NHS
Portsmouth
Clinical Commissioning Group

Portsmouth
CITY COUNCIL

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Dear Sir Neal

**Hampshire and Isle of Wight Sustainability Programme System Reform**

Portsmouth's Health and Wellbeing Board (HWB) considered the System Reform Statutory Board Pack at its public meeting on 28th November. The emerging proposals have previously been discussed by the HWB and its members in a number of different fora. This response can be taken as the combined response of the Portsmouth HWB, the Portsmouth CCG Governing Board (which formally considered the System Reform Statutory Board Pack at its meeting on 21 November) and Portsmouth City Council.

Members of the HWB were clear that they have participated in shaping the proposals so far, and acknowledged that the paper is trying to capture a very complex set of functions, relationships and dependencies. It was also recognised that the terminology and understanding of the tiers emerging from NHS England over the gestation period have also created uncertainty. Notwithstanding this, the broad vision for the system as set out in the paper was supported, and it was noted that it is aligned with the local 'blueprint' for health and care in Portsmouth. However, the very constructive discussion did highlight some of the clear tensions from this city's perspective.

Firstly, there is a challenge from the local perspective to the **geography** around which the proposal to form an Integrated Care System is based. Whilst there may be a role for some specific activities to be undertaken at a HIOW geography, the compelling case to support an ICS on HIOW boundary is not made. Many of the functions identified for an ICS - not just in these proposals but also in national thinking - are being delivered within systems working around acute catchment areas (such as Frimley, West Berkshire or Surrey Heartlands) or places based on local authority boundaries (and the two usually work in partnership).

Consequently, the roles and functions being set out for the HIOW tier in these proposals

are unfocused. We do believe that there are functions best delivered at the HIOW level (commissioning services that are required for a 2m+ population, assurance interface with NHSE) but the proposals risk missing the need for health and care for residents to reflect where they live and receive the majority of their care. Our view is that the functions described for an ICS are best delivered on a Portsmouth and South East Hampshire (PSEH) basis.

Community and primary healthcare are interdependent on a whole range of wider community resources, including social care, schools, housing, leisure provision and the local network of voluntary and community provision. In this city, there is a complex set of relationships and we broadly understand how these relate to each other. These are the relationships that will be characteristic of clusters - but in a compact, densely populated city, there will be many cases where the city operates as a cluster in its own right. What we cannot support is a system that requires multiple layers of governance, management and bureaucracy to enable this to happen, as appears to be the case in these proposals.

Our perspective is that in the attempt to distil complexity to an easily expressed formula, and to find a purpose for a +2m HIOW geography, a default single specification for levels has been developed, which does not map easily onto our circumstances. There needs to be local flexibility to develop the system that is right for the place.

This links to our second concern which is around **local accountability**. The resource for the HIOW STP should be applied to those issues that are best planned and delivered at HIOW level and should not be focused on developing and assuring the whole system or other elements of it such as cluster arrangements. Such an approach inevitably undermines subsidiarity and is liable to stifle creativity and tailored approaches to local needs. These are better developed by local place leaders working together in their local systems. This means recognising the strong part that local authorities play, as service commissioners and providers and advocates for their communities. The interface with social care services and early help and prevention is critical, and needs to be worked through locally.

This brings challenges around mandate. Decision-makers in local authorities have a direct democratic mandate from their electorate, and tensions within the system are best resolved in that system. Local health systems have already started to think through how this works in the development of health and wellbeing boards, and these boards have developed differently to reflect different local circumstances and dynamics. Our HWB has regard to the line of decision-making and resource allocation back to local governance bodies.

This dynamic means that there are real difficulties with the proposals around HIOW strategic commissioning and an 'alliance' of Health and Wellbeing Boards. Whilst there may be much to gain from the exchange of experience, the concept of an alliance is in itself questionable given the differing scope and authority of boards; and it is unclear how the two proposed entities will relate. Again, it makes sense to ensure that proposals are developed on a footprint that makes sense when viewed through the lens of local democracy and accountability.

Our third main concern links to the issue of local accountability and decision-making, and is about **ensuring 'equity' across a wider footprint**. In the city, we have gained an

understanding of the challenges faced by our population, and how these manifest themselves. We have developed responses to address this and allocated resources accordingly. This means that in some areas (for example, mental health services for young people) we are doing things differently to other parts of HIOW. We are always concerned when we hear suggestions that 'equity' is required, suggesting a homogenous response. What is needed is actually 'equity' in how communities are understood, advocated on behalf of, and responded to by decision-makers. This is achieved by allowing resources to be directed as flexibly as possible at the lowest possible level of geography, not by aggregating and levelling.

In Portsmouth, we are fully committed to innovative thinking about the delivery of all health and care services in our area, and have developed our local Blueprint to deliver this. We have many examples of how we are integrating and designing services around our residents to better serve the population, and are moving towards a new operating model for services that encompasses CCG and local authority functions. We understand how to make community and primary care work for our population, and understand what needs to be done to improve it. We strongly believe that as a local system, we should retain the discretion to do this as we see fit without being required to comply to a model that sees the world in uniform blocks. We also believe that there are services and needs that are appropriately organised on a wider footprint, and look forward to supporting the discussion about these as it develops.

As well as these thematic concerns, various discussions have highlighted specific issues with the text in the proposals, and we attach a summary of these points as Appendix One. We trust that you will take this feedback in the constructive spirit it is intended, and we look forward to continuing to work with you on shaping the proposals to ensure we serve the various HIOW communities as well as we possibly can.

Yours sincerely

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Portsmouth City Council

Joint Chairs of Portsmouth Health and Wellbeing Board, on behalf of:

Portsmouth City Council
Portsmouth Clinical Commissioning Group
Portsmouth Hospitals NHS Trust
Portsmouth Voluntary and Community Network
Solent NHS Trust
Portsmouth Healthwatch

**Appendix One - detailed comments on Hampshire and Isle of Wight Sustainability Programme System Reform proposals.**

**The Vision (Slide 10+)**
In line with the Board's vision and Portsmouth Blueprint

**HIOW as a system for an ICS (Slide 12+)**
Role and functions at the HIOW tier in these proposals are unfocused - for example, what is the relationship between strategic commissioning body and HWBB Alliance – is there a hierarchy?

Unclear about the sovereignty of the Health & Wellbeing Boards – sovereignty of HWB sits with respective LA not at HIOW

Muddles ICP (PSEH) and HIOW functions

**Clusters (Slide 19+)**
Proposals suggest there will be/needs to be cluster-based budgets, leadership and governance – we are opposed to this as it builds in additional layers of management and bureaucracy. The narrative suggests separate entities/areas below this level which does not make sense for us. In many instances the City will operate as a 'cluster' in its own right.

Common specification for clusters – not supportive of this approach, needs to be developed locally to reflect the local variation; can see sense in a coming together for good practice and possibly peer challenge (although this may be better from another region). Board expectation is that clusters will have a direct relationship to 'place' (ie. Portsmouth City) reporting to them, being resourced by them, being managed by them. Reporting lines are unclear in this proposal and seem to be based on a number of different expectations of the STP – is it an arm of the NHS regulator or not?

Balance of effort – strong view that in an environment of challenged resource, the priority should be to focus our collective resource on supporting front line operational delivery – thus would not support STP being resourced to drive and assure cluster development as this happens locally as well

Whilst place and clusters will be the priority for the City, PSEH system will be of similar priority – aligning the work in the city with work in footprint of PHT is required.

**Place (Slide 26+)**
Principles outlined here reflect the expectations of 'place' by the Board.

**Integrated Care Partnerships (Slide 30+)**
Strong view that the PSEH system should be the basis for an Integrated Care System. The notion of forming an ICS at a HIOW geography needs testing: does not stand up to many of the national criteria for ICS (such as acute catchment areas and LA boundary continuity), recent self assessment of HIOW to prepare for ICS suggests many of the functions expected of an ICS are currently being delivered at a City and PSEH level

The Board does not accept the underlying assumption in the proposals that ICPs have the

primary direct line relationship with clusters and thus drive their resourcing and development - this should remain with the 'place' (Portsmouth City). However, ICPs are the way that respective places come together to align their work around the acute - the Board is strongly committed to building the PSEH integrated system given the prominence and importance of the hospital to Portsmouth residents.

We do need to put more effort into defining and building this at a PSEH level – current collaboration is good but need to move on from a loose affiliation of the willing to having strongly defined delivery responsibilities, much clearer leadership based on roles within the City and also stronger governance. City Operating model can help to define this with a single voice for the City.

ICS self-assessment confirmed this view.

Also seems to align with the national thinking:

**'Round two for STP plans: a fresh start or a dangerous distraction?'**
Kings Fund, Nov 2018
*'Our work with local systems has highlighted the value of local authority involvement and leadership, including a stronger connection with local communities, closer working across health and social care, and opportunities to act on the wider determinants of health. ICSs and STPs will only be able to realise the ambition of integrating care and improving population health if their primary focus is outwards towards local partners and residents, rather than upwards towards the asks of national NHS bodies.'*

**What should the NHS long-term plan say about STPs and ICSs?**
October 2018
*'national leaders should encourage further changes to the organisation of commissioning while avoiding the imposition of a national blueprint. There is particular need to work with the tension between reducing the number of clinical commissioning groups to align NHS commissioning with STPs and ICSs on the one hand, and a desire to secure greater engagement with local authorities on the other hand. The form of commissioning should reflect emerging understanding of the functions of commissioners in future at both the system level and in the places that make up the larger systems. Integrated commissioning between the NHS and local authorities is especially important in these places.'*

*'national leaders should also be cautious about unsettling the work of successful STPs and ICSs by prescribing their size and working arrangements. Progress is fastest where relationships and partnerships have been built, particularly where there has been continuity in the leadership community. This work would be undermined if systems were required to merge around larger footprints. Collaboration between smaller systems is already enabling issues to be dealt with at scale and is preferable to redrawing lines on the map.'*

**HIOW Strategic Planning (Slide 35+)**

Previous comments apply re: weak case for HIOW as an ICS.

In principle support subject to the final scope, remit and terms of Reference of proposed joint committee returning to the Board prior to establishment.

If established, Board strongly supports the need for NHS provider, NHSE specialist commissioning and Local Authorities to have a presence on the committee, respecting that this will need to be cognisant of current legal and legislative requirements.