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Health and Social Care Scrutiny Sub (Community and Children's Services) Committee

Date: **TUESDAY, 25 SEPTEMBER 2012**

Time: **1.45pm**

Venue: **COMMITTEE ROOMS, WEST WING, GUILDHALL**

Members:
Revd Dr Martin Dudley (Chairman)
Angela Starling (Deputy Chairman)
Nicolas Cressey
Deputy Henry Jones
Peter Leck
Deputy Joyce Nash
Sheriff & Deputy Wendy Mead
Deputy Revd Stephen Haines
Dr Peter Hardwick
Vivienne Littlechild
Court of Common Council Vacancy
Nick Kennedy
Steve Stevenson

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Lunch will be served in the Guildhall Club at 1.00pm

John Barradell
Town Clerk and Chief Executive

AGENDA

Part 1 - Public Reports

1. **APOLOGIES**

2. **DECLARATIONS BY MEMBERS OF PERSONAL AND PREJUDICIAL INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA**

3. **MINUTES**
To agree the minutes of the meeting held on 2 May 2012 (copy attached).

For Decision
(Pages 1 - 6)

4. **ESTABLISHING HEALTHWATCH CITY OF LONDON**
Report of the Director of Community and Children's Services (copy attached).

For Information
(Pages 7 - 18)

5. **UPDATE ON THE TRANSITION OF PUBLIC HEALTH FUNCTIONS TO THE CITY OF LONDON CORPORATION**
A report of Vicky Hobart, Public Health Consultant (NHS North East London and City) and co-Chair City Shadow Health and Wellbeing Board (copy attached).

For Information
(Pages 19 - 26)

6. **GP CHOICE PILOT UPDATE**
Report of the Director of Community and Children's Services (to follow).

For Information

7. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

8. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

9. **EXCLUSION OF THE PUBLIC**
MOTION - That under Section 100A(4) of the Local Government Act 1972, the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A of the Local Government Act.

Part 2 - Non-Public Reports

10. **NON-PUBLIC MINUTES**
To agree the non-public minutes of the meeting held on 2 May 2012 (copy attached).

For Decision
(Pages 27 - 28)

11. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

12. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

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HEALTH AND SOCIAL CARE SCRUTINY SUB (COMMUNITY AND CHILDREN'S SERVICES) COMMITTEE

WEDNESDAY, 2 MAY 2012

MINUTES OF THE MEETING OF THE HEALTH AND SOCIAL CARE SCRUTINY SUB (COMMUNITY AND CHILDREN'S SERVICES) COMMITTEE HELD AT GUILDHALL, EC2 ON WEDNESDAY, 2 MAY 2012 AT 1.45 PM

Present

Members:
Revd Dr Martin Dudley (Chairman)
Angela Starling (Deputy Chairman)
Nicolas Cressey
Deputy Henry Jones
Peter Leck
Deputy Joyce Nash
Deputy Revd Stephen Haines
Vivienne Littlechild
Nick Kennedy

Officers:

Julie Mayer	-	Town Clerk's Department
Neal Hounsell	-	Community & Children's Services
Farrah Meherali	-	Community & Children's Services

In Attendance:

Dr Steve Gilvin	-	Director of Primary Care Commissioning
Celine Van Valkenhoef	-	Programme Manager
Emma Williams	-	Service Development and Policy Manager
Anna Starling	-	Service Development Officer
Anna Stewart	-	Associate Director, Technical Contracting NHS ELC
Dr Maggie Harding	-	Locum Health Consultant NHS ELC
Jakki Mellor-Ellis	-	City LINk Urgent Care Lead
Jenny Purcell	-	City LINk Officer
Emma Marwood Smith	-	Manager, Substance Misuse Team
Dr Cynthia White	-	LINk Representative

1. **APOLOGIES**
   Apologies were received from Deputy and Sherriff Wendy Mead, Dr Hardwick and Mr Stevenson.

2. **DECLARATIONS BY MEMBERS OF PERSONAL AND PREJUDICIAL INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA**
   City of London resident Members declared personal interests in all the agenda items, as users of the services under discussion. They did not consider these to be prejudicial interests.

3. **MINUTES**

The public minutes and summary of the meeting held on 17 February 2012 were approved.

Matters arising

GP Choice Pilot - update

Members noted that this pilot would open nationally on 12 May. Local GPs had some issues outstanding in respect of referral and prescribing costs. Whilst these would be covered in future years, the short-term issues would need to be resolved before the pilot could commence in the City. The City workers health research, due to be published on 9 May, would inform the size of demand and the local Clinical Commissioning Group were due to meet with the City of London, NHS East London and the City and the Department of Health later this month to discuss ways in which the pilot could be delivered in the City.

In response to a question from the Chairman about a pending planning application, which might increase local residency by 260, the Director of Primary Care Commissioning advised that the Neaman practice would be able to meet this capacity. Members noted that all GPs had been given the opportunity to volunteer for the Pilot but that, to date, the Neaman Practice had not.

4. **OUTLINE BUSINESS CASE FOR ST LEONARD'S HOSPITAL**

The Committee received an outline business case, presented by the Director of Primary Care Commissioning. The report proposed a new resource centre at St Leonard's Hospital, Hackney, which would provide high quality community services and new premises for GPs. The scheme would allow the demolition of existing poor quality buildings on site and, subject to planning permission, the disposal of the site to provide a significant capital receipt for the NHS.

Members noted that the plans had been refreshed, with the existing and new estate scaled down to 3,200 sqm. The outline business case would be presented to the Board shortly and engagement with users would follow. A full business case would be ready within the next 12 months.

Members commended a clear and concise report but expressed some concerns about podiatry services remaining at St Leonard's, as the level of foot health services accessible to City residents was already low. The Director of Primary Care Commissioning agreed to communicate the broader concerns of the Sub Committee to the Clinical Commissioning Group. The Director explained that St. Leonards would be one of three 3 hubs in Hackney that were planned for foot health, with transport available for anyone with mobility problems who would meet the criteria.

RECEIVED

5. **CITY AND HACKNEY URGENT CARE PROGRAMME**

The Committee received a verbal update from the Director of Primary Care Commissioning. Members noted that, following discussion with the London Borough of Hackney's Health Scrutiny Committee, two walk-in centres in North East Hackney would close but GP access would be increased by 60%. The Committee was content that this was an issue which would not have an impact on City residents.

RECEIVED

6. **LONDON AMBULANCE SERVICE**

The Committee receive a report from the Service Development and Policy Manager. Members asked for reassurance that, given the extent of roadworks and the resulting changes to access arrangements; i.e. for the Barbican and social housing estates in the City, all crews are immediately issued with updated keys/passes. The Service Development and Policy Manager responded that although local crews already had keys, ambulances could often be called out from other areas of London to attend emergencies and it was not possible to equip all ambulance crews with keys and passes for all estates across London.

In response to a question about extra pressure during the Olympics, the Manager advised that although more ambulance services would be required for the Games period additional crews would be drafted in from outside London to ensure that the Olympics would be no adverse effect on normal services to residents.

RECEIVED

7. **ASSISTED CONCEPTION POLICY FOR SUB-FERTILITY**

The Committee received a report from the NHS ELC. This Policy defined the assisted conception treatments being offered in NHS East London and the City and set out the eligibility criteria for patients wishing to access those services.

In response to questions about the timescales referred to in paragraph 5.1 of the report, the Health Consultant explained that women over 36 are assisted for unexplained infertility after one year, because the treatment is only available for women up to the age of 40. Members noted that, given the sensitivities surrounding this type of treatment, the service do not retain patient details; this is held by the PCT.

The Health Consultant explained to the LINk representative who was concerned about the public consultation arrangements for this proposal, that legal advice had been taken on the appropriate level of consultation, and it was proportionate to the changes proposed. Some modifications had been made following further testing with LINks.

RECEIVED

8. **LEAVING HOSPITAL**

The Committee received a report from City LINk and noted that a 'leaving hospital' leaflet would be available in the next few weeks. Officers endorsed the report and offered to convene a meeting with Adult Social Care, Toynbee Hall and Bart's and the London to produce a single action plan in response to the report's recommendations

Members commended this report for its joined up thinking, particularly in the current financial climate.

RECEIVED

9. **INSIGHT IN TO CITY DRINKERS**

The Committee received a report of the London Substance Misuse Partnership which explored the nature, prevalence and attitudes towards alcohol misuse amongst 'City Drinkers'. Using these findings, it provided recommendations to inform possible actions to reduce alcohol-related harm in the Square Mile. Members noted that the results of the survey had conclusively found high and increasing levels of alcohol misuse, when compared to both regional and national averages.

The Chairman suggested, and Members agreed, that the problem would require a holistic approach with other lifestyle choices, such as smoking and obesity. The Manager from the Ambulance Service confirmed that they are working with the Police on this matter and are asking for more details about patients' lifestyles during call-outs.

RECEIVED

10. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

There were no questions.

11. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

Members were asked to note the Committee's visiting to the new A&E Department at the Royal London, on 12 July, at a time to be confirmed.

It had come to the Chairman's attention that Bart's and the London had reduced the hours of the Minor Injuries Unit at St. Bartholomew's Hospital. As it is used primarily in the mornings, the Unit would close in the afternoons, for a 3-month trial period. Officers confirmed that the Deputy Chief Executive of the Trust would write to the Committee l about the basis of the trial and consult on the outcome with the Health Scrutiny Committee prior to any long term decision being made. The Chairman suggested that Members raise this issue during their proposed visit to the A&E Department in July. The Manager from the Ambulance Service advised that they would raise it with their commissioners.

12. **DATE OF NEXT MEETING**

Thursday 25 September at 1.45pm

13. **EXCLUSION OF THE PUBLIC**
RESOLVED - That under Section 100A(4) of the Local Government Act 1972, the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A of the Local Government Act as follows:-

Item No.	Exempt Paragraph(s) in Schedule 12A
14	2
15-16	-

SUMMARY OF MATTERS CONSIDERED WHILST THE PUBLIC WERE EXCLUDED

14. **PROFILING MENTAL HEALTH SERVICE USE IN THE SQUARE MILE**
The Committee received a report from Canterbury Christ Church University (Centre for Health and Social Care Research).

15. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
There were no questions.

16. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**
There were no urgent items.

The meeting ended at 3.45 pm

Chairman

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Committee(s):	**Date(s):**
Health and Social Care Scrutiny Sub Committee	25th September 2012
Subject: Establishing Healthwatch City of London	**Public**
Report of: Director of Community and Children's Services	**For Information**
Ward (if appropriate): All	

Summary

From 1st April 2013 the City of London has a duty to provide, under the Health and Social Care Act 2012, a Local Healthwatch. This report outlines the background and development of Local Healthwatch nationally and the creation of Healthwatch England. It outlines the key priorities and characteristics of the proposed Healthwatch City of London specification which has been developed with the DoH Joint Improvement Partnership (JIP) and partner local authorities.

The report also updates Members on the work of the City LINk (Local Involvement Network) as an interim Healthwatch Pathfinder.

As a result of the work with the JIP and a consultation process with partner's and stakeholders, and having sought advice and guidance from the Comptroller and the Strategic Procurement Unit it is recommended that; to reduce any potential risk to the CoLC and to provide a credible, sustainable and cost effective Local Healthwatch the service should be tendered.

Recommendations

Members are asked to:

- Note the progress to establish Local Healthwatch and the current proposals for Healthwatch England,
- To agree the recommendations that (para 38) Healthwatch City of London should be established by tender process,
- To agree that the authority to appoint the successful provider of Healthwatch City of London be delegated to the Director of Community and Children's Services.

Main Report

Background

1. Members of the Health and Social Care Scrutiny Subcommittee have been monitoring the developments and progress of Healthwatch and received reports from Officers in February 2012 and from the City LINk in May 2011.

2. On 21 March Parliament passed the Health and Social Care Act 2012 which proposes the replacement of the LINks (Local Involvement Network) with a Local Healthwatch (LHw) on the 1st April 2013. In future the LHw will be the organisation that will act as the consumer champion for health and social care and a 'statutory function' of a Local Authority and the City of London.

3. The legislation requires the new LHw delivery organisation to be "not for profit" i.e. a Social Enterprise (charity, voluntary or community organisation). This makes LHw substantially different from the existing LINk which is a network of volunteers supported by a host organisation.

4. It is anticipated that the funding for HwCoL will be approx. £50,000 per annum (with a possible additional £20,000 in year one). This is the same as the current funding for the City LINk host organisation. The funding is non-ringfenced and will not be confirmed until November.

Progress nationally and regionally

5. Nationally the Department of Health (DoH) is sharing lead responsibility for LHw with the Local Government Association (LGA), each taking responsibility for health and local authority functions respectively.

6. The Health and Social Care Act 2012 also creates a new overarching body, Healthwatch England (HwE), from October 2012. HwE will represent LHw at a national level and will be a committee of the Care Quality Commission (CQC).

7. HwE will advise the NHS Commissioning Board, English local authorities, Monitor and the Secretary of State. HwE will have the power to recommend that action is taken by the CQC when there are concerns about health and social care services.

8. HwE will provide training, promote best practice, facilitate relationships with national bodies, collate intelligence and potentially coordinate 'enter and view' functions with CQC inspections.

9. CoLC has been part of the DoH Joint Improvement Partnership (JIP) Healthwatch Commissioner Group and has been working on a national

specification and guidance and advising the DoH and LGA on the implementation of the legislation.

10. The DoH issued Secondary Legislation on the 30 July 2012 and it aims to issue the final regulations (on contracts) and draft regulations (on entry and viewing) in October and November respectively.

Healthwatch City of London specification

11. Some of the existing responsibilities and features of the City LINk will be retained:
    - Promoting local involvement in health and social care matters,
    - Obtaining patient and public views, and keeping an 'issues log',
    - Monitoring health and social care services (adults),
    - Making reports and recommendations to Commissioners, Local Authorities and the NHS,
    - Carrying out Enter and View visits.
    - Maintaining and managing a volunteer membership base.
12. In addition HwCoL will be required to carry out the following new functions and roles:
    - Be the consumer champion for health and social care services in the City of London.
    - Obtain the views of people about their needs for and experience of local care services and make those views known to those involved in the commissioning, provision and scrutiny of care services, and make recommendations to HwE,
    - Be a member and responsible to the H&WBB, inform the local Joint Strategic Needs Assessment (JSNA) and the Health & Wellbeing Strategy,
    - Working in partnership to develop services with both statutory and SME
    - Have a scrutiny role for children's health care services (excluding Enter and View) and involved in service inspections.
13. The main HwCoL specification has been developed in conjunction with partner Boroughs and the JIP. The key characteristics are outlined in Appendix A and the full specification is available on request.

14. Due to its limited funding, the specification will require that HwCoL's main operational focus will be to work with the City's communities and promoting its services in the City. The national LHw role will be led by HwE and HwCoL's only wider responsibilities will be with a London regional LHw group.

15. The main features of the specification are a Governance framework, requiring the HwCoL Executive to be representative of the City's

communities, and measures to ensure the Executive has the skills and abilities to lead such an organisation. Also governance with regard to clear reporting lines and the raising of 'concerns'.

16. The specification will also require HwCoL to develop a partnership working approach, especially with the City's voluntary sector, to improve outcomes, reduce duplication and provided added value and value for money. Also to attract additional funding from other sources to endure the sustainability of the service.

17. An initial three year contract is proposed, subject to available funding each year. This would support the City's statutory duty and allow the new organisation time to develop the service and provide some organisational security.

18. A LHw is also required to provide a Signposting Service to the public to improve access to health and social care services. This replaces the current PALS service. For the first year it is proposed that this service will be provided with CityAdvice (managed by Toynbee Hall).

19. This would obligate the need to tender immediately and allow HwCoL to concentrate on establishing itself and developing a credible and effective operational structure. It will also ensure City residents and service users receive a responsive and knowledgeable service from day one.

Progress by Healthwatch City Pathfinder (City LINk)

20. City LINk was one of 75 LINks that applied and were granted Healthwatch Pathfinder status in autumn 2011. The City LINk has shadowed the national Healthwatch development. The Chairman of the City LINk represents LINks on the national HealthWatch Advisory Group, and the HealthWatch Programme Board.

21. The City LINk Steering Group has produced draft Terms of References, a Constitution and Articles of Association in readiness to become a Social Enterprise should it be required to transition to LHw. However it has not submitted applications.

22. A core group of members has been identified to stand as potential Trustees and a mailout to the wider membership has gathered considerable interest for support roles in a new organisation.

23. City Link has provided a position statement on their progress for Members, Appendix B. Further performance information is available on request.

Options for providing Healthwatch City of London

24. The commissioning officers in the Department have worked and consulted with partner Local Authorities regionally, the LGA and the JIP to develop the following options for providing a HwCoL;

Option One

25. To openly tender the HwCoL specification. CoLC would invite established Social Enterprises to provide their proposals for how they would create, support and deliver an effective and credible HwCoL.

26. A large percentage of authorities will be tendering LHw simultaneously and there is already a high degree of interest in LHw from Social Enterprises. This includes some of those who already provide services for CoL.

27. The tendering processes could create an opportunity for Social Enterprises to submit bids that demonstrate innovation and creativity as well as encourage ideas to obtain added value and value for money.

28. City LINk could submit a tender as an incorporated body or establish a legal agreement with a partner organisation (Social Enterprise). However, it would need to ensure that the organisation was viable and sustainable.

29. CoLC would need to begin the tender process immediately after Members decision to ensure a new service was in place for the 1st April 2013.

Option Two

30. For CoL to 'create' a HwCoL. A small number of Local Authorities have decided to form a new dedicated independent organisation and are proposing to provide administration support from within their Authorities.

31. With the CoLC's limited resources and small resident population this may prove difficult to sustain. Concerns have been raised about independence and probity of such an organisation.

Option Three

32. To 'transition' City LINk into HwCoL. To take on the additional responsibilities the City Link would need to finalise its preparations to become an incorporated body. The new organisation would have to be fit for purpose by the 1st April 2013. Should the City LINk become HwCoL it would need to be grant funded.

33. The City LINk would also need to agree to the HwCoL specification. To do so it would need to re-establish its governance in line with new the specification and offer all existing members an 'opt-in' to the new organisation.

34. It would also either have to agree a contract with a support agency (Social Enterprise) or recruit new staff to support the Executive and membership.

Option Four

35. To jointly tender with a neighbouring Local Authority. The City's partner boroughs are now already committed to tender independently in-borough. It is also still unclear, under the new legislation, whether joint tendering would be possible.

36. However, the JIP intends to hold a North East London 'meet the buyer event' in October to attract interested Social Enterprises on behalf of LB Hackney, Newham, Tower Hamlets and CoLC.

37. This may result in a pool of organisations tendering and winning multiple contracts in the NEL area. CoLC would pursue any arising opportunity to develop a joint or framework arrangement from the parallel tender processes with partner boroughs.

Recommendations

38. The Comptroller and City Solicitor, Town Clerk and Strategic Procurement Unit have been consulted on the options (para's 25-35) and for advice on the new legislation and to provide an assessment of the risks involved, (paragraph 40 below).

39. Following the consultation exercises and considering the advice received; it is recommended that, to reduce the potential risks, invite creativity, and improve value for money CoLC should tender for the HwCoL service (Option One).

40. It is proposed to invite a Member of Community and Children's Services Committee and a member of the H&WBB to be included on the tender evaluation and appointment panel.

Consultees

41. At the time of writing, both the Comptroller and City of London Procurement Service have considered the legislation and bearing in mind the significant 'duty' place on all local authorities, the unknown aspects of the provision and the current risks associated with transition tendering the HwCoL would be the better course of action.

42. The Town Clerks Department has also been consulted in the production of this report.

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Appendix A

Key Characteristics Summary of Healthwatch City of London Specification

Overview- Key Activities
1. Provide information and advice to the public about accessing health and social care services and choice in relation to aspects of those services; 2. Promote and support the involvement of people in the monitoring, commissioning and provision of local care services; 3. Obtain the views of people about their needs for and experience of local care services and make those views known to those involved in the commissioning, provision and scrutiny of care services and 4. Make reports and make recommendations about how those services could or should be improved. 5. Make the views and experiences of people known to Healthwatch England helping it to carry out its role as national champion; 6. Make recommendations to Healthwatch England to advise the Care Quality Commission to carry out special reviews or investigations into areas of concern (or, if the circumstances justify it, go direct to the CQC with their recommendations, for example if urgent action were required by the CQC);
Objectives
7. Produce a model for a single point of access for statutory services to access the service. 8. Provide a single operating gateway to ensure that all people who wish to become engaged are able to influence policy and health and social care provision. 9. Develop a sustainable network and work in partnership with local service User/carer organisations and groups across all service areas. 10. Develop strong working communication and relationships with the City and its partner organisations, inc the NHS and neighbouring borough LHws. 11. To work in partnership to ensure services are delivered within budget and bring added value and value for money to the CoLC, City residents and service users 12. To prioritise its operations according to the needs of the City's population (JSNA, etc) and issues raised by monitoring trends, issues and complaints. 13. Develop strong links with Black and Minority Ethnic groups. 14. Ensure that all member organisations of Healthwatch CoL have policy and procedures which have equality and diversity embedded in them. 15. Healthwatch CoL will sustain networks of service users and carers, patients and communities, including children and young people's groups, who are used for engagement on health and social care issues and be able to take on the delivery of user led services. 16. Healthwatch CoL will develop and maintain a membership structure for individuals and organisations as well as patients and communities including children and young people to join and take part in Healthwatch activities. 17. Healthwatch CoL will ensure its activities will reach all aspects of the CoL, and that will be its primary focus.

Core functions

Influencing

18. Co-ordinating and representing local voices.
19. Scrutinising the quality of service provision.
20. Championing the consumer voice on the Health and Wellbeing Board.
21. Informing the commissioning decision making process.
22. Providing local evidence based information.
23. Participating with commissioners in evaluating service change.
24. Ensuring that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment (JSNA).

Watchdog & Consumer Champion

25. Obtaining the views of local people,
26. Making those views known,
27. Making recommendations on the basis of views and information collected,
28. Championing quality and supporting people or groups to pursue and resolve issues,
29. Approaching commissioners and providers of services on people's behalf and seeking responses to particular concerns raised,
30. Alerting Healthwatch England to concerns about specific care providers.

Partnership Working

31. Develop and maintain networks and working relationships with all health and social care related providers working in the CoL and those providing services to CoL residents.
32. Work and develop working practices with stakeholders and partner organisations of the CoL to provide added value and value for money,
33. Liaise with partner LHw's where CoL residents receive services, as and when required.

Signposting

34. CoLC will not expect Healthwatch CoL to perform this function in year one or two.

Sustainability

35. Work with partner agencies to avoid duplication and improve effectiveness.
36. To extend reach and impact and improve services seek funding from other sources e.g. external grant giving and funding bodies.

Skills and Abilities

37. Use a mix of communication methods to reach the public including:
    a. Face to face (121, regular and one-off events)
    b. Telephone
    c. Traditional mass media
    d. Internet based communication
    e. Social media
    f. Workshops
38. Focus its activities on:
    a. Resident and Service Users of the CoL

b. Quality of services
c. Co-design and co-production of services
d. Monitoring and evaluation of services
e. Service commissioning
f. Accessibility of services
g. Risk and patient safety

39. Collect, analyse and share information by:
    a. Using data from the JSNA and other sources
    b. Triangulating data with insight from other local community and voluntary organisations
    c. Gathering individuals stories and experiences
    d. Knowing where hard to reach groups are located
    e. Making links between Health inequality and equality and diversity data
40. Work with specialist community and voluntary sector groups in the area
    a. Where there are already existing networks for these groups across London or a local authority area, making strategic contact with the network coordinators
    b. Understanding the different engagement strategies needed with different groups
41. A Healthwatch CoL will be able to demonstrate that they will have:
    a. An appreciation of the learning, experience and knowledge that already exists and has been collected in the City,
    b. A strategy to retain and build on this experience to ensure Healthwatch CoL is effective
    c. A culture which values the contributions of volunteers, members, governors and staff
    d. The skills and insight to understand commissioner and provider data to be able to analyse it and make informed challenge. This should include an understanding of the methodologies used to collect data,
    e. A development programme for staff and volunteers,
    f. Sufficient trained individuals to provide specialised functions e.g. enter and view, data analysis, information and advice,
    g. The skills to commission and monitor aspects of their functions from third parties if this is part of the proposed operating model.

Outcomes

42. Healthwatch CoL will make a positive contribution to the successful local achievement of outcomes set out in national frameworks for the NHS, primary care, adult social care and public health. Particular attention will be paid to:
    i. Improved patient and user experience.
    ii. Improved communication.
    iii. Improved satisfaction with health in CoL.
    iv. Greater patient and public involvement in health and social care.
    v. Strong relationship with commissioners and the Health and Wellbeing Board.
    vi. Improved access to services.
    vii. Improved people's understanding of their rights (consumer champion).
    viii. High public Awareness/Profile of HealthWatch CoL.
    ix. Good image/trust of Healthwatch CoL with the public.
    x. Develop a greater understanding of Children and Families Services, and have a scrutiny role for Children's Healthcare Services(excluding 'enter and View')

Governance

To ensure the credibility of Healthwatch CoL, it will need to demonstrate it has:

43. Representation at Board/Executive level that mirrors the City's communities and stakeholder groups.

Independence

44. Robust governance and management structures to fulfil its responsibilities to:
    I. Represent local service users and resident individuals in the CoL,
    II. The CoLC in terms of value for money,
    III. Healthwatch England and CoLC in terms of quality standards,
    IV. The governing organisation for the chosen corporate vehicle e.g. Charity Commission, Companies House and all UK legislation relevant to the organisations activities,
    V. The Nolan principles of standards in public life, the public sector equality duty under the Equality Act 2010 and the Freedom of Information Act,
    VI. Safeguard vulnerable adults and children in contact with it,

Accountability

45. Processes in place to ensure local accountability including:
    I. an annual meeting, open and accessible to local stakeholders/ members,
    II. a published annual report,
    III. audited accounts available for public inspection,
    IV. published organisational governance structures,
    V. twice yearly reports to the Health and Wellbeing Board,

Practice

46. Effective relationships with commissioners, decision makers and health and social care service providers,
47. A supported, skilled and competent Board/Executive, team of staff and volunteers,
48. The ability to present a range of views and voices of local people,
49. Systems in place to evidence the effectiveness of their influence and impact,
50. An understanding of the health and social care commissioning and decision making processes,
51. The ability to present data and findings in an effective, evidence based and influential way,
52. Sufficient accessible services for patients, service users and the public across their area,
53. Clarity of communications with the public and stakeholders resulting in a visible presence in the area they serve,
54. Transparency of internal processes, prioritisation, decision making and impact analysis,
55. Processes in place for seeking and responding to feedback and/or complaints about Healthwatch CoL development and its on-going work,

Appendix B

City of London LINk – Healthwatch Position Paper
10th August 2012
By the City of London LINk Steering Group

The City of London LINk seeks to achieve transition into Healthwatch City of London. It was awarded Healthwatch pathfinder status in August 2011 and since then has followed a clear action plan to build a suitable legal and financial foundation to enable it to become Healthwatch. This has included devising appropriate governing documents such as a memorandum and articles of association.

In order for Healthwatch to be successful in the City of London, the LINk believes that Healthwatch will need to be:

Sufficiently funded to undertake its duties
Local Healthwatch will need to represent the resident and worker population as well as tertiary service users at Barts. However, provisional funding levels from central government are calculated in relation to the number of residents in the City. This funding may not be sufficient alone, and if the organisation is to carry out its statutory duties, it must be sufficiently funded.

Structured to work independently
It is essential that Healthwatch can carry out its functions independently from commissioners and providers of health and social care services, enabling it to conduct its scrutinizing role without fear or favour.

Seen to be independent, competent and professional.
It is vital that Healthwatch is trusted by those who may use the organisation, and be accountable to them.

Seamless in transition
It is critical that momentum is maintained during the transition. The public need to receive an on-going service through the transition period and the work and enthusiasm of the current members of the City of London LINk must be transferred into Healthwatch. The LINk has formed a strong foundation on which Healthwatch can be built, and through which a smooth transition can be implemented.

Key achievements include:

Robust governance arrangements
The LINk has developed clear and transparent governance structures enabling the LINk to work as an accessible and inclusive body. It has formed a strong and accountable Steering Group, elected by the membership and reflecting the diversity of the members.

Strong membership
The LINk has a membership of over 180 local people and organisations and through these relationships has access to a wealth of local knowledge, skills and experience about health and social care provision across the local area. Active members contribute their knowledge into our work to influence service planning, policy and delivery.

Improved local services

The LINk is guided by community intelligence and priorities identified in the JSNA the LINk has a developed an effective work plan which is focused on a range of local priority issues. The LINk has made significant contributions towards developing the Joint Strategic Needs Assessment. This work has enabled the LINk to use its local knowledge to help develop local policy, influence local service development, and to strengthen relationships with partner organisations.

Engagement with the wider population (beyond LINk membership)
The LINk has developed a varied programme for engaging with the local community. The Community Champions Programme has enabled the LINk to reach diverse communities and ensure there is a regular dialogue about their health and social care issues which can be included into the LINk work plan. Through regularly attending community events such as residents meetings, local fetes and volunteering fairs the LINk has forged strong relationships with local residents.

Constructive working relationships
The LINk has developed positive, effective relationships with local statutory partners, including the City of London Corporation. The LINk has already developed good working relationships with new bodies being created by the Health and Social Care Act, including the Health and Wellbeing Board, the Clinical Commissioning Group, and the PCT cluster.

Committee(s):	Date(s):
Health and Social Care Scrutiny Sub Committee	25th September 2012
Subject: Update on the transition of public health functions to the City of London Corporation	Public
Report of: Vicky Hobart, Public Health Consultant (NHS North East London and City) and co-Chair City Shadow Health and Wellbeing Board	For Information
Ward (if appropriate): All	

Summary

This report seeks to update members on progress in the transition of responsibility for public health from the NHS to the City of London Corporation from 1st April 2013. In particular:

1. Appointment of a Director of Public Health
2. Publication of shadow public health grant allocation, and consultation on the proposed formula for future public health grant allocations
3. Health and Wellbeing Board, and new strategy
4. Joint strategic needs assessment
5. Transition programme
6. Transfer of commissioning responsibilities, including emergency planning and public health advice to NHS commissioners
7. Financial and risk implications

Recommendations

- That Members receive the report for information, and consider reviewing progress in light of the 2013/14 public health grant allocation, once published.

Main Report

Background

1. The Health and Social Care Act 2012[1] signalled the transfer of responsibility for Public Health from the NHS to Local Authorities, the NHS Commissioning Board, Public Health England and Clinical

[1] Health and Social Care Act (2012), www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Commission Groups from 1st April 2013. The vision for the new public health system was set out in 'Healthy People, Healthy Lives'. The impacts of guidance from Government relating to Public Health in the City of London were discussed at Health and Social Care Scrutiny Committee on 17th February 2012.

2. The City of London Corporation is considering the strategic changes to delivery of the public health function that will need to take place in order for it to improve the health of its communities, coordinate efforts to protect the public's health and wellbeing, and ensure health services effectively promote population health.

Current Position

3. The City of London will appoint a Director of Public Health. The appointment will be undertaken in collaboration with Public Health England, as required. Options for this post are being developed.

4. The City of London Corporation will receive a Public Health grant from April 2013. A shadow allocation of £1.4 million was published on February 7th 2012, based on historic levels of spend. This was the second highest allocation per head of resident population in the country- reflecting the levels of spend in Hackney, the second most deprived borough in the Country.

5. Subsequently, "Healthy Lives, Healthy People: Update on Public Health Funding"[2] set out proposals for the formula on which future public health grant allocations will be made. Notably for the City of London, the proposals do not include consideration of the public health needs arising form the non-resident population (e.g. commuters) and would lead to a significant reduction in the size of Public Health grant if implemented as is. The response to the consultation from the Shadow Health and Wellbeing Board is attached at Appendix A.

6. "Healthy Lives, Healthy People: Update on Public Health Funding"[3] reiterated that '*we have committed that the amount allocated to local authorities for 2013-14 will not fall below these (February 7th 2012) estimates in real terms, other than in exceptional circumstances'*. The actual grant allocation is expected by the New Year, and therefore the current working assumption is that the grant will be at least £1.4m.

7. The City of London Health and Wellbeing Board will oversee public health across the City of London Corporation. This Board currently meets in shadow form, and is developing the first health and well being strategy for the City of London. One of the key tasks of the Board from April 2013 will

[2] Department of Health (2012) Healthy Lives, Healthy People: Update on Public Health Funding
[3] Department of Health (2012) Healthy Lives, Healthy People: Update on Public Health Funding

be to oversee progress in the City of London against the outcomes set out in the new national public health outcomes framework (as well as the new NHS, adult social care and children's outcome frameworks).

8. The City of London Corporation will be required to produce an up to date Joint Strategic Needs Assessment. Historically this has been produced as the City and Hackney health and wellbeing profile. The Shadow Health and Wellbeing Board has requested that a JSNA handy guide is produced in 2012/13 for the City, incorporating the outcomes of recent research on the needs of City workers and alcohol.

9. The Director of Children and Community Services leads for the City of London on a recently established executive Health Transition Programme Board for City and Hackney. The Board has been established to steer the transition from the NHS to the City of London Corporation and London Borough of Hackney, given that the current NHS (primary care trust) budget is aggregated for the two localities, and from April 2012 the Clinical Commissioning Group budget for healthcare services will continue to be aggregated.

10. The Health Transition Programme Board has established a Public Health Strategy and Commissioning sub group, to work through the commissioning and procurement issues relating to those public health services and functions that will transfer to local authorities from April 2013. The group will make recommendations on;

    - Whether the City of London and Hackney commission jointly or separately,
    - Whether current public health services transfer as is, or require review.
    - Priorities for 2013/13 commissioning intentions.
    - How the requirement for local authority public health teams to provide public health advice to NHS commissioners will be met.

    The final decisions on these arrangements remain with the City of London Corporation and Hackney Council.

11. The City of London Corporation will be responsible for ensuring that there are plans in place to protect the health of the population, including public health, input to emergency planning arrangements, outbreak control, screening and immunisation. The City of London Corporation already holds responsibility for Port Health in London, and an initial meeting has been held between the Directors of the Health Protection Unit, Port Health and Public Protection, Children and Community Services, and Public Health to scope issues and risks.

12. A public health transition risk log is monitored at the Shadow Health and Wellbeing Board. Key risks identified to date include: uncertainty around funding, loss of key staff, loss of goodwill impacting on partnership working, and lack of clarity on the interface between different organisations delivering public health functions (for example, with the NHS commissioning board for screening and immunisation).

Conclusion

13. Plans to transfer Public Health responsibilities from the NHS to the City of London are progressing, and will be finalised once the 2013/14 public health grant is announced.

Background Papers:

1. 17th February 2012: Impacts of recent government guidance relating to public health (Farrah Meherali, Healthy City Development Manager, Children and Community Services)
2. 11th February and 22nd February 2011: Impacts of recent government legislation relating to health and adult social care (Sarah Greenwood, Policy and Communications Manager, Children and Community Services)

Appendices

1. City of London Corporation response to 'Healthy people, healthy lives: Update on Public Health Funding (August 2012)

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CITY OF LONDON

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Date 13th August 2012

Dear Sir/Madam

City of London Shadow Health and Wellbeing Board

Response to Healthy Lives, Healthy People: Update on Public Health Funding (June 2012)

The City of London's Shadow Health and Wellbeing Board involves representation from the following partners:

- Elected members of the City of London Corporation
- Officers of the City of London Corporation, including the Director of Community and Children's Services and the Director of Environmental Health and Public Protection
- Public Health Consultant for City and Hackney, NHS East London and the City
- City and Hackney Clinical Commissioning Group
- The City Local Involvement Network (City LINk – to be replaced by HealthWatch in April 2013)
- The City of London Police

The Board welcomes the transfer of public health responsibilities to local authorities, and the opportunity that this brings to tackle inequalities and improve population health. It welcomes the opportunity to respond to the recommendations made by ACRA regarding the move to a formula-based public health allocation.

The principle on which the proposed funding changes are based – moving away from the current model of funding, based upon historic spend, towards a needs-based approach grounded in population health, is both welcome and supported by the City's HWB.

The HWB's key concern is whether the actual formula proposed will truly be needs-based, whether it might actually increase health inequalities in certain areas, and whether the proposed measure is suitable for use in an area with a small population, such as the City.

Paragraph 2.12 details that ACRA's interim recommendation is based on the standardised mortality ratio (SMR) for those aged under 75 years (SMR<75).

The rationale for using SMRs over other indicators (e.g. Healthy life expectancy, Disability free life expectancy, IMD, etc.) has not been communicated in detail. In particular it is unclear if the SMR < 75 is a good measure when monitoring progress in reducing health inequalities in the early

years, which has been highlighted as key priority area for public health in the Marmot review. Use of SMR < 75 years also diverges from ACRA proposals for the allocation of funding to NHS health services – which is based on 'Disability-Free Life Expectancy[1]. In the public health outcomes framework the overarching indicator used is healthy life expectancy[2].

When calculating SMRs for a small population such as in the City, the uncertainty around this estimate will be large, and subject to variation year on year. There is a risk therefore that resources allocated on this basis would vary year on year, hindering service planning and development.

Other modifying factors that are relevant to the City include:

- High population churn/ turnover caused by migration into and out of the local authority. This is challenging for population health programmes, including the NHS health checks, and may get worse in another period of recession.
- The pace of change, and the extent to which the resource allocation keeps up with changes in the size and needs of the local population.
- The diverse ethnic profile of the population: leading to a variation in needs and effectiveness of interventions
- The communicable disease profile, and the need for local prevention and response (TB, blood borne viruses, infections acquired overseas) is particularly important for the City, which has the highest daytime population density of any local authority in the UK.

With regards to **paragraph 2.15**, we agree that an Area Cost Adjustment should be included to reflect the very high cost of providing services in the City of London.

With regards to **paragraph 2.16**:

Fixed cost adjustment

Some functions will need to be carried out by all authorities irrespective of size, supporting a fixed minimum allocation; this is very relevant to the City of London as the resources associated with a small resident population may be insufficient to deliver mandatory services. We strongly agree that a minimum fixed allocation will be necessary to deliver services in the City, particularly if we are to deliver the public health functions mandated to us.

Non-resident population

We strongly agree that the non-resident population of the City should be taken account of. With over 360,000 commuters entering the City each day, open access services must cover a population much wider than which we are funded for. There are also unprecedented opportunities to improve the health of workers who spend the majority of their waking hours here, and public health interventions that are applied here have the potential to deliver huge cost-savings to other parts of the NHS, across the south east and beyond. Unlike other authorities the City of London

[1] DH (2011) *Resource Allocation: Weighted Capitation Formula.*
[2] DH (20120) *Improving outcomes and supporting transparency.*

Corporation does not have sufficient public health funding for its resident population to deliver additional services for its non-resident population.

This is also important for the future planning of open access services in London i.e. those for whom access is not restricted to residents, such as sexual health services. In the absence of an effective recharging mechanism it will be challenging for local authorities to commission open access services.

Updates to the ONS population projections based on the 2011 census
We would like to point out that we have been working on allocating our original budget, based upon the government's original assertion that it would not change substantially from the original allocation. A sudden revision of budgets would leave us in an extremely precarious situation with regards to contracting and our arrangements with London Borough of Hackney.

With regards to **paragraph 2.17**, we are unaware of any evidence or rationale for using SMR<75 years to replace the current allocation formula for the pooled treatment budget for drug services, which the national audit office deemed effective. In the absence of the evidence/rational for this proposed change, it is hard to comment on the correlation between SMR< 75 years and the need for drug treatment services in that locality.

Previous work by the Universities of Glasgow and Manchester has focused on triangulation of data from drug treatment services, police, probation and prisons to identify opiate and/or crack users (OCUs)[3]. Resource allocation for substance misuse services should acknowledge poly drug use (including alcohol and stimulants), emerging drugs/legal highs, and the complexity/vulnerability of users (including housing status).

The NTA has acknowledged that the City of London provides drug treatment services to a small group of rough sleepers. The need component will make up 24% of the PTB, so understanding the impact of the shift to SMR <75 years is important.

With regards to **paragraph 2.23**, we would recommend that the pace of change is suitably slow to allow the City to adapt to what might be a 75% cut in public health budget.

The proposed changes in funding would make it extremely challenging to reduce health inequalities in our area. Unlike traditional health services, public health is inextricably linked with non-NHS local and regional funding, as it influences the social determinants of health. Local authorities are experiencing a decline in this funding, so scope for pooled funding may be limited in future. In addition, there is a pressing need to address public health challenges arising from changes to the housing and welfare system[4].

[3] http://www.nta.nhs.uk/uploads/prevalencestats2009-10fullreport.pdf
[4] Marmot review of Health Inequalities in England

There is a general question as to whether the 4% of the total health budget allocated for public health is adequate given the current and projected burden of ill health and health inequalities. Also whether the circa 42% of the national public health resource being allocated to Local Government is sufficient to enable them to develop the new system and address health inequalities over the medium term.

To conclude, whilst we agree that a formula-based mechanism based on population need is the most fair means of allocating public health funding, we are unclear that the SMR<75 measure is the most appropriate measure on which to base this formula. We think that a formula which combines multiple measures of health and population need would be more suitable. We agree that a *de minimis* allocation will be required to deliver services for a small population such as those resident in the City, and that a further allocation for non-resident populations would be appropriate in this instance.

We look forward to seeing the final recommendations at the end of 2012, and hope that they will take our comments and concerns into account.

Yours sincerely

Joy Hollister
Director of Community & Children's Services
Chair of Shadow Health & Wellbeing Board, City of London

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