prices of equipment to deal with the response to the virus which aren't offset by reductions elsewhere; extra costs of decontamination and transport for the ambulance service; higher testing volumes in acute-based laboratories; and community-based swabbing services.

9. Top ups

9.1. A national top-up payment for months 1-6 was provided for providers and commissioners to reflect the difference between the actual costs and income.

9.2. This process has changed for months 7-12 with a fixed envelope given, if expenditure exceeds this then NHS bodies will overspend.

10. Temporary Covid-19 related services

10.1. Temporary Covid-19 related services which are funded by government on an actual cost basis (e.g. PPE acquired through the national system and Covid-19 testing services) – relevant organisations will be funded on an actual cost basis.

10.2. Costs will be monitored, and services will be subject to amendment based on costs incurred and the maximum budget available.

11. National service development funding (SDF)

11.1. System-level SDF allocations will be issued which consider revised priorities for 2020/21. Organisations should not include costs related to SDF-funded programmes in plans except where these programmes have been explicitly confirmed already.

11.2. At this point, this applies to all mental health SDF funding programmes and specific notified primary care programmes. Additional revenue allocations for 111 First are also expected but yet to be confirmed.

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From the Chief Executive Sir Simon Stevens
& Chief Operating Officer Amanda Pritchard

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Regional Incident Directors & Heads of EPRR
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

31 July 2020

Dear Colleague

IMPORTANT – FOR ACTION – THIRD PHASE OF NHS RESPONSE TO COVID-19

We are writing to thank you and your teams for the successful NHS response in the face of this unprecedented pandemic, and to set out the next – third – phase of the NHS response, effective from 1st August 2020.

You will recollect that on 30th January NHS England and NHS Improvement declared a Level 4 National Incident, triggering the first phase of the NHS pandemic response. Since then the NHS has been able to treat every coronavirus patient who has needed specialist care – including 107,000 people needing emergency hospitalisation. Even at the peak of demand, hospitals were still able to look after two non-Covid inpatients for every one Covid inpatient, and a similar picture was seen in primary, community and mental health services.

As acute Covid pressures were beginning to reduce, we wrote to you on 29th April to outline agreed measures for the second phase, restarting urgent services. Now in this Phase Three letter we:

- update you on the latest Covid national alert level;
- set out priorities for the rest of 2020/21; and
- outline financial arrangements heading into Autumn as agreed with Government.

Current position on Covid-19

On 19th June 2020 the Chief Medical Officers and the Government's Joint Biosecurity Centre downgraded the UK's overall Covid alert level from four to three, signifying that the virus remains in general circulation with localised outbreaks likely to occur. On 17th July the Government set out next steps including the role of the new Test and Trace programme in providing us advance notice of any expected surge in Covid demand, and in helping manage local and regional public health mitigation measures to prevent national resurgence.

Fortunately, Covid inpatient numbers have now fallen nationally from a peak of 19,000 a day, to around 900 today. As signalled earlier this month, the current level of Covid demand on the NHS means that the Government has agreed that the NHS EPRR incident level will move from Level 4 (national) to Level 3 (regional) with effect from tomorrow, 1st August. This approach matches the differential regional measures the Government is deploying, including today in parts of the North West and North East. The main implications of this are set out in Annex One to this letter.

However Covid remains in general circulation and we are seeing a number of local and regional outbreaks across the country, with the risk of further national acceleration. Together with the Joint Biosecurity Centre and Public Health England (PHE) we will therefore continue to keep the situation under close review, and will not hesitate to reinstate the Level 4 national response immediately as circumstances justify it. In the meantime NHS organisations will need to retain their EPRR incident coordination centres and will be supported by oversight and coordination by Regional Directors and their teams.

NHS priorities from August

Having pulled out all the stops to treat Covid patients over the last few months, our health services now need to redouble their focus on the needs of all other patients too, while recognising the new challenges of overcoming our current Covid-related capacity constraints. This will continue to require excellent collaboration between clinical teams, providers and CCGs operating as part of local 'systems' (STPs and ICSs), local authorities and the voluntary sector, underpinned by a renewed focus on patient communication and partnership.

Following discussion with patients' groups, national clinical and stakeholder organisations, and feedback from our seven regional 'virtual' frontline leadership meetings last week, we are setting out NHS priorities for this third phase. Our shared focus is on:

A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter

B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.

C. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

As part of this Phase Three work, and following helpful engagement and discussion, alongside this letter yesterday we published a more detailed 2020/21 People Plan, and will shortly do the same on

inequalities reduction. DHSC are also expected to set out equivalent phase three priorities and support for social care.

Nationally, we will work with the wide range of stakeholders represented on the NHS Assembly to help track and challenge progress against these priorities. As we do so it is vital that we listen and learn from patients and communities. We ask that all local systems act on the Five principles for the next phase of the Covid-19 response developed by patients' groups through National Voices.

A: Accelerating the return of non-Covid health services, making full use of the capacity available in the window of opportunity between now and winter

A1. **Restore full operation of all cancer services. This work will be overseen by a national cancer delivery taskforce, involving major patient charities and other key stakeholders. Systems should commission their Cancer Alliance to rapidly draw up delivery plans for September 2020 to March 2021 to:**

- To reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.

- Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by:

  - Ensuring that sufficient diagnostic capacity is in place in Covid19-secure environments, including through the use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres
  - Increasing endoscopy capacity to normal levels, including through the release of endoscopy staff from other duties, separating upper and lower GI (non-aerosol-generating) investigations, and using CT colonography to substitute where appropriate for colonoscopy.
  - Expanding the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid19-secure environments.
  - Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
  - Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.

- Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days.

A2. **Recover the maximum elective activity possible between now and winter**, making full use of the NHS capacity currently available, as well as re-contracted independent hospitals.

In setting clear performance expectations there is a careful balance to be struck between the need to be ambitious and stretching for our patients so as to avoid patient harm, while setting a performance level that is deliverable, recognising that each trust will have its own particular pattern of constraints to overcome.

Having carefully tested the feasible degree of ambition with a number of trusts and systems in recent weeks, trusts and systems are now expected to re-establish (and where necessary redesign) services to deliver through their own local NHS (non-independent sector) capacity the following:

- **In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October** (while aiming for 70% in August);

- This means that systems need to very swiftly return to **at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October**.

- **100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).**

Block payments will flex meaningfully to reflect delivery (or otherwise) against these important patient treatment goals, with details to follow shortly once finalised with Government.

Elective waiting lists and performance should be **managed at system as well as trust level** to ensure equal patient access and effective use of facilities.

Trusts, working with GP practices, should ensure that, between them, **every patient whose planned care has been disrupted by Covid receives clear communication** about how they will be looked after, and who to contact in the event that their clinical circumstances change.

Clinically urgent patients should continue to be treated first, with next priority given to the **longest waiting patients**, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.

To further support the recovery and restoration of elective services, a modified national contract will be in place giving **access to most independent hospital capacity** until March 2021. The current arrangements are being adjusted to take account of expected usage, and by October/ November it will then be replaced with a re-procured national framework agreement within which local contracting will resume, with funding allocations for systems adjusted accordingly. To ensure good value for money for taxpayers, systems must produce week-by-week independent sector usage plans from August and will then be held directly to account for delivering against them.

In **scheduling** planned care, providers should follow the new streamlined patient self isolation and testing requirements set out in the guideline published by NICE earlier this week. For many patients this will remove the need to isolate for 14 days prior to a procedure or admission.

Trusts should ensure their e-Referral Service is fully open to referrals from primary care. To reduce infection risk and support social distancing across the hospital estate, clinicians should consider avoiding asking patients to attend physical **outpatient appointments** where a clinically-appropriate and accessible alternative exists. Healthwatch have produced useful advice on how to support patients in this way. This means collaboration between primary and secondary care to use advice and guidance where possible and treat patients without an onward referral, as well as giving patients more control over their outpatient follow-up care by adopting a patient-initiated follow-up approach across major outpatient specialties. Where an outpatient

appointment is clinically necessary, the national benchmark is that at least 25% could be conducted by telephone or video including 60% of all follow-up appointments.

A3. **Restore service delivery in primary care and community services.**

- General practice, community and optometry services should **restore activity to usual levels where clinically appropriate**, and **reach out proactively** to clinically vulnerable patients and those whose care may have been delayed. Dental practices should have now mobilised for face to face interventions. We recognise that capacity is constrained, but will support practices to deliver as comprehensive a service as possible.

- In restoring services, GP practices need to make rapid progress in addressing the backlog of childhood **immunisations** and cervical **screening** through specific catch-up initiatives and additional capacity and deliver through their Primary Care Network (PCN) the service requirements coming into effect on 1 October as part of the Network Contract DES.

- GPs, primary care networks and community health services should build on the enhanced support they are providing to **care homes**, and begin a programme of structured medication reviews.

- CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time. All GP practices must offer face to face **appointments** at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate – whilst also considering those who are unable to access or engage with digital services.

- Community health services **crisis responsiveness** should be enhanced in line with the goals set out in the Long Term Plan, and should continue to support patients who have recovered from the acute phase of Covid but need **ongoing rehabilitation** and other community health services. Community health teams should fully resume appropriate and safe **home visiting care** for all those vulnerable/shielding patients who need them.

- The Government is continuing to provide funding to support timely and appropriate discharge from hospital inpatient care in line with forthcoming updated Hospital Discharge Service Requirements. From 1 September 2020, hospitals and community health and social care partners should fully embed the **discharge to assess** processes. New or extended health and care support will be funded for a period of up to six weeks, following discharge from hospital and during this period a comprehensive care and health assessment for any ongoing care needs, including determining funding eligibility, must now take place. The fund can also be used to provide short term urgent care support for those who would otherwise have been admitted to hospital.

- The Government has further decided that CCGs must resume NHS **Continuing Healthcare assessments** from 1 September 2020 and work with local authorities using the trusted assessor model. Any patients discharged from hospital between 19 March 2020 and 31 August 2020, whose discharge support package has been paid for by the NHS, will need to be assessed and moved to core NHS, social care or self-funding arrangements.

A4. **Expand and improve mental health services and services for people with learning disability and/or autism**

- Every CCG must continue to **increase investment** in mental health services in line with the Mental Health Investment Standard and we will be repeating the independent audits of this. Systems should work together to ensure that funding decisions are decided in partnership with Mental Health Providers and CCGs and that funding is allocated to core Long Term Plan (LTP) priorities.

- In addition, we will be asking systems to validate their existing LTP **mental health service expansion** trajectories for 2020/21. Further advice on this will be issued shortly. In the meantime:
  - IAPT services should fully resume
  - the 24/7 crisis helplines for all ages that were established locally during the pandemic should be retained, developing this into a national service continue the transition to digital working
  - maintain the growth in the number of children and young people accessing care
  - proactively review all patients on community mental health teams' caseloads and increase therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with SMI in the community;
  - ensure that local access to services is clearly advertised
  - use £250 million of earmarked new capital to help eliminate mental health dormitory wards.

- In respect of support for people with a **learning disability, autism or both**:
  - Continue to reduce the number of children, young people and adults within a specialist inpatient setting by providing better alternatives and by ensuring that Care (Education) and Treatment Reviews always take place both prior to and following inpatient admission.
  - Complete all outstanding Learning Disability Mortality Reviews (LeDeR) by December 2020.
  - GP practices should ensure that everybody with a Learning Disability is identified on their register; that their annual health checks are completed; and access to screening and flu vaccinations is proactively arranged. (This is supported by existing payment arrangements and the new support intended through the Impact and Investment Fund to improve uptake.)

B: Preparation for winter alongside possible Covid resurgence.

B1. Continue to follow good **Covid-related practice** to enable patients to access services safely and protect staff, whilst also preparing for localised Covid outbreaks or a wider national wave. This includes:

- Continuing to follow PHE's guidance on defining and managing communicable disease **outbreaks**.

- Continue to follow PHE/DHSC-determined policies on which patients, staff and members of the public should be tested and at what frequency, including the further PHE-endorsed actions set out on testing on 24 June. All NHS employers should prepare for the likelihood that if background infection risk increases in the Autumn, and DHSC Test and Trace

secures 500,000+ tests per day, the Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine **Covid testing** of all asymptomatic staff across the NHS.

- Ongoing application of PHE's infection prevention and control guidance and the actions set out in the letter from 9 June on minimising **nosocomial infections** across all NHS settings, including appropriate Covid-free areas and strict application of hand hygiene, appropriate physical distancing, and use of masks/face coverings.

- Ensuring NHS staff and patients have access to and use **PPE** in line with PHE's recommended policies, drawing on DHSC's sourcing and its winter/EU transition PPE and medicines stockpiling.

B2. **Prepare for winter** including by:

- Sustaining current NHS staffing, beds and **capacity**, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021.

- Deliver a very significantly expanded seasonal **flu vaccination** programme for DHSC-determined priority groups, including providing easy access for all NHS staff promoting universal uptake. Mobilising delivery capability for the administration of a Covid19 vaccine if and when a vaccine becomes available.

- Expanding the **111 First** offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly. This includes increasing the range of dispositions from 111 to local services, such as direct referrals to Same Day Emergency Care and specialty 'hot' clinics, as well as ensuring all Type 3 services are designated as Urgent Treatment Centres (UTCs). DHSC will shortly be releasing agreed **A&E capital** to help offset physical constraints associated with social distancing requirements in Emergency Departments.

- Systems should maximise the use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments.

- Continue to make full use of the NHS Volunteer Responders scheme in conjunction with the Royal Voluntary Society and the partnership with British Red Cross, Age UK and St. Johns Ambulance which is set to be renewed.

- Continuing to **work with local authorities**, given the critical dependency of our patients – particularly over winter - on resilient social care services. Ensure that those medically fit for discharge are not delayed from being able to go home as soon as it is safe for them to do so in line with DHSC/PHE policies (see A3 above).

C: Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.

C1. **Workforce**

Covid19 has once again highlighted that the NHS, at its core, is our staff. Yesterday we published We are the NHS: People Plan for 2020/21 - actions for us all which reflects the strong messages from NHS leaders and colleagues from across the NHS about what matters most. It sets out practical actions for employers and systems, over the remainder of 2020/21 ahead of Government decisions in the Autumn Spending Review on future education and training expansions. It includes specific commitments on:

- Actions all NHS employers should take to keep staff safe, healthy and well – both physically and psychologically.
- Specific requirements to offer staff flexible working.
- Urgent action to address systemic inequality that is experienced by some of our staff, including BAME staff.
- New ways of working and delivering care, making full and flexible use of the full range of our people's skills and experience.
- Growing our workforce, building on unprecedented interest in NHS careers. It also encourages action to support former staff to return to the NHS, as well as taking steps to retain staff for longer – all as a contribution to growing the nursing workforce by 50,000, the GP workforce by 6,000 and the extended primary care workforce by 26,000.
- Workforce planning and transformation that needs to be undertaken by systems to enable people to be recruited and deployed across organisations, sectors and geographies locally.

All systems should develop a local People Plan in response to these actions, covering expansion of staff numbers, mental and physical support for staff, improving retention and flexible working opportunities, plus setting out new initiatives for development and upskilling of staff. Wherever possible, please work with local authorities and local partners in developing plans for recruitment that contribute to the regeneration of communities, especially in light of the economic impact of Covid. These local People Plans should be reviewed by regional and system People Boards, and should be refreshed regularly.

C2. **Health inequalities and prevention.**

Covid has further exposed some of the health and wider inequalities that persist in our society. The virus itself has had a disproportionate impact on certain sections of the population, including those living in most deprived neighbourhoods, people from Black, Asian and minority ethnic communities, older people, men, those who are obese and who have other long-term health conditions and those in certain occupations. It is essential that recovery is planned in a way that inclusively supports those in greatest need.

We are asking you to work collaboratively with your local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and regularly assess this progress. Recommended urgent actions have been developed by an expert national advisory group and these will be published shortly. They include:

- Protect the most vulnerable from Covid, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.

- Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October. Develop digitally enabled care pathways in ways which increase inclusion, including reviewing who is using new primary, outpatient and mental health digitally enabled care pathways by 31 March.

- Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes. This should include more accessible flu vaccinations, the better targeting of long-term condition prevention and management programmes, obesity reduction programmes including self-referral to the NHS Diabetes Prevention Programme, health checks for people with learning disabilities, and increasing the continuity of maternity carers including for BAME women and those in high risk groups.

- Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation. Each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.

- Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. All NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later 31 December, with general practice prioritising those groups at significant risk of Covid19 from 1 September.

Financial arrangements and system working

To support restoration, and enable continued collaborative working, current financial arrangements for CCGs and trusts will largely be extended to cover August and September 2020. The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government. More detail is set out in Annex Two.

Working across systems, including NHS, local authority and voluntary sector partners, has been essential for dealing with the pandemic and the same is true in recovery. As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes:

- Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.

- Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed governance and decision-making arrangements including high

standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.

- Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September 2020.

- A plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health.

Finally, we are asking you – working as local systems - to return a draft **summary plan by 1st September** using the templates issued and covering the key actions set out in this letter, with **final plans due by 21st September**. These plans need to be the product of partnership working across STPs/ICSs, with clear and transparent triangulation between commissioner and provider activity and performance plans.

Over the last few months, the NHS has shown an extraordinary resilience, capacity for innovation and ability to move quickly for our patients. Like health services across Europe, we now face the double challenge of continuing to have to operate in a world with Covid while also urgently responding to the many urgent non-Covid needs of our patients. If we can continue to harness the same ambition, resilience, and innovation in the second half of the year as we did in the first, many millions of our fellow citizens will be healthier and happier as a result. So thank you again for all that you and your teams have been – and are – doing, in what is probably the defining year in the seven-decade history of the NHS.

With best wishes,

Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX ONE: IMPLICATIONS OF EPRR TRANSITION TO A LEVEL 3 INCIDENT

As previously signalled, effective 1 August 2020 the national incident level for the Covid19 response will change from level 4 (an incident that requires NHS England National Command and Control to support the NHS response) to level 3 (an incident that requires the response of a number of health organisations across geographical areas within an NHS England region), until further notice.

It is entirely possible that future increases in Covid demands on the NHS mean that the level 4 incident will need to be reinstated. In which case, there will be no delay in doing so. However this change does, for the time being, provide the opportunity to focus local and regional NHS teams on accelerating the restart of non-Covid services, while still preparing for a possible second national peak.

The implications of the transition from a level 4 to level 3 incident are as follows:

- *Oversight*: Transition from a national command, control and coordination structure to a regional command, control and coordination structure but with national oversight as this remains an incident of international concern.

- *Reporting*: We will be stopping weekend sit rep collections from Saturday 8th August 2020 (Saturday and Sunday data will be collected on Mondays with further detail to follow). Whilst we are reducing the incident level with immediate effect reports will still be required this weekend (1st and 2nd August 2020) and we will subsequently need to be able to continue to align to DHSC requirements. Additional reporting will be required for those areas of the country experiencing community outbreaks in line with areas of heightened interest, concern or intervention.

- *Incident coordination functions*: The national and regional Incident Coordination Centres will remain in place (hours of operation may be reduced). The frequency of national meetings will decrease (for example IMT will move to Monday, Wednesday, Friday). Local organisations should similarly adjust their hours and meeting frequency accordingly. It is however essential that NHS organisations fully retain their incident coordination functions given the ongoing pandemic, and the need to stand up for local incidents and outbreaks.

- *Communications:* All communications related to Covid19 should continue to go via established Covid19 incident management channels, with NHS organisations not expected to respond to incident instructions received outside of these channels. Equally, since this incident continues to have an international and national profile, it is important that our messaging to the public is clear and consistent. You should therefore continue to coordinate communications with your regional NHS England and NHS Improvement communications team. This will ensure that information given to the media, staff and wider public is accurate, fully up-to-date and aligns with national and regional activity.

ANNEX TWO: REVISED FINANCIAL ARRANGEMENTS

The current arrangements comprise nationally-set block contracts between NHS providers and commissioners, and prospective and retrospective top-up funding issued by NHSE/I to organisations to support delivery of breakeven positions against reasonable expenditure. The M5 and M6 block contract and prospective top-up payments will be the same as M4. Costs of testing and PPE will continue to be borne centrally for trusts and general practices funded by DHSC who continue to lead these functions for the health and social care sectors.

The intention is to move towards a revised financial framework for the latter part of 2020/21, once this has been finalised with Government.

The revised framework will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and the restoration of elective services. The intention is that systems will be issued with funding envelopes comprising funding for NHS providers equivalent in nature to the current block and prospective top-up payments and a system-wide Covid funding envelope. There will no longer be a retrospective payment mechanism. Providers and CCGs must achieve financial balance within these envelopes in line with a return to usual financial disciplines. Whilst systems will be expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions. The funding envelopes will comprise:

- CCG allocations – within which block contract values for services commissioned from NHS providers within and outside of the system will continue to be nationally calculated;

- Directly commissioned services from NHS providers – block contract values for specialised and other directly commissioned services will continue to be nationally calculated;

- Top-up – additional funding to support delivery of a breakeven position; and

- Non-recurrent Covid allocation – additional funding to cover Covid-related costs for the remainder of the year.

Funding envelopes will be calculated on the basis of full external income recovery. For relationships between commissioners and NHS providers we will continue to operate nationally calculated block contract arrangements. For low-volume flows of CCG-commissioned activity, block payments of an appropriate value would be made via the Trust's host CCG; this will remove the need for separate invoicing of non-contract activity.

However block payments will be adjusted depending on delivery against the activity restart goals set in Section A1 and A2 above.

Written contracts with NHS providers for the remainder of 2020/21 will not be required.

For commissioners, non-recurrent adjustments to commissioner allocations will continue to be actioned – adjustments to published allocations will include any changes in contracting responsibility and distribution of the top-up to CCGs within the system based on target allocation.

Reimbursement for high cost drugs under the Cancer Drugs Fund (CDF) and relating to treatments under the Hepatitis C programme will revert to a pass-through cost and volume basis, with adjustments made to NHS provider block contract values to reflect this. For the majority of other high cost drugs and devices, in-year provider spend will be tracked against a notional level of spend

included in the block funding arrangements with adjustments made in-year to ensure that providers are reimbursed for actual expenditure on high cost drugs and devices. This will leave a smaller list of high cost drugs which will continue to be funded as part of the block arrangements.

In respect of Medical pay awards, on 21 July 2020 the Government confirmed the decision to uplift pay in 2020/21 by 2.8% for consultants, specialty doctors and associate specialists, although there is no uplift to the value of Clinical Excellence Awards, Commitment Awards, Distinction Awards and Discretionary Points for 2020/21. We expect this to be implemented in September pay and backdated to April 2020. In this event, NHS providers should claim the additional costs in September as part of the retrospective top-up process. Future costs will be taken into account in the financial framework for the remainder of 2020/21, with further details to be confirmed in due course.

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	CCG REFORM IN HAMPSHIRE AND ISLE OF WIGHT
DATE OF DECISION:	22 OCTOBER 2020
REPORT OF:	CLINICAL CHAIR, NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP

CONTACT DETAILS				
Executive Director	**Title**	**Clinical Chair, NHS Southampton City CCG**		
	Name:	**Mark Kelsey**	**Tel:**	**023 8029 6075**
Author:	**Title**	**Managing Director**		
	Name:	**James Rimmer**	**Tel:**	**023 8029 6075**

STATEMENT OF CONFIDENTIALITY		
N/A		
BRIEF SUMMARY		
The Boards of six CCGs (North Hampshire CCG, West Hampshire CCG, South Eastern Hampshire CCG, Fareham & Gosport CCG, Isle of Wight CCG and Southampton City CCG) have developed a business case to merge, and create a new CCG for Hampshire, Southampton and Isle of Wight from April 2021. The CCG Governing Bodies met on 24th September where a decision with regards to proceeding with the merger was approved. The application to merge is currently being considered by NHS England for final approval. The attached report outlines the proposal to merge.		
RECOMMENDATIONS:		
	(i)	That the Panel considers the proposal for six local CCGs to merge.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To enable the Panel to provide feedback for consideration by the CCGs as they seek to develop new organisational arrangements.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None.	
DETAIL (Including consultation carried out)		
3.	In line with national policy, the health and care system in Hampshire & Isle of Wight will be designated as an Integrated Care System (ICS) by the end of 2020. In an ICS, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. An ICS is an evolved form of the existing Sustainability and Transformation Partnership.	
4.	Integrated Care Systems will further enable shared leadership and collaboration in order to deliver improvements for residents. Collaboration is key to successfully achieving our objectives, and significant strides forward	

	have been made. CCGs work increasingly closely together and increasingly closely with local authorities, with NHS providers and with other partners to deliver our shared goals.
5.	CCGs have been working together to determine how commissioning should evolve to better meet the needs of the local population. Our aim is to retain the benefits of the current CCG model – the local focus, local relationships with partners and local clinical leadership - whilst also gaining greater benefits of working together.
6.	North Hampshire CCG, West Hampshire CCG, Southampton City CCG, Isle of Wight CCG, Fareham & Gosport CCG and South Eastern Hampshire CCG have concluded that coming together to form one CCG is the appropriate next step to accelerate progress. This will deliver benefits for patients and residents, benefits for primary care, and benefits for health and care partners.
RESOURCE IMPLICATIONS	
Capital/Revenue	
7.	None.
Property/Other	
8.	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
9.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
10.	None
RISK MANAGEMENT IMPLICATIONS	
11.	None.
POLICY FRAMEWORK IMPLICATIONS	
12.	None.

KEY DECISION?	**No**
WARDS/COMMUNITIES AFFECTED:	ALL
SUPPORTING DOCUMENTATION	
Appendices	
1.	Future ways of working for Clinical Commissioning Groups in Hampshire, Southampton and Isle of Wight

Documents In Members' Rooms

1.	None
Equality Impact Assessment	

Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?		**No**
Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.		
2.		

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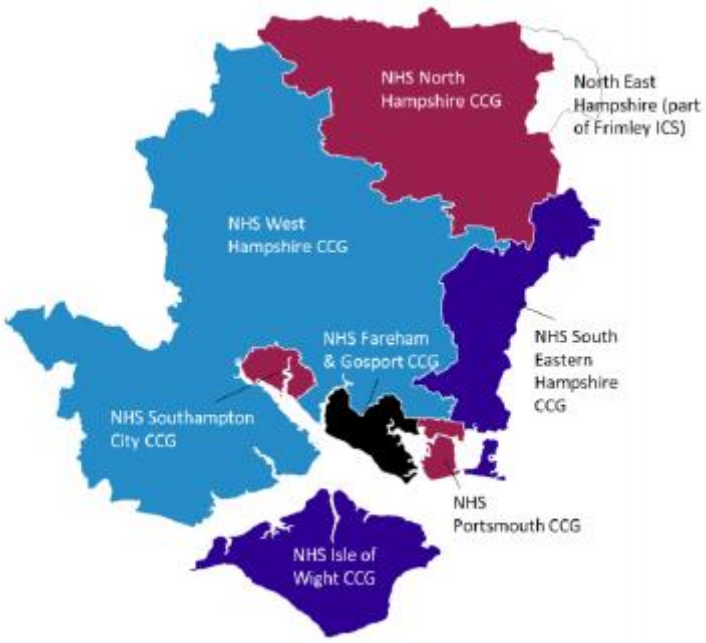
Future ways of working for Clinical Commissioning Groups in Hampshire, Southampton and Isle of Wight

1. Context

1.1. Clinical Commissioning Groups (CCGs) were established in 2013 and have statutory responsibility for commissioning services for the population they serve. The primary objectives of CCGs are to improve the health and wellbeing of the populations we serve, and to ensure residents have access to high quality healthcare when they need it.

1.2. Seven CCGs serve the 1.9 million people living in Hampshire & Isle of Wight and are responsible for a budget of £2.7 billion, which is about two-thirds of the NHS budget for Hampshire and Isle of Wight. The remaining NHS budget (for dentists, opticians, specialised services and some public health services) is commissioned by NHS England. The figure below outlines the current geographical make up of CCGs in Hampshire and Isle of Wight.



1.3. In line with national policy, the health and care system in Hampshire & Isle of Wight will be designated as an Integrated Care System (ICS) by the end of 2020. In an ICS, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. An ICS is an evolved form of the existing Sustainability and Transformation Partnership.

1.4. Integrated Care Systems will further enable shared leadership and collaboration in order to deliver improvements for residents. Collaboration is key to successfully achieving our objectives, and significant strides forward have been made. CCGs work increasingly closely together and increasingly closely with local authorities, with NHS providers and with other partners to deliver our shared goals.

1.5. CCGs have been working together to determine how commissioning should evolve to better meet the needs of the local population. Our aim is to retain the benefits of the current CCG model – the local focus, local relationships with partners and local clinical leadership - whilst also gaining greater benefits of working together.

1.6. North Hampshire CCG, West Hampshire CCG, Southampton City CCG, Isle of Wight CCG, Fareham & Gosport CCG and South Eastern Hampshire CCG have concluded that coming together to form one CCG is the appropriate next step to accelerate progress. This will deliver benefits for patients and residents, benefits for primary care, and benefits for health and care partners.

2. The case for change

2.1. We have concluded that CCGs need to change the way they work in order to accelerate improvements for residents and better support the health & care system in Hampshire & Isle of Wight to deliver its 5-year plan. Change is needed so that we can:

- **Overcome complexity and fragmentation**
  Having multiple CCGs operating independently creates complexity and fragmentation, and means that we do not always have all of the skills needed to address the challenges or to enable the scale of transformation required. CCGs have begun working together more closely, retaining their local focus and operating at scale; we want to go further with this.

- **Reduce duplication and cost**
  There is also now duplication across CCGs and with some STP functions which needs to be overcome as the Integrated Care System is established. Duplication causes waste and confusion, which we can 'design-out.' There are currently c700wte staff working in CCGs and additional staff working in the STP. We need to make sure that CCGs are as efficient and effective as possible.

- **Adapt to the new ways of working in an Integrated Care System**
  Our view is that the best way to deliver high quality sustainable care is through collaboration. Too often in the past – in part as consequence of the market environment - commissioning was undertaken remotely, separate from provision. As we look ahead, we see commissioning as a joint endeavour, requiring the combined skills, experience, perspective and expertise of NHS providers, CCGs and local government – as well as with the input of local people.

- **Align with national policy**
  The NHS Long Term Plan, published in January 2019, sets out the policy direction for the NHS. The expectation is that every Integrated Care System will have streamlined commissioning arrangements to enable a single set of commissioning decisions at system level, which will typically involve a single CCG for each Integrated Care System. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long-Term Plan implementation.

2.2. By merging, we believe there will be benefits for patients and residents, benefits for primary care, and benefits for health and care partners, as outlined below:

1 **Better health & better services for local people**	▪ Retaining our **local focus**, local teams and relationships with local communities ▪ Deeper **partnerships with local government** to improve health outcomes ▪ Gaining **benefits of scale** to accelerate improvements in health outcomes and services – sharing skills & best practice, more specialist support for local teams ▪ Reducing duplication and redirecting clinical and managerial resources to **tackling the critical issues faced by our patients and residents**
2 **Better for primary care**	▪ Primary care is the foundation of the NHS and the first port of call ▪ We are **increasing the focus of local teams on supporting primary care** and increasing support for PCN development ▪ Shared, **improved expert support for primary care** eg for estates and IT ▪ Ensuring a **strong voice for primary care** in planning and redesigning services
3 **Better for health and care partners**	▪ Creating clear, **consistent and coherent** commissioning for Hampshire & IoW ▪ Reducing duplication & complexity, **taking out layers of bureaucracy** ▪ Enabling **collaboration and delivery** through the Integrated Care System ▪ CCG **teams aligned with local authorities and NHS partners** to improve health and health services ▪ Increasing efficiency and **reducing costs**

3. **Our proposal**

3.1. It is proposed to become one CCG named Hampshire, Southampton and Isle of Wight CCG.

3.2. This proposal has been informed by feedback from local GPs and member practices, patients, local stakeholders (including scrutiny panels) and our staff. The feedback we received included the following key themes:

- The importance of keeping a local 'place' focus and not losing sight of the individual needs of different communities
- Recognition that streamlining and joining up care across the areas could benefit patients
- The importance of building on existing good practice

3.3. This CCG will have one CCG board, which will hold the statutory responsibilities of the CCG and provides strategic leadership to the CCG. The Board will be responsible for setting NHS commissioning policy to deliver the ICS strategy and priorities in Hampshire & Isle of Wight, and for oversight of system performance (financial, operational & quality). The Board is accountable to NHS England for NHS performance and delivery for the population it serves. There will also be a single executive team for the CCG.

3.4. Clinical leadership has been central to the success of CCGs to date, and we envisage a range of different types of clinical leadership roles in the single CCG. These will include clinical leaders in local teams, clinical roles spanning Hampshire and Isle of Wight, and clinical Board-level roles.

3.5. One of the key strengths of CCGs has been their important local focus on the places and communities where people live and work. When at their best, CCGs have strengthened primary care delivery, leadership and engagement in the NHS; co-produced solutions with residents; enabled service transformation and improved patient outcomes, service quality and efficiency. CCGs have been most successful where they have worked in partnership with primary care, local government, providers, voluntary organisations and local people. CCGs are rightly proud of the good work that has been done to improve services, deliver better outcomes and enable people to be as healthy and independent as possible.

3.6. These strengths of CCGs will be retained. The new arrangements will build on the best aspects of what happens now, as well as adapting to what is needed in future. The proposed single CCG for Southampton, Isle of Wight and Hampshire will be a clinically led membership organisation,

focussed on the needs of local people, and retaining the current partnership arrangements in place, in particular with local authorities and NHS providers.

3.7. In order to better support the planning and delivery of improvements in outcomes and service performance, we plan 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 primary care networks are at the heart of the integrated care model.

- **Pursue deeper integration of health and care with local council partners** in order to make a step change in the impact we have on preventing ill health, reducing inequalities, joining up health and care delivery, and improving people's independence, experience and quality of life. Where we have existing integrated commissioning arrangements we will retain and further strengthen these.

- **Align CCG teams with local partnerships/alliances of providers and local authorities.** Members of CCG teams will support alliances of providers to transform delivery and improve care pathways in Portsmouth & South East Hampshire, on the Isle of Wight, in North & Mid Hampshire, in Southampton & South West Hampshire, and across Hampshire as a whole.

- **Create a single strategic commissioning function for the Hampshire & Isle of Wight ICS**, reducing duplication and providing clear, consistent and coherent commissioning policy for the health and care system.

4. Retaining a local focus

4.1. The importance of a strong, local focus was highlighted in feedback from stakeholders to our initial proposal to merge. In the new CCG, teams, resources, structures and governance will be organised to provide the strong local focus and local decision making needed to support general practice.

4.2. It is proposed that the CCG is organised with five local teams, one for each of North & Mid Hampshire, Isle of Wight, Southampton City, South West Hampshire, and South East Hampshire.

4.3. Each local team will be accountable for improving health outcomes, service quality and NHS performance for the local population, and for the allocated population budget. The local team also has responsibility for supporting local primary care and PCN development, and for engagement with and acting as the interface with member practices.

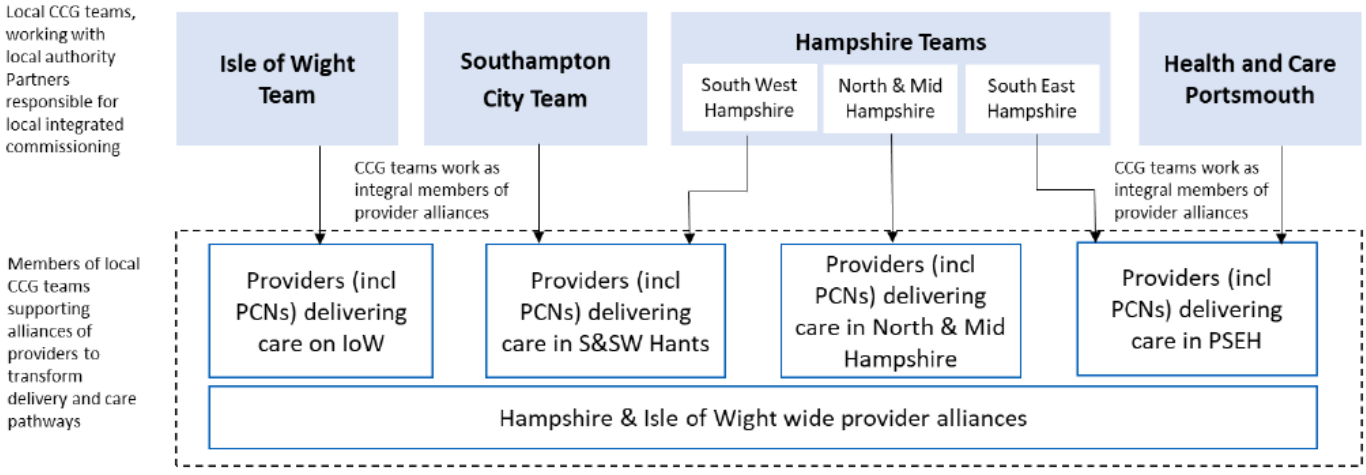
4.4. Each local team will comprise of clinicians and managers who work together and with partners to meet the needs of the local population. The local team will be led by a clinical leader with a senior manager.

4.5. Members of local teams will work as an integral part of the partnerships of providers, local authorities and CCGs based around each acute hospital to support the transformation of delivery and care pathways. This means members of the Southampton City and South West Hampshire local CCG teams working with providers delivering care in Southampton & South West Hampshire, in line with the University Hospital Southampton NHS Foundation Trust catchment area.

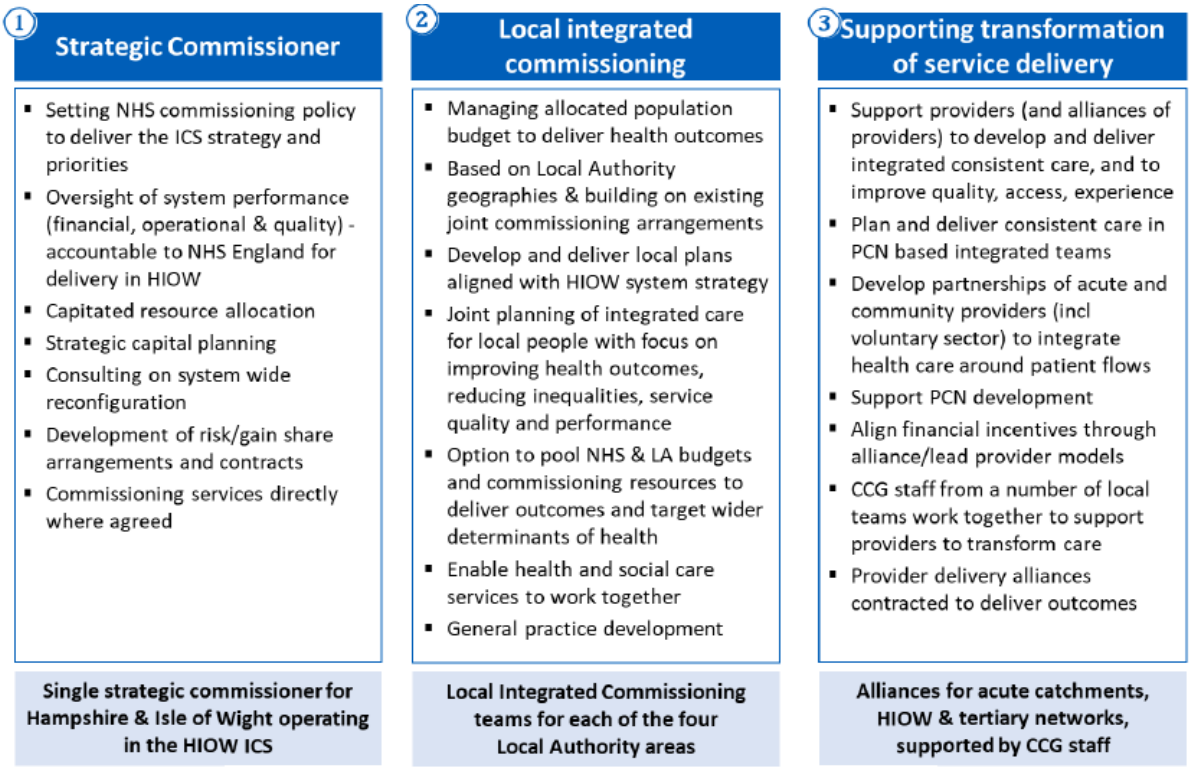
4.6. Local integrated commissioning arrangements will allow for the option to pool NHS and local authority budgets, and commissioning resources to deliver outcomes and target wider determinants of health, in addition to enabling health and social care services to work together.

4.7. Where there are existing integrated NHS and local government commissioning arrangements (for example, the Joint Commissioning Board in Southampton) these will remain unchanged. Our aim is to further deepen integrated commissioning, building on these existing arrangements.

4.8. The figure below illustrates the design with local CCG teams aligned to each local authority area, supporting service transformation in local delivery systems:



4.9. The figure below summarises the role of strategic commissioner, the role of local integrated commissioning teams, and the role of CCG teams supporting transformation and service delivery in delivery alliances:



5. Next steps

5.1. At the end of September 2020, governing bodies recommended to approve the proposed merger of North Hampshire CCG, West Hampshire CCG, Southampton City CCG, Isle of Wight CCG, Fareham & Gosport CCG and South Eastern Hampshire CCG from 1 April 2021.

5.2. The merger application was submitted to NHS England on 2 October for approval (with a decision expected from NHS England by the end of October)

5.3. A single executive team will be appointed shortly and the management of the transition from the current arrangements to the new arrangements has started.

5.4. Staff and partners, including the Health Overview and Scrutiny Panel, will continue to be involved in order to implement the changes successfully and realise the benefits. Work continues on the design of the governance and culture for the new organisation.

5.5. A full impact assessment for both our population and staff has been undertaken, which has informed the development of this proposal.

5.6. If the proposal is approved, all of the existing staff, assets and liabilities of NHS Southampton City CCG will transfer to the new statutory organisation on 1 April 2021.

5.7. The internal programme board overseeing the merger have discussed the impact of Covid 19 on the merger. Much of the work to technically merge the organisation will be undertaken by back office suppliers to create a new financial ledger and new staff record system. Both of these systems are provided by the same suppliers across the NHS and have undertaken a number of other CCG mergers. This however is kept under constant review internally and in discussion with the mergers team at NHS England.

5.8. We will continue to keep the Health Overview and Scrutiny Panel updated.