Department of Health

Attachment 2

Department of Health – South East
Social Care & Local Partnerships Programme
Bridge House (1st Floor)
1 Walnut Tree Close
Guildford GU1 4GA

Switchboard: 01483 882255
Direct-Line: 01483 882504
Mobile: 07917 174917
Fax: 01483 882284
dave.shields@dh.gsi.gov.uk

Date: 30th June 2010

To:
South East LINk Chairs/ Leaders Network

South East LINk host organizations

South East local authority LINk leads

RAISE

My Ref. LINks 2010/ 012

cc:

Deputy Regional Director, Social Care, Local Government & Care Partnerships Programme (DHSE)

ADASS South East Regional Contract & Commissioning Group

SE ULO Leads Network

TASC Programme Lead (DHSE)

National LINk Forum members

Dear Colleague,

Funding for LINks in the South East – Planning for the Future

Please find attached a briefing paper in order to assist discussions within the region (and with other regional LINk programme leads) about developing an approach to how LINks might be supported in the South East after the current contract arrangements between the 19 upper tier local authorities and LINk 'host' organisations end in or before March 2011.

The financial situation is uncertain but – until such time as there is any legislative change – it is necessary to plan ahead on the assumption that LINks will continue and that local authorities will be required – by statute – to provide support to them. A government white paper on the NHS is expected shortly and this will include proposals for strengthening patient involvement and possibly a different role for LINks.

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I plan to hold separate briefings for LINk chairs/ leaders, host organisations and local authority LINk leads in late July in order to assess the situation in light of the forthcoming white paper's proposals and recommendations that affect LINks and wider user, patient and public involvement.

In the meantime I thought it would be useful to circulate this paper to the region's LINk stakeholder community to facilitate and kick start discussion within local government (principally the LINk leads, adult social care contract & commissioning leads, ULO leads and Health Overview & Scrutiny officers) and between local authorities and their LINks and host organizations in sub-regional 'clusters'.

I would suggest the following sub-regional groupings in the first instance although it may make sense in some areas to break these down to a more manageable size.

- **South Central (North**): Milton Keynes, Buckinghamshire, Oxfordshire and Berkshire
- **South Central (South)**: Southampton, Hampshire, Isle of Wight and Portsmouth
- **South East Coast**: West Sussex, Brighton & Hove, East Sussex, Kent, Medway and Surrey

Yours sincerely

Dave Shields, LINk Programme Lead (South East)

Discussion Paper: Funding for LINks in the South East – Planning for the Future

Although the financial situation for LINks after March 2011 is uncertain it is necessary – until such time as there is any legislative change – to plan ahead on the assumption that they will continue and that local authorities will be required – by statute – to provide support to them. A government white paper on the NHS is expected shortly and this will include proposals for strengthening patient involvement and possibly a different role for LINks.

The Secretary of State has set out his vision for a patient-centred NHS and the key points and some challenges arising from this for LINks in the South East are set out in an annex to this paper.

Context

During the period 2008-11 the 19 upper-tier local authorities in the South East region received a total of £10.42 Million from the DH to support the development of LINks in their area. This money formed a small element of the DH's contribution to the Councils' area-based grant (ABG) which allows local authorities flexibility in how the grant should be apportioned in line with local area agreement priorities.

Generally the region's local authorities have used most of the LINk component of their ABG to procure support services for their LINk from a 'host' organisation. A number of host organisations have been contracted to provide support to the region's LINks and help them evolve and develop. The host organisations also hold the funds for LINk member activities. In some instances local authorities have retained a small part of the ABG for LINks to support other related activities such as:

- costs associated with contracting and procurement
- ongoing contract performance and monitoring
- any interim host arrangements provided in-house or through an alternative provider
- publicity for LINks and wider citizen involvement in health and social care
- research to support the Council's health overview and scrutiny function
- social care user and carer involvement
- citizens surveys to assist with commissioning and the Joint Strategic Needs Assessment

It is possible that by March 2011 as much as 25% of the £10.42 million originally provided by DH for supporting LINks in the south east will have been spent on other items (both related and un-related). The money actually spent directly on or by LINks over this period, therefore, is likely to be nearer £8 million. This is for a number of reasons:

- a delayed start in the letting of host contracts in year 1
- underspends arising from a lack of LINk activity during the formative 18 months (years 1 and 2)
- termination of contracts with hosts and the need to bring LINk support services in-house while alternative arrangements are being sought (years 2 and 3)
- claw back of grant from local authorities experiencing severe financial pressures in-year (Year 3)

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Current Legislative Requirements

Arrangements for supporting LINks are described in Section 221 of the Local Government and Public Involvement in Health Act 2007 (see below) and this sets out the statutory obligations for local authorities.

The legislation requires that the LINk and any person contracted by the local authority to provide services to it cannot be the same. Local authorities and NHS organisations are also proscribed from being a LINk or a provider of support services. This has necessitated a triangular relationship between the local authority, a 'host' organisation and a LINk (once it has agreed and adopted a system for governance). This can be a complicated arrangement and relies heavily on good relationships and a bond of trust between all three parties.

The legislation does not prevent a LINk from securing additional funding from other sources (e.g. grants, commissions, trading activities or donations) either by itself or in partnership with another party such as its host organisation. However the DH, in making funding available to local authorities has reasonable expectations, that this money will be used to enable LINks to undertake its activities. Some of these activities will include the LINk contributions to DH and NHS consultation exercises and the provision of a commentary on health and social care organisations as part of the community intelligence gathering by the regulatory agencies (e.g. CQC). Although in some instances LINks can (and should) combine with neighbouring LINks or with overview and scrutiny committees there are very real costs associated with delivery of these types of activities. If LINks were to receive no income from local or national government it could not fulfill the minimum requirements.

LOCAL GOVERNMENT & PUBLIC INVOLVEMENT IN HEALTH ACT 2007, PART 14
PATIENT AND PUBLIC INVOLVEMENT IN HEALTH AND SOCIAL CARE

Local involvement networks

221 Health services and social services: local involvement networks

(1) Each local authority must make contractual arrangements for the purpose of ensuring that there are means by which the activities specified in subsection (2) for the local authority's area can be carried on in the area.

(2) The activities for a local authority's area are—

(a) promoting, and supporting, the involvement of people in the commissioning, provision and scrutiny of local care services;
(b) enabling people to monitor for the purposes of their consideration of matters mentioned in subsection (3), and to review for those purposes, the commissioning and provision of local care services;
(c) obtaining the views of people about their needs for, and their experiences of, local care services; and
(d) making—
(i) views such as are mentioned in paragraph (c) known, and
(ii) reports and recommendations about how local care services could or ought to be improved, to persons responsible for commissioning, providing, managing or scrutinising local care services.

(3) The matters referred to in subsection (2)(b) are—

(a) the standard of provision of local care services;
(b) whether, and how, local care services could be improved;
(c) whether, and how, local care services ought to be improved.

Improving LINk Performance

There have been some daunting challenges in establishing LINks mainly due to the very short time scale allowed to local authorities for procuring host arrangements following legislation (October 2007) and the announcement of the funding available (December 2007).

The requirement for local authorities to go down an open tendering route for a completely untested service in a relatively underdeveloped market place and – in the absence of timely and more definitive national guidance, performance indicators or model specification documents – this contributed to a hurried approach and a number of delays in starting the contract. In some instances the pressure to appoint a host led to the selection of organisations with insufficient local knowledge to meet short term expectations. Where host organizations held multiple contracts for supporting LINks, this stretched capacity still further. This was a particular feature of the pattern in the South East where no fewer than 13 of the region's 19 LINks were initially supported by two organisations.

Notwithstanding this the region's LINks have started begun to make a real impact through engagement of almost 10,000 members and 2,000 community and voluntary sector affiliates. Currently the main challenges for LINks in the south east are to strengthen relationships with and add value in the following areas:

1. elected members – primarily through the overview and scrutiny committees but also engaging ward councillors and district council level and town/ parish councillors
2. commissioners – building on existing good work with PCTs and extending this to social care commissioning and practice-based commissioning
3. regulators such as the CQC – providing community intelligence on services
4. the wider community and voluntary sector – with a particular emphasis on voluntary sector infrastructure organisations (councils of voluntary service), local social care 'user-led organisations' and local carers networks

It is by no means impossible to envisage that, by 2015, there should be 250,000 local residents and 10,000 local community and voluntary organisations with an interest in health and social care in the south east involved in the region's LINks. Moreover, it is entirely feasible that improved LINk performance on this scale can be achieved with fewer financial resources than that which was made available previously by adopting improved commissioning practices (based on experience and evidence of what works well) and by releasing the 'social capital' of the LINk members themselves.

Future Funding Scenarios

There is a growing body of opinion that DH support for LINks should perhaps in future be made available through a different funding route than the local authority ABG, thereby avoiding the temptation for some Councils experiencing intense budget pressures to divert resources to other local priorities.

Whatever funding mechanism is adopted, it will be important not to lose the valuable expertise and knowledge of those local authority officers who have been involved in establishing and supporting LINks over the past three years. However at present there is uncertainty about how LINks will continue to be supported financially after March 2011 and what impact legislative change may have.

It is very unlikely that the financial position for supporting LINks will be made until after the Comprehensive Spending Review announcement in late October 2010 and any legislative change will be informed by a white paper consultation exercise which won't be completed until early November.

Nevertheless local authorities and LINks need to prepare for how they will make arrangements for supporting LINks when the current host contracts expire in March 2011. There are a number of steps that can be usefully taken before the funding position is eventually clarified:

1. agreeing and setting out a local vision for the LINk describing key success criteria, outcomes and performance measures

2. signalling local commissioning intentions to the market, seeking expressions of interest and brokering consortia where necessary

3. establishing commissioning clusters where this might achieve better value for money and economies of scale

4. developing the capacity of LINk members to enable them to have input to the tendering process and - should insufficient finance be available from local and central government - secure alternative sources of funding for meeting their support needs

It may be helpful to assume that any formula for allocating DH finance for LINks will be in the same general proportions as before, even if the aggregated total for the region changes. It might also be useful to consider how LINk commissioning budgets could be divided into four separate different functional areas:

1. commissioning and procurement costs (10% of the total)

2. regionally commissioned specialist support such as website, communications, research and training (20% of the total)

3. local LINk member support such as community development, finance and administration (50% of the total)

4. LINk activities such as meetings, travel, publicity and local advertising (20% of the total)

Following informal network discussions with the some of the region's LINk leaders, local authority LINk leads and host organisations a number of potential funding scenarios have been identified. These are summarised overleaf.

Given the financial pressure on public services it would be prudent to assume that any central DH funding for LINks might be less than that which was provided previously. This in turn may require some local authorities to pool or align their funding for LINks in order to achieve the necessary economies of scale and/or ensure a consistent approach within local and sub-regional health and social care systems. If the level of central DH support for LINks falls below 60% of that currently provided, and no alternative sources of funding can be identified, there are fears that some LINks will cease to be viable.

Potential Funding Scenarios

Scenario 1

Where central DH funding is provided to the same extent as before via the Area-based Grant (£10.42 Million over 3 years in the South East)

Probability - Low

Scenario 2

Where central DH funding is provided via an alternative to the Area-based Grant but with:

1. a 20% reduction (£8.336 Million over 3 years in the South East)
2. a 30% reduction (£7.294 Million over 3 years in the South East)
3. a 40% reduction (£6.252 Million over 3 years in the South East)

Probability – Medium/High

Scenario 3

Where responsibility for funding for LINks is left to the total discretion of local authorities meeting costs out of their baseline grant from central government and local taxation

Probability – Medium/ Low

Scenario 4

Where central DH funding for LINks is transferred from local authorities to an arms length body (possibly in shadow form) with effect from either:

1. April 2011' or
2. April 2012, therefore requiring an interim LA-led solution during the transition period

Probability – Medium/High

Annex

Responding to the Challenges arising from the Secretary of State's Vision for a Patient-led NHS

The Vision

To realise our ambition for the ***NHS patients must be at the heart of everything we do****, not just as beneficiaries of care, but* ***as participants****, sharing decisions about their care with professionals.*

For patients, there should be "no decision about me, without me".

We must ***focus on outcomes and results that matter to patients*** *not the system.*

It means ***seeing things through patients' eyes as well as from a clinical perspective****.*

A "Patient Led NHS" will have an information revolution at it heart with ***shared decision making at every stage of an individual's care pathway****.*

Learning from patients' experience of care will become increasingly important and everyone – ***patients and professionals will be empowered to challenge and intervene*** *when things go wrong.*

A ***patient-led NHS will work from the front-line****, not the top, so that services are more responsive and timely for individuals, their communities and NHS services.*

Challenge 1.

How can the voluntary sector, social enterprises and professional bodies help to make empowerment work?

Sherry Arnstein's ladder of participation (see Figure 1 overleaf) has been used extensively by community development practitioners for a number of decades with an emphasis on a community approach to empowerment. This contrasts with an empowerment model favoured by health and social care policy makers where this tends to see things more from an individual client/ patient level.

The region's LINks, by working with the community, voluntary and social enterprise sector as well as service users are potentially well placed to assist various empowerment processes in a number of ways:

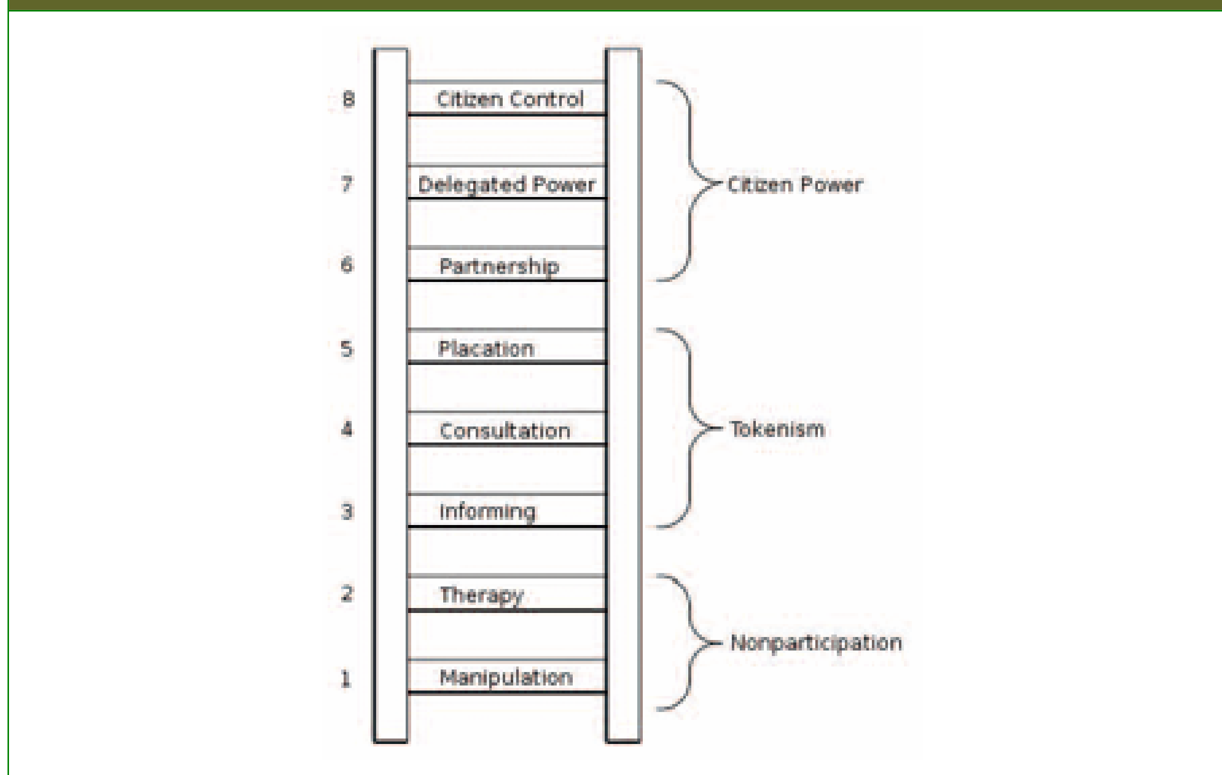
1. by enabling communities to have a stronger voice (e.g. through residents groups, patient forums, user-led organisations, carers networks etc.)

2. through development of alternative models of service delivery based on co-operation, co-production, mutualism etc.

3. by acting as intermediaries and advocates for particular groups

Commissioning processes (at each point in the cycle and at every level) should ensure effective input from service users and community and voluntary sector organizations. Currently certain professions are able to exert a strong influence over commissioning decisions and it will be important to ensure that this is balanced with the views, opinions and experiences of others working at the frontline of service delivery.

Figure 1: Ladder of Citizen Participation (Arnstein, 1969)



Challenge 2.

How can the culture of care ensure that patients' experiences and views are given weight and acted on?

The various systems for greater public and patient involvement supported by the DH at a national, regional and local level need to be effectively co-ordinated and aligned more closely to local authority and NHS systems for complaints and safeguarding. This could provide a key role for LINks at a local level as an *independent* 'network of networks', designed to operate along care pathways but provided with additional support to be able to participate more in supra-local, regional and national involvement activities provided by Monitor, the CQC, National/ Regional Voices and other umbrella-type organizations.

Currently there are a plethora of DH, NHS, and various other web-based systems for sharing information and data in relation to user experience, patient safety, quality etc., but these can often be bewildering and difficult to access for most NHS patients and service users. There is increasing support within the region's LINks for a simpler, user-led and accessible system to enable LINks and their members to exchange information and experiences.

Challenge 3.

What needs to happen for people's views, aspirations and experiences to be the reason for changes to be made?

Reciprocity, honesty and trust provide the key to effective community engagement and ownership. This means involving more local people more often when making important decisions on commissioning or, increasingly, de-commissioning. This may mean earlier engagement of people likely to be affected and a clearer exposition of the various options available to commissioners (including a rigorous financial and health impact assessment).

Commissioners need to ensure that the voice of front-line service users and providers (not just the professional bodies) is heard throughout each stage of the commissioning cycle. This should apply to commissioning at the GP practice cluster level as well as joint commissioning at a Unitary/ County Council level and more specialist areas of commissioning to be retained by PCTs (including public health).

This in turn requires far greater transparency of how the finances for health and social care services are apportioned locally and how the money flows through the system. Integrated health and social care commissioning systems need incentives to make more use of the local voluntary sector and social enterprises in enabling and adopting user-led innovative practice that can achieve outcomes at a lower cost to conventional practices.

In the current financial climate, serious thought will need to be given to which publicly funded services should be prioritised and how. Innovative approaches should involve service users as key drivers of change in order to achieve the degree of scale and diffusion necessary to achieve tangible savings in the short term. A review of whole systems planning and commissioning can also provide opportunities for more involvement of community and voluntary sector organisations in the delivery of some functions for which they are particularly fit for purpose.

It would be important to resist the temptation of seeing this sector solely as a means for driving down unit costs of some elements of care provision in the short term, especially if there is a risk that this would lead to a threat to patient safety, a diminution of quality and/or a transfer of a financial burden to other parts of the public sector. Commissioners would need to ensure that appropriate and transparent safeguards are put in place that would minimise these risks.