Public Document Pack

Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW & SCRUTINY COMMITTEE
AGENDA
(SPECIAL MEETING)

7.00 pm	Thursday 6 September 2012	Committee Room 3B - Town Hall

Members 6: Quorum 3

COUNCILLORS:

Conservative Group (4)	Residents' Group (2)	Labour Group (0)	Independent Residents' Group (0)
Wendy Brice-Thompson (Chairman) Jeffrey Brace Pam Light Keith Wells	June Alexander (Vice-Chair) Linda Van den Hende		

For information about the meeting please contact:
Anthony Clements Tel: 01708 433065
anthony.clements@havering.gov.uk

AGENDA ITEMS

1 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – received.

2 DISCLOSURE OF PECUNIARY INTERESTS

Members are invited to disclose any pecuniary interest in any items on the agenda at this point in the meeting.

Members may still disclose any pecuniary interest in an item at any time prior to the consideration of the matter.

3 CHAIRMAN'S ANNOUNCEMENTS

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

4 REQUISITION OF CABINET DECISION - COMMISSIONING OF A LOCAL HEALTHWATCH SERVICE (Pages 1 - 20)

The Committee are asked to consider the requisition of the Cabinet decision on the Commissioning of a Local Healthwatch service (report attached).

Ian Buckmaster
Committee Administration &
Member Support Manager

Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW AND SCRUTINY COMMITTEE

6 September 2012

Subject Heading:	Commissioning of a Local Healthwatch Service
CMT Lead:	Lorna Payne Group Director – Adults and Health 01708 432488
Report Author and contact details:	Anthony Clements Principal Committee Officer Committee Administration 01708 433065
Policy context:	The Health and Social Care Act 2012 requires the commissioning of a local Healthwatch service which will replace the LINk (Local Involvement Network) with some additional functions.

In accordance with paragraph 17 of the Overview and Scrutiny Committee Rules, a requisition signed by two Members representing more than one Group (Councillors Keith Darvill and Gillian Ford) has called in the decision of Cabinet dated 15 August. The text of the requisition appears at the end of this report.

CABINET DECISION

1. To note the consultation on models for the commissioning of a local Healthwatch service.

2. To confirm the inclusion of the Independent Complaints' Advisory Service in the function to be carried out by Healthwatch.

3. To delegate the consideration of consultation responses, the LINk's legacy analysis, consultation with the host organisation and current chair/vice chair of LINk and selection of the appropriate commissioning route to the Cabinet Member for Individuals and Deputy Leader.

4. To note that further work would be undertaken to draw up the specification and proposed operating model for Healthwatch in Havering once the procurement route has been established.

(Note: The full report to Cabinet, including appendix, is shown at the end of this report).

Reasons for decision:

As previously explained, consultation is currently taking place on three options. The reasons for and against each of them are detailed in appendix A (of the Cabinet report).

The timescales are short, but this needs to be balanced with the need for local people to influence the future shape of Healthwatch and ensure that the legacy of LINk forms a firm foundation to build upon. It is recommended to delegate the final decision on the arrangements for commissioning a local Healthwatch to the Lead Member for Individuals and Deputy Leader. This will allow the Lead Member to undertake further detailed work in relation to a detailed specification for future Healthwatch services.

REASONS FOR REQUISITION

We the undersigned members of the Council hereby 'Call in' the above mentioned decision of Cabinet for the following reasons:-

1) to address the concerns of the Local Involvement Network (Havering LINk) about the recommendations within the Cabinet Report;

2) to ensure that the consideration of consultation responses, the LINk's legacy analysis, consultation with the host organisation and current chair/vice chair of LINk and selection of the appropriate commissioning route is not delegated the Lead Member for Individuals and Deputy Leader;

3) to give more detailed consideration of the advantages and disadvantages of a shared Healthwatch 'Hub & Spoke' model with joint commissioning led by LB Barking & Dagenham.

Councillor Keith Darvill
Leader of the Labour Group

Councillor Gillian Ford
Deputy Leader Residents Group.

RECOMMENDATION

That the Committee considers the requisition of the Cabinet Decision and determines whether to uphold it.

Havering
LONDON BOROUGH

CABINET REPORT

15 August 2012

Subject Heading:	Commissioning of a local Healthwatch service
Cabinet Member:	Councillor Steven Kelly, Lead Member for Individuals and Deputy Leader
CMT Lead:	Lorna Payne, Group Director, Adults & Health
Report Author and contact details:	Lorna Payne, Group Director Adults and Health, lorna.payne@havering.gov.uk 01708 432488
Policy context:	The Health and Social Care Act 2012 requires the commissioning of a local Healthwatch service which will replace the LINk (Local Involvement Network) with some additional functions.
Financial summary:	Indicative allocations for the different elements of the new service have been given for Havering for 2013/14. The funding is not expected to be confirmed until January 2013 but it has been announced that funding will not be ring fenced.
Is this a Key Decision?	Yes
Is this a Strategic Decision? Yes/No	Yes
When should this matter be reviewed?	12-18 months from April 2013 (April 2014 – September 2014)
Reviewing OSC:	Individuals and Health

The subject matter of this report deals with the following Council Objectives

Ensuring a clean, safe and green borough	X
Championing education and learning for all	[]
Providing economic, social and cultural activity in thriving towns and villages	[]
Valuing and enhancing the lives of our residents	X
Delivering high customer satisfaction and a stable council tax	X

SUMMARY

1.1. The Health and Social Care Act 2012 places a duty on the Council (all councils with Social Service responsibilities) to commission a fully operational Healthwatch by April 2013.

1.2. Healthwatch is to be the new local Health and Social Care consumer champion and watchdog and will be required to represent the views of local residents of all ages, advocating and influencing the delivery and commissioning of Health and Social Care services.

1.3. The local representative of Healthwatch will have a statutory role on the new Health and Wellbeing Board from April 2013, ensuring that the voices of patients, users and the wider public are heard, and that the vision and objectives of the Health and Wellbeing Strategy reflect the priorities of local people.

1.4. The Council is keen to embrace the opportunities offered by the reconfiguration of health services locally and has been working closely with the Clinical Commissioning Group (CCG) for Havering to develop an ambitious set of priorities targeted on improving outcomes for patients and carers locally. The Council is therefore particularly keen to commission a Healthwatch function that will champion the views of patients, users and carers and improve public health and wellbeing as these new priorities are pushed forward.

1.5. Healthwatch will replace LINk (Local Involvement Network) and will have additional responsibilities.

1.6. A consultation paper has been issued which covers the commissioning options facing the Council with regard to the new Healthwatch function as the Council needs to decide how it wishes to commission Healthwatch in order for it to be in place in Havering by March 2013. It puts forward three possible models, subject to the consultation and legacy analysis.

MODEL A - Havering Healthwatch evolving from either the current LINk steering group or the host organisation

MODEL B - Havering stand-alone organisation procured by Havering Council

MODEL C - Shared Healthwatch 'Hub and Spoke' model, with joint commissioning led by Barking and Dagenham but with added local specification reflecting local priorities.

1.7. The closing date for the 21 day consultation is Friday 17th August 2012.

RECOMMENDATIONS

2. Cabinet is asked to:

2.1 Note the consultation on models for the commissioning of a local Healthwatch service.

2.2 Confirm the inclusion of the Independent Complaints' Advisory Service in the function to be carried out by Healthwatch.

2.3 Agree to delegate the consideration of consultation responses, the LINks legacy analysis, consultation with the host organisation and current chair/vice chair of LINk and selection of the appropriate commissioning route to the Lead Member for Individuals and Deputy Leader.

2.4 Note that further work will be undertaken to draw up the specification and proposed operating model for Healthwatch in Havering once the procurement route has been established.

REPORT DETAIL

3. BACKGROUND

3.1 The Health and Social Care Act 2012 represents a watershed for how health services will be commissioned in England and Wales. In line with the Government's Localism agenda, particularly its vision for the NHS of "no decision about me without me", local communities are to have more of a say in the provision and quality of local health services.

3.2 Local Authorities will have new responsibilities in public health and a statutory responsibility to lead Health and Wellbeing Boards. Havering's Health and Wellbeing Board has been set up, in shadow form, and its statutory responsibilities will come into effect from April 2013. This will include agreeing with Havering's Clinical Commissioning Group and other health and social care commissioners what the health priorities are of the local population, to inform commissioning plans.

3.3 The Health and Wellbeing Board will agree a Health and Wellbeing Strategy for the borough, informed by the Joint Strategic Needs Assessment, which provides commissioners with an analysis of the health and wellbeing issues affecting the population.

3.4 Under the new arrangements, it will be vital to ensure the appropriate community engagement mechanisms are in place to capture the opinions of the public, patients, users and carers, so that their experiences of the local

health and social care system can be heard, and acted upon, to improve local services.

3.5 Going forward, we will therefore need to ensure that the Joint Strategic Needs Assessment and Health and Wellbeing Strategy reflects the views of the local population. Healthwatch will be a key engagement mechanism to enable this to happen.

3.6 'Healthwatch England' is to be the new Health and Social Care consumer champion and watchdog at a national level and will advise the NHS Commissioning Board, English local authorities, Monitor and the Secretary of State. It will also have the power to recommend that action is taken by the Care Quality Commission (CQC) when there are concerns about health and social care services.

3.7 It is envisaged that local Healthwatch organisations will have a reporting line into Healthwatch England and will be able to report concerns about the quality of health care to Healthwatch England, which can then recommend that the CQC take action.

3.8 A representative from Havering's local Healthwatch will have a statutory seat on the Health and Wellbeing Board, which will ensure the views of patients, users and carers influence the commissioning (and decommissioning) of services and that the vision and objectives of the Health and Wellbeing Strategy remains relevant and reflects the priorities of local people.

4. HEALTHWATCH IN HAVERING

4.1 The Health and Social Care Act 2012 places a duty on the Council (all councils with Social Services responsibilities) to commission a fully operational Healthwatch by April 2013.

4.2 Healthwatch will replace LINk (Local Involvement Network), hosted locally by the Shaw Trust, as the main organisation responsible for the voice of local patients of health and social care services, and the voice of the wider community. Healthwatch will also bring in the NHS advocacy service, currently provided across London by POhWER. The PALS (Patient Advice and Liaison Service) currently provided by PCTs will also transfer, with its funding, to the Council and become the Independent Complaints Advisory Service. This can either also be provided by Healthwatch or be commissioned as a separate service. It is proposed that it will be included in the Healthwatch functions. Unlike LINk which had to be hosted, the new service will be directly commissioned.

4.3 Healthwatch will have broader remit than LINK with the additional functions of:

- Advice and information about access to and choice of health and social care services

- An advocacy service for people wishing to make an NHS complaint

4.4 Additional funding is to be made available for these functions; however, it will not be substantial and is not to be ring fenced.

4.5 In summary, Healthwatch will have seven main functions:

- Gathering views and understanding the experiences of patients and the public
- Making people's views known
- Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinised
- Recommending investigations or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC)
- Providing advice and information about access to services and support for making informed choices
- Making the views and experiences of people known to Healthwatch England and providing a steer to help it carry out its role as national champion
- NHS complaints advocacy

4.6 The Council's vision for our local Healthwatch organisation is that it will represent the voice of **all** Havering residents in the improvement of local health and care services. The chosen provider will need to ensure it has the appropriate engagement mechanisms in place to allow the wider population of Havering to have their voice heard, and make special provision for ensuring the voices of disabled people and those with long term illnesses, older people, vulnerable adults and children, as well as carers.

4.7 Healthwatch will be a vital way of monitoring the real impact of the Health and Wellbeing Strategy on improving the quality of local health and care services, and ensure that the Health and Wellbeing Board is able to hear and respond to those messages.

4.8 The Health and Well Being Board is currently preparing this strategy, in close working partnership with Havering Clinical Commissioning Group. The strategy is linked to a wide range of other Council strategies, such as those for vulnerable adults, safeguarding children and culture. So far, priorities for health and wellbeing improvements have been agreed in line with the evidence available from the Council's Joint Strategy Needs Assessment of local people's health and well being needs and the following themes have emerged:

Theme 1: Prevention, keeping people healthy, early identification, early intervention and improving wellbeing

Priority 1: Early help for vulnerable people to live independently for longer

Older and vulnerable people, especially those with long-term conditions, are the most intensive and costly users of health and social care services and there is a clear need for their experience and outcomes achieved to be improved. They account for half of all GP appointments, two thirds of all outpatient appointments and nearly three quarters of all inpatient bed days. As our older population continues to grow, we are faced with increasing demands on these services. By focusing on prevention and early intervention, we hope to relieve some of this pressure on services and enable more people to live independently and safely in their own homes for longer. We will:

- Help more vulnerable people, including those with long-term conditions and complex needs, maintain their independence in the community and reduce use of acute/complex services
- Tackle isolation and support vulnerable people to help maintain independent living
- Improve choice and control over the health and social care people receive
- Deliver more community based support, including volunteer-led services for people recently discharged from hospital and provision of reablement services to help them re-adjust to independent living.

Priority 2: Improved identification and support for people with dementia

Dementia is a clinical syndrome characterised by a widespread loss of cognitive function, including memory loss, language impairment, disorientation, change in personality, self neglect and behaviour that is out of character. It is an extremely distressing illness and a particularly pertinent issue for Havering due to our large, and growing, older population. We will:

- De-stigmatise dementia and ensure sufferers and their carers receive the best possible support in managing their condition
- Ensure high quality and accessible dementia information by improving data collection on the prevalence of dementia and data sharing between organisations
- Clinically train professionals to recognise the symptoms of dementia leading to earlier diagnosis and improved outcomes for sufferers and their carers
- Deliver more universal services and better quality of care for people with dementia.

Priority 3: Earlier detection of cancer

Cancer is a common disease, with about 1,200 people in Havering (one in every 200) diagnosed with some form of cancer each year. The cost of cancer care is high and national research has shown that more than 40% of cases are attributable to avoidable risk factors such as smoking, alcohol, poor diet and lack of exercise and could have been prevented if people lived more healthily. We will:

- Raise public awareness of the signs and symptoms of cancer, so that we can improve survival rates for those diagnosed with cancer
- Maintain excellent performance on waiting times between referral of patients with suspected cancer and first consultant contact

- Improve access to optimal treatment, particularly radiotherapy and surgery for Havering residents
- Maximise uptake of cancer screening
- Improve assessment and detection/suspicion of cancer in primary care settings
- Improve quality of cancer care services.

Priority 4: Tackling obesity

Being overweight or obese increases a person's risk of diabetes, cancer and cardiovascular disease. It can also restrict mobility and contribute to poorer mental health, which can limit a person's participation in their community and reduce their quality of life. Obesity is a complex issue that is affected by a range of behavioural, psychological, social, cultural and environmental factors. We will:

- Reduce obesity levels in adults and children
- Promote healthier lifestyles to maintain healthy weight
- Raise awareness of health risks associated with being overweight/obese.

Theme 2: Better integrated support for people most at risk

Priority 5: Better integrated care for the 'frail elderly' population

Havering's population is ageing and as a result the number of 'frail elderly' residents is increasing and placing huge pressure on our health and social care services. This very vulnerable group consumes a disproportionate amount of resources in terms of managing their care due to delays in hospital discharges, an overreliance on bed-based solutions and a high incidence of repeat hospital admissions. We will:

- Ensure with partners, seamless, integrated and efficient care pathways for 'frail elderly' people with care needs
- Improve pathways into and through community-based health services and general practice by working closely with the hospital and GPs
- Reduce the incidence and impact of falls leading to critical care/hospitalisation
- Enhance independence and capability of individuals to manage their circumstances/ conditions at home
- Improve outcomes and efficiency of care following injury as a result of a fall, including hip fracture
- Provide support to people within the community who have recently been discharged from hospital or who are at risk of admission/readmission
- Improve care in nursing and residential homes, including better management of demand to reduce avoidable hospital admissions
- Improve support to people not currently engaged with social care such as self funders and those with currently lower levels of need to ensure that greater opportunities to benefit from prevention, improved health and wellbeing and support are provided.

Priority 6: Better integrated care for vulnerable children

Healthy, happy and educated children are more likely to become healthy happy and productive adult members of society. Setbacks experienced in childhood as a result of troubled family backgrounds can result in long-lasting harm that persists throughout life and has a spiral effect leading to significantly reduced outcomes for those young people. Vulnerable children, such as those in care or with learning disabilities, face particular, more complex, issues and our priority is to support them to realise the same positive and sustainable outcomes as the rest of the population. We will:

- Provide intensive, bespoke, support to families with multiple complex needs to address their problems earlier
- Improve the stability of care placements and reduce placement breakdown, including reducing the number of placements between foster care and adoption
- Improve health outcomes for children and young people, particularly those in care
- Reduce teenage conceptions, terminations and improve sexual health through the delivery of targeted campaigns that raise awareness of health risks
- Commission universal and targeted access to health visitors and schools' nurses as a basic entitlement
- Provide access to high-quality therapies for vulnerable children and young people.

Priority 7: Reducing repeat hospital admissions

Hospital admissions, especially unplanned and repeat admissions, are extremely costly to the NHS and disrupt the lives of those affected and cause distress to family and friends and can cause increased dependency and ill health through such events as infections and length of stays that reduce people's confidence to manage at home. We are keen to reduce unnecessary hospital admissions, particularly for ill-health or injury that could have been avoided and repeat hospital admissions where individuals are admitted into hospital on a frequent basis. We will:

- Manage the care of patients proactively in the community through integrated case management
- Increase independence skills of people within the community who have recently been discharged from hospital or who are at risk of admission/readmission
- Reduce delayed transfers of care and seek greater collaborative approaches to ensure that planning for discharges can take place closer to an individuals point of admission
- Ensure informed choice on end of life care through robust information and guidance for patients and carers.

4.9 Delivering these strategic ambitions will be challenging and it will be vital that Havering has an effective Healthwatch with the skills and expertise to work with the Health and Well being Board to ensure that there is effective monitoring and engagement of patient and carer views whilst the Council and the CCG work with other health service providers to deliver these improved outcomes.

4.10 Some of the strategic outcomes set out above will mean close working with parts of the health economy that do not serve Havering alone, such as BHRUT. The Council is therefore working closely with the other local authorities that are also served by BHRUT and NELFT to ensure that we can jointly manage the improvements we would all like to see. For example, an Integrated Care Commission has been set up to establish how we can improve care for frail elderly people in the hospital, primary care and social care system. In addition, the three Clinical Commissioning Groups that serve Havering, Redbridge, and Barking and Dagenham Councils have decided to share a Chief Operating Officer and some back office functions. For these reasons, for each of the structures it is considering as part of the new health environment, the council is exploring whether we can share any services with either or both of our neighbouring boroughs. There is no commitment to do so at this stage, but there is as agreement to consider shared options as part of the Council's decision making. One of the options with regard to Healthwatch is therefore to share a Healthwatch with the London Borough of Barking and Dagenham who have expressed a wish to explore this option with Havering. Havering Council has not taken a decision on this option, but it is included in the consultation paper to gather any external views on this proposition prior to a decision on a commissioning route being determined.

4.11 The consultation paper (See appendix A) covers the functions of the local Healthwatch, funding, and possible commissioning strategies for Havering.

4.12 It puts forward three possible models:

MODEL A - Havering Healthwatch evolving from either the current LINk steering group or the host organisation

MODEL B - Havering stand-alone organisation procured by Havering Council

MODEL C - Shared Healthwatch 'Hub and Spoke' model, with joint commissioning led by Barking and Dagenham but with added local specification reflecting local priorities

4.12 The attached paper (Appendix A) has been issued as part of a 21 day consultation, which will end on Friday 17th August 2012. Subject to the recommendation being approved, the responses will be reported to the Lead Member for Individuals and Deputy Leader for a decision on the arrangements for commissioning a local Healthwatch.

4.13 Following on from this consultation Local Authority will be carrying out a detailed analysis of the legacy of the LINk following a methodology supported by the LGA. The current host organisation, current chair and vice chair will also be consulted before planning the next steps to fulfil the requirement set out in National guidance to ensure Healthwatch benefits

fully from the foundation put in place by LINk Havering. Only then will the Council set out its detailed commissioning intentions for Healthwatch, including the form and shape of any future service to be developed.

4.14 The final operating model will take into account existing infrastructure that could support the success of Healthwatch locally to maximise its impact and profile. This could include support with premises, websites, customer insight information and marketing expertise.

REASONS AND OPTIONS

Reasons for the decision:

As previously explained, consultation is currently taking place on three options. The reasons for and against each of them are detailed in appendix A.

The timescales are short, but this needs to be balanced with the need for local people to influence the future shape of Healthwatch and ensure that the legacy of LINk forms a firm foundation to build upon. It is recommended to delegate the final decision on the arrangements for commissioning a local Healthwatch to the Lead Member for Individuals and Deputy Leader. This will allow the Lead Member to undertake further detailed work in relation to a detailed specification for future Healthwatch services.

IMPLICATIONS AND RISKS

Financial implications and risks:

Although the actual 2013/14 funding has still to be determined by central government, from April 2013 funding for Healthwatch will have two different elements:

- LINks funding – DCLG Business Rates Retention Scheme (i.e. non ring-fenced part of the government funding provided to Havering to deliver all services)
- Additional Healthwatch funding – route still to be determined
  (Guide figure for Havering = £46,983)

In addition, there will be funding for the Independent Complaints Advocacy Service (Indicative grant allocation for Havering = £58,287)

In summary, in addition to the former LINks funding, the PALS/complaints functions are expected to transpose as additional budget of some £105k.

Funding for local Healthwatch will not be ring fenced as decisions on actual funding requirements are expected to be made by each local authority.

Legal implications and risks:

The Council has a duty to commission the functions previously the responsibility of the LINks and the Independent Complaint Advisory Service, but it has a degree of discretion in how it does so provided that the resulting Healthwatch is locally based. While there has been an assumption that the existing LINk may form the basis of the new Healthwatch, it is not a forgone conclusion given the requirement to commission the work. There may be the need to consider the relevance of the limited EU procurement regime depending upon the exact format and length of the work commissioned.

Human Resources implications and risks:

There are no direct HR implications or risks for the Council that can be identified from the proposed actions in this report. The LiNK service is directly commissioned through a host organisation (Shaw Trust) and does not include any staff that are employed by the Council. The new local Healthwatch is to be commissioned from a social enterprise. The consultation paper refers to possible TUPE implications that may affect the current and new providers only. A dialogue with the host organisation needs to take place to progress this issue.

Equalities implications and risks:

An Equality Analysis and Impact has been produced. Based on the national EIA, it is unlikely the changes will have any effect on discrimination, harassment or victimisation nor are they expected to have a direct impact on particular equality groups.

BACKGROUND PAPERS

- "Supporting Healthwatch Pathfinders - Building Successful Healthwatch Organisations" Local Government Association, April 2012 http://www.local.gov.uk/c/document_library/get_file?uuid=c96a438b-dbb5-4cfa-8669-8c42a999cbdd&groupId=10171

- "Local Healthwatch: a strong voice for local people – the policy explained" DH March 2012 http://healthandcare.dh.gov.uk/files/2012/03/Local-Healthwatch-policy.pdf

- "How will local Healthwatch work?" DH webpage March 2012 http://healthandcare.dh.gov.uk/how-will-local-healthwatch-work/

This page is intentionally left blank

Appendix A

Consultation note on establishing a local Healthwatch

Purpose

- To outline the statutory requirements
- To outline the funding available
- To set out the current working arrangements, funding and staff of the existing Havering Links and PCT PALs service
- Summarise the issues facing Havering
- Identify the key priorities for Havering and issues requiring decisions
- Set out the options open to Havering with opportunities and risks

Background

Healthwatch is to be the new local Health and Social Care consumer champion and watchdog and will be required to represent the views of local residents of all ages, advocating and influencing the delivery and commissioning of Health and Social Care services.

The Health and Social Care Act 2012 places a duty on the Council (all councils with Social Service responsibilities) to commission a fully operational Healthwatch **by April 2013.**

Healthwatch will replace LINk (Local Involvement Network). It will also bring in the NHS advocacy service, currently provided across London by Pohwer. The PALS (Patient Advice and Liaison Service) currently provided by PCTs will also transfer, with its funding, to the Council and the Independent Complaints Advisory Service. This can either also be provided by Healthwatch or be commissioned as a separate service. It is proposed that it will be included in the Healthwatch functions. Unlike LINk which had to be hosted, in Havering's case by the Shaw Trust, the new service will be directly commissioned.

Healthwatch will have broader remit including providing information and signposting people to Health and Social Care services and promoting choice. Additional funding is to be made available for these functions; however, it will not be substantial and is not to be ring fenced.

In summary, local Healthwatch will have seven main functions:

- Gathering views and understanding the experiences of patients and the public
- Making people's views known
- Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinized
- Recommending investigations or special review of services via Healthwatch England or directly to the Care Quality Commission CQC)
- Providing advice and information about access to services and support for making informed choices
- Making the views and experiences of people known to Healthwatch England and providing a steer to help it carry out its role as national champion
- NHS complaints advocacy

The local Healthwatch will receive some support and guidance from Healthwatch England and will be expected feed up concerns and issues to the national level. Health watch England will be an independent statutory committee of the Care Quality Commission (CQC), the national regulator.

The main lessons from the Healthwatch pathfinders were that the development of successful local Healthwatch is dependent upon having a clear local vision and values, as well as understanding the local picture through engagement and mapping.

Each local authority area is, under the legislation to have a Healthwatch and Healthwatch will have a statutory place on each Health and Wellbeing Board.

Funding

LINks funding is being carried forward as the baseline for local Healthwatch funding in 2012/2013. (DH provided direct grant funding for LINks in 2010/11 through area based grant (£132k) but this year, funding is included in the DCLG formula grant). Current annual funding to Havering LINks amounts to £60k (Cost of one member of staff, volunteer expenses and payment to host organisation). All LINKS will cease to exist on 31 March 2013, including the Havering LINKS.

Although the precise funding has still to be determined by central government, from April 2013/14 funding for Healthwatch will have two different elements:

- LINks funding – DCLG Business Rates Retention Scheme (i.e. non ring-fenced part of the government funding provided to Havering to deliver all services)
- Additional Healthwatch funding – route still to be determined (Guide figure for Havering = £46,983)

In addition, there will be funding for the Independent Complaints Advocacy Service. (Indicative grant allocation for Havering = £58,287)

Funding for local Healthwatch will not be ring fenced and decisions are to be made by each local authority.

TUPE may apply to the current individual in the host organisation (the Shaw Trust) who provides administrative support to the Havering LINk, as the functions carried out will transfer to either the new Healthwatch organiser or a supplier to Healthwatch who provides that function. This can only be determined with certainty nearer the transfer date.

Key priorities for Havering and issues

Some details of future operating arrangements for Healthwatch are still to be clarified at national level.

The service is being expanded to include responsibilities for **children's services** but unlike adults, will not include the ability to enter and view premises. The details are still being discussed with Ministers and Ofsted. The intention is that there is not duplication with Ofsted, the Children's commissioner / children's rights officers. It will be a **major challenge to provide a comprehensive service** which includes children and young people through a period of whole service review.

Current commissioning in Havering of preventative services for children and young people in social care is under going change with a shift towards a more holistic, whole family approach aimed at bringing about more sustainable solutions and care long-term. This includes a fully integrated health and social care package that is supported effectively through transition as well as better provisioning of therapies to families in need. Further challenges will come in involving numerous stakeholder groups that represent the views of young people as well as the young people themselves.

There is a **very short time scale** – the technical regulations will not be confirmed until November at the earliest and the new service has to be in place by April 2013.

Each local Healthwatch has to provide a member for the local **Health and Wellbeing Board** – the individual will have to cover a very broad brief.

The **funding** is likely to make it difficult to commission the required range of services. The local authority has a duty to ensure the local Healthwatch operates effectively and is value for money.

It has been stipulated that the local Healthwatch will be a **social enterprise 'body corporate'.** The model raises a number of questions especially as the term social enterprise is not recognised in law, but it is anticipated that a Community Interest Company, Charitable Trust or similar organisation will fulfil this criteria.

Areas are taking different stances on the way they are setting up the new Healthwatch organisations. Some areas are commissioning new organisations while others want the new organisation to evolve from their existing LINks. Regardless of which route is followed, if some of the staff involved in the new structures are sufficiently similar to the old roles of LINks, **TUPE may apply**.

The legislation requires each Council to make contractual arrangements to a carry out via a local Healthwatch body, which must be a social enterprise organisation, the involvement of local people in the commissioning, provision and scrutiny of local care services in its area. This was framed to ensure there were no gaps in provision across the country. The draft Bill originally was going to require there to be a local Healthwatch organisation in each local authority area, and this was reflected in the guidance issued by the Department of Health prior to the Bill becoming law. However, the provision for individual Healthwatches for each area was excluded from the final wording of the Act, and the most recent advice from the Department of Health has confirmed that 'the policy position is that we recognise **cross boundary working** and as long as they meet the spirit of the Healthwatch vision i.e. that local people know how to access their Healthwatch, it is for the local authority to decide how best they think to meet this'.

Havering is aware that there are some considerable challenges within the health system in outer north east London. In particular there have been much publicised challenges with the Acute hospital Trust, BHRUT, both in terms of quality of service and budget viability and sustainability. Both Havering and its neighbouring boroughs of Barking and Dagenham and Redbridge recognise and share these concerns. The boroughs are working collectively to work in partnership to assist in redesigning the health system to better serve local people. The challenges remaining to BHRUT are still substantial and it is likely that improvement will be ongoing for some time. In addition, the hospital is the subject of reconfiguration plans which have yet to be fully delivered. In these circumstances it is crucial that there is a very strong voice on the part of patients and users and that there is a degree of co-ordination between the outer London boroughs in playing a significant part in the improvements that are still required.

Havering and its neighbouring boroughs also recognise there is a need to realign services to provide more preventative services and more services in the community to better align with the needs and aspirations for the community. To this end the three boroughs in outer north east London are engaged in an integrated care commission, alongside the CCGs and Trusts in order to develop improved outcomes for local people. Again this calls for a strong Healthwatch body to work alongside and champion the needs of patients and local people in this work.

The above response could enable Havering to proceed with **a shared service** with Barking and Dagenham (and possibly also with another neighbouring London borough). Barking and Dagenham council has confirmed an interest in such an arrangement and could take the commissioning lead for a 'Hub and Spoke' model (a central organisation with locality arrangements) which would ensure there was a local Havering service able to respond to local

priorities. Such an approach would require a competitive tender to secure innovative solutions, meet local requirements and secure value for money. It would have an annual budget of £158k of which Havering would contribute up to £60k. Arrangements would also be made for the PALS functions and complaints advocacy which would add an additional £105k to the commissioning pot.

Key issues about why the decision is urgent

- There is a statutory requirement to have a Healthwatch in place covering Havering by April 2013 – a very short lead-in time
- Healthwatch is to be a new organisation with a broader range of responsibilities than LINks and Havering wants this in place as soon as possible to support the ongoing improvement work described above
- There is a low level of funding and there are similar concerns about the low level of funding for the other changes such as the transfer of Public Health to the council and therefore a decision about how to obtain the best value for money is needed
- The preferred model must ensure the new organisation provides value for money and is able to 'hit the ground running' by establishing early credibility and with the means to meet the agreed local outcomes
- There are high expectations of the new Health and Wellbeing Boards; the Healthwatch member of the Board must be able to make their mark as an effective consumer champion across the whole local system - working collaboratively to influence change but also to challenge poor quality services
- These challenges are greater than in most areas because of the ongoing concerns over BHRUT's performance; this suggests that working closely with other local CCGs and councils covered by the Acute Trust will be essential.
- A service able to utilise a broader range of skills and knowledge through a shared arrangement is much more likely to have the critical mass and influence (with CQC and local stakeholders) to champion local service improvements.

Possible models

MODEL A - Havering Healthwatch evolving from either the current LINk steering group or the host organisation

For	Against
• Would provide continuity • Local lobby for option • Should reflect local priorities • Should avoid TUPE costs	• Possible insufficient experience of broader responsibilities • Missed opportunity to commission new service with appropriate skills • Likely to be insufficient funding / not cost effective given level of funding available • May not have required influence with CQC & local stakeholders to champion essential service improvements • Would need to put cross boundary linkages in place to have a consistent influence on health system overall and BHRUT position

MODEL B - Havering stand-alone organisation procured by Havering council

For	Against
• Local lobby for this option • Should reflect local priorities • May avoid TUPE costs • More likely to cover the range of skills required for the new Healthwatch responsibilities • Focussed on Havering issues only	• May be TUPE costs • Likely to be insufficient funding / not cost effective given level of funding available • May not have required influence with CQC & local stakeholders to champion essential service improvements • Risk of not meeting timescales given Havering has not started commissioning process • Would need to put cross boundary linkages in place to have a consistent influence on health system overall and BHRUT position

MODEL C - Shared Healthwatch 'Hub and Spoke' model, with joint commissioning led by Barking and Dagenham but with added local specification reflecting local priorities

For	Against
• Already system has some shared arrangements with CCGs and possibly with Public Health • Share some NHS Trust services e.g. BHRUT • Some shared concerns about performance of services covering both areas • More likely to have required influence with CQC & local stakeholders to champion essential service improvements • Most cost effective option with reduced spend on support costs • Barking & Dagenham has procurement plan which would meet tight timescales • Low risk of service not being in place by April 2013	• May not reflect local priorities • Havering could be the 'poor relative' • May be TUPE costs. • May be opposition from local community & voluntary sector

A very early decision on the preferred model will be essential in order to meet the challenging timescale of having a local Healthwatch in place for April 2013. A 21 day consultation will be undertaken and a formal political decision made. Barking and Dagenham has developed an indicative tender timescale which would commence with advertising on 30 August, therefore Havering will need to make a decision before then.