



Making Sense of the Changes

Understanding the Policy Context for Health Organisations in London



July 2011



Executive Summary

Approximately 80% of voluntary organisations work in the health and social care field. These are two areas that are seeing the most radical reforms started by the last Government and extended by the Coalition. Matched with the drive for localism and the Big Society the funding, influence and operational environment for all Civil Society Organisations (CSOs) is changing dramatically. This report aims to give an overview of the changes and consider how they might impact on frontline and strategic organisations.

On January 19th 2011, the Health and Social Care Bill was published and started its passage through Parliament. It is the largest piece of legislation since the creation of the NHS and lays the foundations for a radically different health service as well as bringing together several pieces of social care legislation. Along with the personalisation of social care and its expansion into health and support for children with special educational needs (SEN), frontline voluntary organisations will see a reduction in grant funding and less finance available for commissioning. Therefore selling to individuals will have to become a greater focus for organisations as a method of income generation.

Prevention will increase in importance for the statutory agencies, who want support in ensuring those in need are kept away from statutory services as long as possible to reduce costs. The eligibility threshold for social care is also increasing in most boroughs, leaving those with moderate or low needs to look to the voluntary sector, their community, family and friends for support to live independently.

The localism and Big Society agenda sees greater emphasis on communities helping themselves and stimulating the social capital within neighbourhoods. This poses a challenge to borough, sub-regional and regional organisations in London. It will also potentially impact on how commissioners want to see purchased services, expecting more localised delivery models.

As a result of these changes, LSX is making a series of recommendations: -

1. Both strategic and frontline organisations need to work with their committees to explore, consider and identify a strategic way forward for their organisations.
2. It will be vital that both frontline and strategic organisations to engage with their new HealthWatch.
3. Those organisations working in the health field will have to devote energy and time to positively engage with the new Clinical Commissioning Consortia. This will take time and is unlikely to result in quick wins.
4. In those boroughs that are actively supporting the Right to Provide for public sector employees, there may be opportunities for these new mutual organisations to involve voluntary sector organisations on their boards.
5. The personalisation of health, social care and some children's services will require voluntary organisations to be ready to realign their income profile to selling to individuals. This will involve unit costing all interventions, developing a marketing strategy, building relationships with brokers, getting a presence on brokerage websites and ensuring you have the cash reserves to move to payment on results/delivery.

6. For those organisations wishing to secure contracts, these will be of a larger scale and sometimes cross borough. Collaborative and consortium working may be required, especially for smaller groups if they wish to be successful in this arena. Getting tender ready now is an imperative for those organisations wanting to bid for contracts.
7. Consider how you engage and work with volunteers to achieve your mission. With less funding in the system from both statutory and independent funders, building a strong volunteer base will become more critical.
8. Strategic organisations need to align their activities to the new environment and consider their sustainability and mode of operation. This may require charging for some support services or operating more on neighbourhoods to have the most impact.

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Health Reform Introduction

On January 19th 2011, the Health and Social Care Bill was published and started its passage through Parliament. It is the largest piece of legislation since the creation of the NHS and lays the foundations for a radically different health service. The new Bill also has implications for social care by amending and bringing together elements from previous social care legislation. The reconfiguration of public health back to local authorities will also lead to a new route of engagement for voluntary organisations within those local authorities; away from the traditional voluntary sector grants officers or commissioners.

The Bill contains provisions covering five themes:

- strengthening commissioning of NHS services;
- liberating provision of NHS services (more freedoms in providers);
- increasing democratic accountability and public voice;
- strengthening public health services;
- reforming health and care arm's-length bodies.

As well as restructuring and modernising the NHS, The Bill also aims to make savings in the healthcare budget of over £5bn by 2014/15 and then £1.7bn every year after that. A large proportion of these savings would come from a significant reduction in bureaucracy following the abolition of strategic health authorities and primary care trusts and a reduction in management staff. The cost savings will impact on civil society organisations currently funded through Primary Care Trusts (PCTs), leading to increased applications to non-statutory funders. This will present pressures on trust funders especially who are likely to see increased applications from health based organisations.

80% of civil society organisations work in the health and social care field¹, and will therefore see a disproportionate impact to changes in health and social care policies, structures and legislation. The personalisation of social care and health will additionally change the way civil society organisations secure their income, moving from a grant or contract funding base to having to sell to individuals.

The majority of civil society organisations focus their work on prevention in healthcare which will link to the new public health arrangements. The largest intervention in health service provision is in end of life care, such as hospices, which are all charitable or private sector. Since it was created the NHS has focused on making people better and it is only in recent years that there have been efforts to improve the quality of care and service to those people who have terminal illnesses or are at the end of their lives (through old age).

Following the 'pause' in the Bill's progression through Parliament, The NHS Future Forum was created to engage a broad range of health and social care professionals, members of the public, voluntary and community organisations, patients and user groups to scrutinise the Bill. Their work completed in June 2011 and The Government has made a commitment to take all of their recommendations on board and amend the Bill accordingly. It will restart its progress through the parliamentary system and is expected to be approved later in 2011.

¹ NCVO Almanac

NHS Reform

Structural Change

Mirroring the Coalition Government's ambition to reduce bureaucracy and red tape across all areas of public service, the NHS reforms will see a new structure for the NHS, removing two tiers to save on management costs.

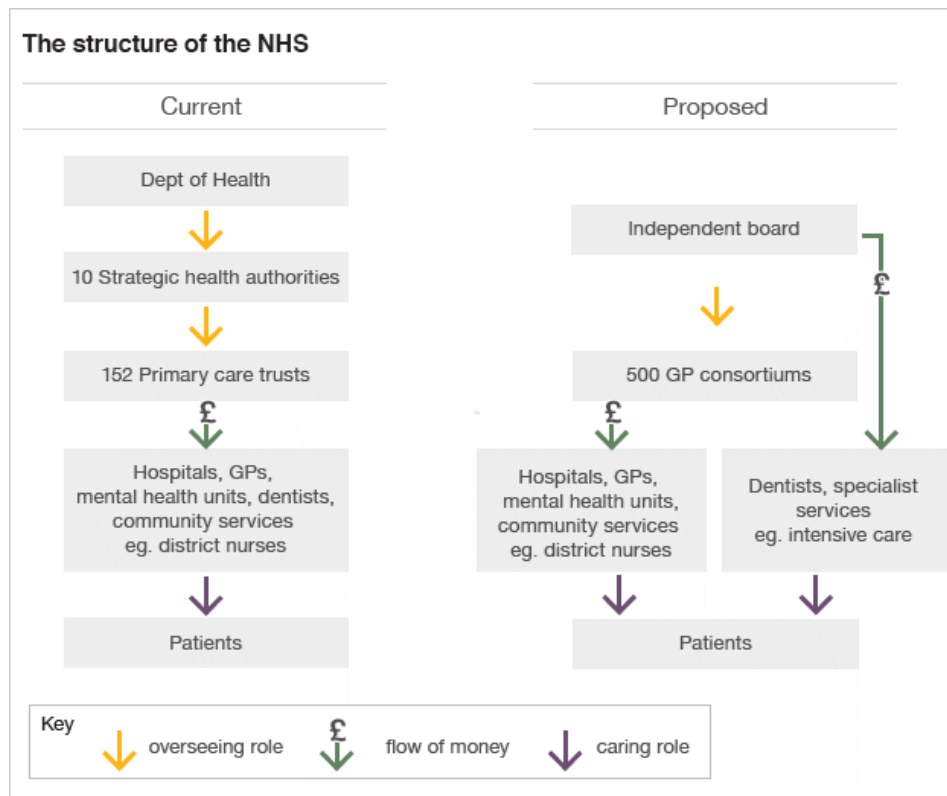
The power and responsibility for commissioning services is being devolved from Strategic Health Authorities and PCTs to local consortia of GPs. This fits in with The Government's localism agenda also going through Parliament currently in the form of the Decentralisation and Localism Bill 2011. This proposal gives GP Consortia financial accountability for the consequences of their decisions.

A new NHS Commissioning Board is to be developed and places operational management of the NHS at arm's length from ministers. However, the Secretary of State will still account to parliament for the performance of the NHS. The Board will need to strike a balance between operating as the 'lean and expert body' described in the White Paper, and having capacity to fulfil its extensive responsibilities, which include commissioning a range of services not commissioned by Clinical Commissioning consortia. The NHS Future Forum recommended that the NHS Commissioning Board is given a '**Choice Mandate**'. This would set the parameters for choice and competition in all parts of the service, for example promoting more integration and a focus on outcomes. It would also ensure that people are not excluded because they have complex conditions and that health inequalities are tackled.

Based on these principles, the NHS Commissioning Board would publish its plans to deliver choice and outline how competition should be used to support patients to exert more choice in the treatment and care they receive. It would then report on progress against these plans in terms of health outcomes and effective use of resources.

From April 2012 Monitor, which is already an independent board of the NHS, was supposed to have its role and funding expanded. The Bill initially proposed that Monitor would become an economic regulator for health and social care, with a focus on promoting competition. However as a direct result of NHS Future Forum, Monitor will now regulate to ensure the framework of patients choice is implemented and to protect citizens' interests.

The new Clinical Commissioning Consortia will have sufficient freedoms to use resources in ways to achieve the best and most cost-efficient outcomes for patients. With Monitor and the NHS Commissioning Board ensuring that commissioning decisions are fair and transparent, and patients' choice promoted. This devolution of power and responsibility for commissioning services to clinicians within consortia will mean that they will need the skills to commission more effectively.



Clinical Commissioning Consortia

Commissioning of healthcare will devolved to groups of GPs, nurses and hospital consultants that come together as a consortium. These local groupings will be responsible for around 80 percent of the total health budget and commission services from a range of providers, including those from the voluntary sector and social enterprises. A **new framework for choice and competition** will be developed to ensure that choice; quality and integration are central to the NHS and establish one set of principles to underpin decisions about delivering real choice and using competition. This would be supplemented by legal duties on the NHS Commissioning Board and Monitor to publish plans on how they are delivering choice².

Discussions and negotiations are currently taking place across the country between PCTs and GPs to formulate the consortia; these will now have to expand to broaden their reach to include hospital consultants and potentially local authority representatives. In some areas these may mirror current PCT boundaries, in others they be more aligned to the grouping of GPs who want to work together. The profile of consortia is expected to be clearer later in 2011. However there have already been three waves of Pathfinder Consortium approved, many of which are in London. The new consortia will take on their statutory responsibilities from April 2013, at which point PCTs will be abolished. The Bill gives the NHS Commissioning Board powers to compel practices to join, or be removed from consortia.

Although the structure diagram above identifies 500 GP consortia, ministers have not specified how many there should be. Some areas are further advanced than others and to date 141 groups of GPs, covering around half the population, have applied for Pathfinder Status (pilot schemes). This gives an early indication of the likely number of commissioning groups we may see.

² Choice and Competition – Delivering Real Choice; NHS Future Forum June 2011

The NHS Constitution embeds competition linked to people's right to choose:-

- **"You have the right** to choose your GP practice, and to be accepted but that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons
- **You have the right** to express a preference for using a particular doctor within your GP practice and for the practice to comply
- **You have the right** to make choices about your NHS care and information to support those choices."

Commissioning

Commissioning has been widely recognised as a weakness under the current arrangements, with PCTs lacking the knowledge and skills to challenge providers about the quality and efficiency of their services. The proposals build on previous initiatives such as GP fundholding in the 1990s and practice-based commissioning (PBC) in the last decade.

The Bill will create a level playing field in which patients' choice will be the driver for competition between agencies to provide NHS-funded services. Encouraging a greater diversity of supply that aims to improve patient choice and help stimulate innovation. It is this diversification of supply that is seen by many to mean the privatisation of the NHS.

Clinical Commissioning Groups must work within the new framework to ensure patients' needs are met through considering a range of providers, including those from the voluntary and private sectors. The best NHS providers should thrive, as more patients choose to use them, and funding follows patients' choices. Those providing poorer quality or unresponsive or inefficient services will come under increasing pressure.

The biggest change resulting from the NHS Future Forum's work is the increased emphasis on service integration, especially between health and social care.

Reforms to Providers

All NHS providers must become Foundation Trusts by April 2014 and The Bill relaxes controls over acquisitions and mergers. The sustainability of hospital trusts under the new NHS will be dependent on their number of referrals and market share. Those hospitals that fail to secure sufficient business will be allowed to fail.

A Provider Development Agency (PDA) has been established to support trusts to achieve Foundation Trust status. If current trusts fail to meet the standards required or do not achieve sufficient business under the new NHS market, the PDA will need to implement a planned reduction in service at hospitals or transfer services from current providers.

The transfer of current services does not have to be to another NHS provider, so there will be increased opportunities for private sector and voluntary and community organisations.

Monitor will be responsible for protecting the public interest in circumstances where providers fail and are allowed to exit the market by guaranteeing the continuity of 'designated' services, for example, ensuring access to A&E and maternity services within safe travel times.

Health & Wellbeing Boards

Under the current Local Strategic Partnership (LSP) arrangements at borough level, there exist Health and Wellbeing Partnerships or Thematic Action Groups (TAGs). As part of the Decentralisation and Localism Bill 2011, all requirements to have such partnerships are being abolished. However three of the partnerships that make up the 'LSP Family'; Crime and Disorder Reduction Board, Health and Wellbeing and Children's Trust Boards have a statutory duty to exist currently.

New proposals will see the statutory duty to have Children's Strategic Partnership removed and more statutory duties given to the Health and Wellbeing Board (HWB). In addition to joining-up the NHS, social care, public health and other local services. HWB Boards will be required to lead the development of the local Joint Strategic Needs Assessment (JSNA) to provide a strong information and intelligence system. They will also lead on the development of a Joint Health and Wellbeing Strategy (JHWS). The Bill will place a legal obligation on NHS and local authority commissioners to refer to the JSNA and to have regard to the JHWS in exercising their commissioning functions. The HWB Board must include a member of HealthWatch.

The Bill includes duties on the NHS Commissioning Board and HWBs to promote integration between health and social care and includes provisions to enable the Board or consortia to establish pooled funds. However, there is no equivalent duty on Clinical Commissioning Consortia to promote integration.

Integration could cover: -

- integration across primary and secondary care – GPs, community services and hospitals working together;
- integration across health, public health, education, and social care;
- integration across public, independent and third sectors; and
- integrated commissioning.

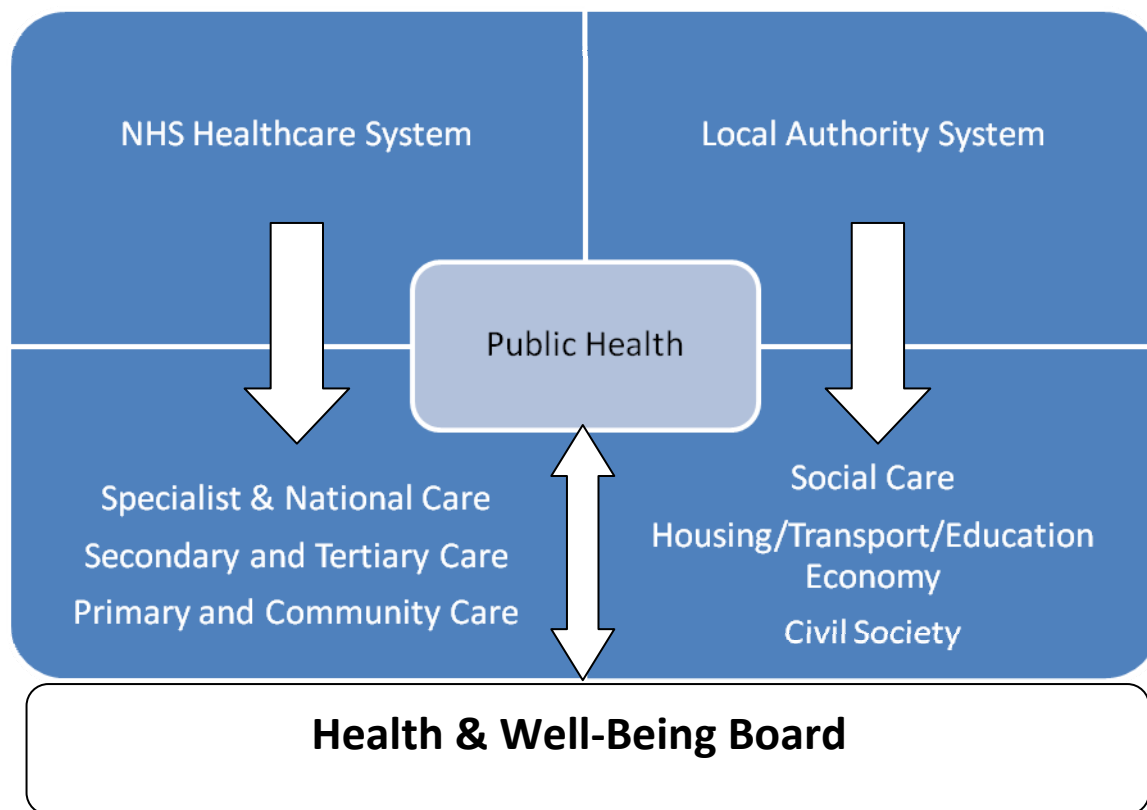
Public Health

The Bill abolishes the Health Protection Agency (HPA) and responsibility for public health leadership will return to local authorities, who will be expected to advise Clinical Commissioning Consortia to inform the commissioning of NHS funded services and facilitate integrated pathways of care for patients. Directors of Public Health will move from the NHS to local authorities. Local authorities will have a new statutory duty to take steps to improve the health of their population and will receive an incentive payment, or 'health premium', dependent on the progress made, based on elements of the Public Health Outcomes Framework.

This proposed change will impact on commissioners, as it will require developing new communication systems and relationships with the public health teams within existing local authority members. The public health teams will have a pivotal role in commissioning services and organisations that promote health and well-being, most of this activity is likely to be community based and delivered through civil society organisations.

The changes will put public health firmly back at the centre of mapping and assessing local health and social care needs and in conjunction with the Health and Well-being Boards agreeing local priorities for intervention. Due to the current cuts in public spending there is likely to be a gap between decommissioning current services and the new teams developing a

new commissioning framework. This gap could seriously undermine the sustainability of some voluntary and community organisations in London, who will be seeking alternative routes to funding as they move away from statutory sector support.



Patient Choice

Patients are currently able to exercise a choice of provider when they are referred for elective care. Choice will be extended into other areas of care including community services, mental health and diagnostics, with the aim of implementing choice for most NHS-funded services by 2013/14. Patients will also be able to register with any GP practice, regardless of where they live. The expansion of choice will be accompanied by an 'information revolution' to provide patients with access to better information about the performance of providers.

Patients Voice

In July 2010, the Government announced plans to set up an independent champion for health and social care consumers called HealthWatch England. Local Involvement Networks (LINKs) will become local HealthWatch organisations, affiliated to the national body.

The Bill retains LINKs' existing responsibilities to promote patient and public involvement, and to seek views on services which can be fed back into local commissioning; as well as having continued rights to enter and view provider services and continue to be able to comment on changes to local services. The role of HealthWatch will also have expanded functions and funding, for providing complaints advocacy services from 2013 and for supporting individuals to exercise choice. In particular, they will support people who lack the means or capacity to make choices. Local HealthWatch will be commissioned by local authorities in the same way operated under the LINK system; however they will have discretion to divide the advocacy element as a

separate contract. The majority of LINKs host contracts are currently held by civil society organisations.

Local HealthWatch will be able to report concerns about the quality of local health and social care services to HealthWatch England. Local HealthWatch will be able to do this independently of their local authority and HealthWatch England will be able recommend that the Care Quality Commission takes action.

The NHS Future Forum has also recommended the establishment of a Citizens Panel to be part of HealthWatch England. Its role will be to monitor patients' choice across the NHS and social care.

Conclusion

The Health and Social Care Bill is one of the largest pieces of legislation to come before Parliament and sees the most radical reform of the NHS. The reforms come at the price of savings in the NHS budget in years to come through less bureaucracy, reduced structures and more competition on price.

The Government is also proposing New Rights to Provide where public sector staff can propose to take over and run their services through social enterprises or mutuals. This could see some NHS teams deciding to float their service off as an independent business or cooperative and charge it back to the NHS, renting space within NHS buildings or specialist clinics. The Government is investing £10m to support this agenda and help new public sector staff mutual organisations get off the ground. Lambeth is the London Pathfinder for this initiative.

London Commissioning Profile

Even before Clinical Commissioning is fully implemented, the profile of London NHS funding will change as of April 4th 2011. This is a result of London NHS having to save over 50% of its management costs in 2011/12. Borough based PCTs will be merged into larger sub-regional arrangements before the full transition to GP commissioning i.e. Barnet, Enfield, Haringey, Islington and Camden will become one PCT in April.

The first wave of GP commissioning 'pathfinder' consortia, announced in December by the government, covers 12.9m people, around a quarter of England's population. However, the differences between the consortia suggest that the Department of Health is happy to allow experimentation over how they should be constructed. An obvious aspect is the range of sizes. The average pathfinder consortia will group together 35 GP practices serving 239,000 people – which, if typical, would suggest that 210 consortia would commission England's healthcare, not many more than the 152 primary care trusts currently doing the job.

At present there are 20 consortia that have been approved Pathfinder status in London, these will all have to reform their structures and agreement to embrace the NHS Future Forum recommendations. This is the current profile: -

Consortium name: Havering First Consortium

Coverage area: Havering (part of)

NHS region: London

Number of GP practices: 27

Population: 108,994

Consortium name: Havering Premier

Coverage area: Havering (part of)

NHS region: London
Number of GP practices: 22
Population: 143,416

Consortium name: Redbridge
Coverage area: London Borough of Redbridge (borough-wide), North West London
NHS region: London
Number of GP practices: 30
Population: 180,085

Consortium name: Waltham Forest Federated GP Consortium
Coverage area: Waltham Forest, UK
NHS region: London
Number of GP practices: 43
Population: 285,712

Consortium name: Barking & Dagenham Quality Healthcare Commissioning Consortia (BDQHCCC)
Coverage area: Barking & Dagenham (part of)
NHS region: London
Number of GP practices: 26
Population: 123,000

Consortium name: United Medical Consortium (UMC)
Coverage area: Barking & Dagenham (part of)
NHS region: London
Number of GP practices: 15
Population: 71,098

Consortium name: Newham Commissioning Group (NCG)
Coverage area: Newham (part of)
NHS region: London
Number of GP practices: 11
Population: 68,199

Consortium name: Bexley Clinical Cabinet
Coverage area: London Borough of Bexley (borough-wide), South East London
NHS region: London
Number of GP practices: 29
Population: 229,652

Consortium name: Croydon Healthcare Consortium
Coverage area: Croydon, UK
NHS region: London
Number of GP practices: 19
Population: 120,000

Consortium name: The Federation
Coverage area: Sutton & Merton
NHS region: London

Number of GP practices: 32
Population: 262,557

Consortium name: Richmond & Twickenham GP Consortium
Coverage area:
NHS region: London
Number of GP practices: 32
Population: 197,524

Consortium name: Wandsworth
Coverage area:
NHS region: London
Number of GP practices: 46
Population: 370,366

Consortium name: Lambeth Commissioning Collaborative
Coverage area:
NHS region: London
Number of GP practices: 52
Population: 377,624

Consortium name: Southwark Health Commissioning (SHC)
Coverage area: London Borough of Southwark (borough-wide), South East London
NHS region: London
Number of GP practices: 47
Population: 319,127

Consortium name: Victoria Commissioning Consortium (Westminster)
Coverage area: Victoria, UK
NHS region: London
Number of GP practices: 8
Population: 354,347

Consortium name: Central London Healthcare (Westminster)
Coverage area: Westminster, UK
NHS region: London
Number of GP practices: 23
Population: 133,947

Consortium name: Camden Commissioning Consortium
Coverage area:
NHS region: London
Number of GP practices: 39
Population: 224,450
Consortium name: Kensington & Chelsea GP Commissioning Consortium
Coverage area: Kensington & Chelsea, UK
NHS region: London
Number of GP practices: 42
Population: 185,000

Consortium name: Brent GP Federation
Coverage area: Brent, UK
NHS region: London
Number of GP practices: 71
Population: 354,347

Consortium name: Hillingdon
Coverage area:
NHS region: London
Number of GP practices: 49
Population: 273,256

The Pathfinders demonstrate there will not always be coterminosity between commissioning groups and local authority or health trust boundaries. 2011 is likely to see the remaining commissioning consortia approved there should be an estimated total of 25-30 in London.

Implications for London Civil Society Organisations

The relationship and funding streams from health to voluntary sector organisations across London has never been consistent and equitable. Some boroughs have a long track record of engagement with the NHS and often funding streams, others have had little historically to with the NHS and their focus has very much been on local authorities.

Direct Providers

1. Those organisations who have worked with or been funded by their local NHS will have to form new relationships as a direct result of the reforms. This is with immediate effect due to the new sub-regional arrangements that started in April 2011.
2. If the move to GP Commissioning goes ahead as planned, voluntary sector organisations will have to dedicate time to engaging and forming new relationships, alliances and partnerships with these groups. Historically GP engagement has been extremely challenging for front line voluntary organisations and will therefore be a drain on resources and energy if it is to be achieved.
3. There could also be opportunities with health promotion moving back to the local authorities. A lot of frontline voluntary organisations focus on prevention and health promotion and therefore getting forging active links to the new health promotion teams could be beneficial in terms of funding and recognition for the valuable work conducted at community level.
4. Strategic influence is possibly going to be the greatest challenge. HealthWatch is the only statutory requirement in terms of external engagement on the Health and Well-Being Boards where needs are mapped, priorities agreed and commissioning intentions scrutinised. Without a voice for the voluntary sector this could mean frontline organisations needing to be more active in their local HealthWatch organisations than they have with LINKs in order to ensure the sector's interests are fairly represented.
5. Some organisations may also be able to take advantage of the intention to open up the NHS market (if it goes ahead). However in order to be a willing provider organisations will have to meet NHS quality standards and frameworks; another layer of standards and compliance that are resource and labour intensive.

Strategic Organisations

The challenge for strategic organisations is ensuring that the interests and voice of the voluntary sector is not lost in the new structures. The local nature of GP commissioning puts pressure on regional strategic organisations of where to place themselves to have the most influence, at the same time the new structures may not be coterminous with borough based strategic organisations. There is a risk that those who speak for the interest of the sector will be marginalised in the proposed reforms.

Social Care Reform

The transformation of social care was started by the last Government and the direction of travel will be continued and expanded by the coalition. 100% of clients must be on self directed support by April 2012. Self directed support will all be available to children with special educational needs (SEN) from 2012.

Self Directed Support

Self-directed support is about people being in control of the support they need to live the life they choose. It is also often referred to as Personalisation.

Depending where you operate it is often referred to in different ways but at the heart of the principles is the desire to give people control and choice over their lives.

People are now able to self-direct their care or support in a number of different ways:

A Personal Budget

A personal budget is money that is available to someone who needs support. The money comes from their local authority services and is based on their needs assessment and personal support plan. Each authority sets tariffs for how much they are willing to pay for certain interventions such as homecare, meaningful daytime activity (formally day care) or respite.

Once someone's personal support plan is costed, the client can take control of this budget or their representative and buy services to meet the agreed support plan outcomes or employ people to support them. In order for the system to work the client or their representative must:

- know how much money that they have for their support
- be able to spend the money in ways and at times that make sense to them
- know what outcomes must be achieved with the money

Personal budgets allow the client flexibility to take money for support they wish to buy and leave responsibility for other areas of service with the local authority. It is this flexibility that really provides control and choice.

An Individual Budget

An individual budget is money for support that could come from several places - including social services, the Independent Living Fund, Access to Work and Supporting People. This is different to a personal budget as it brings together funds from various different Government Departments and has a broader remit than just social care.

To date individual budgets have been piloted in 13 areas across England. It operates on the same model as personal budgets despite having a broader funding base. A prime example of joined up government!

A Direct Payment

A direct payment is money that is paid directly to the client so they can arrange their own support. This was introduced through the Community Care (Direct Payments) Act 1996 and has only had a gradual increase in take up across the country. In most cases those people having direct payments employ their own support staff to help them live independently. In the majority of localities there is a support service for people on direct payments to help manage their money, recruit staff and provide payroll services.

A Personal Health Budget

Personal health budgets are relatively new and the Department of Health is still in the process of piloting them. A personal health budget is an allocation of resources made to a person with an established health need (or their immediate representative). The Health and Social Bill 2011 proposes to expand the role of personal health budgets in the NHS system.

Impact on Commissioning

The more clients who take up self directed support and control of their care or health budget, the less money commissioners will have left to buy services on contract. Over time this will gradually erode the value of public sector contracts available particularly in social care. Those contracts that remain are likely to be larger and over greater geographical areas to offer cost efficiencies to the purchasing authority.

Some contracts that will be available may be offered on a framework basis. This means that providers will tender to provide services to meet outcomes the authority has identified. If successful there may be no guarantee of work, it just means you are an approved provider. When a client then presents a need that you can meet, the authority can contract with you to deliver without having to go through a full tendering process.

Due to pressures on public funds at present a lot of contracts will also focus very much on keeping people away from needing social services support. The prevention element of public sector commissioning is very high on the agenda at the moment and this is characterised by the London Borough of Barnet. They are recommissioning nearly all their social care services with a huge emphasis on interventions that support people to live independently for as long as possible so they do not need to access social care support.

Implications for London Civil Society Organisations

As 80% of voluntary sector organisations work in health and social care, there are huge implications for direct providers and strategic organisations.

Direct Providers

1. Those organisations that rely on or want to benefit from public sector contracts in social care will be competing against other voluntary organisations, private sector providers and possibly public sector employee owned mutuals. It is therefore vital they are tender ready and in some cases depending on your size have partnerships or consortia ready or in development to take advantage of opportunities.
2. More funding will be available from direct sales to those people who have control of their budget. This is fundamentally a cultural shift for many voluntary and community organisations. It requires new approaches to selling and marketing services and challenges traditional cash flow where you were often paid in advance. Under personalisation you will be invoicing in arrears for services delivered requiring sufficient reserves and new financial management and invoicing systems.
3. Enterprise will need to be at heart of those organisations who want to be at the heart of providing services for people who have opted for self directed support. This will impact of skills and flexibility of the workforce as well as how you recruit and engage volunteers in what you do.
4. Many organisations have already decided that engaging with the new funding environment is a cultural step too far. This could see them moving away from public sector funding to other fundraising approaches such as the American model of events, friends and sponsors. Or a return to being totally volunteer led and run which links in nicely with the Big Society agenda.
5. Whatever option is pursued, standing still is not viable. All organisations need to take stock, reflect and seriously consider their objects, approach and strategic path forward if they want to be sustainable.
6. Those services that are commissioned are also in many cases being moved to local delivery. Commissioners appear to want services embedded more in neighbourhoods and less at borough level. For small community groups this could be a real advantage but does pose challenges to borough or cross borough providers in realigning that they do and how it is delivered.
7. There will be great emphasis on commissioned services keeping people away from statutory services at all cost. This is already becoming apparent in Barnet who are recommissioning most services in 2011/12 and the draft framework in Sutton also has a similar focus. Therefore organisations need to look at their outcomes and impacts and clearly demonstrate how their interventions play a role in keeping people living independently in the community as a long as possible.

Strategic Organisations

Those organisations with a strategic role for the third sector, facilitating a voice or providing direct infrastructure support are potentially face bigger challenges than direct providers.

Infrastructure and funding for strategic organisations is under immense pressure due to cuts in public sector spending. It also appears to be valued less by the Coalition. At the same time the demand for support to cope with the changes is increasing from direct service organisations.

In social care there are a number of options available for strategic organisations to ensure sustainability: -

- (i) Charge for support services to the direct service providers. If the services are of sufficient quality and correctly priced *some* organisations may be willing and able to purchase them
- (ii) Transform into a special delivery vehicle (SDV) where you tender for contracts and then sub-contract down to members. This could be especially valuable as a mechanism to support smaller organisations that will be disadvantaged in the contracting environment. It must be recognised however that this would fundamentally change your relationship with your beneficiary organisations or members.
- (iii) Focus on the providing the back office functions that smaller organisations will need support with when selling to individuals through self directed support such as; invoicing, financial management, marketing and brokerage.

The Decentralisation & Localism Bill 2011

The Decentralisation and Localism Bill 2011 is now going through parliament and is at committee stage at present. The Bill outlines and formalises the Coalition Government's ambition to decentralise power from Westminster and give local authorities more powers and flexibility to respond to the needs of their local area without Government targets or monitoring.

The Bill has five main aims: -

- To lift the burden of bureaucracy
- To empower communities
- To increase control of public finance
- To diversify the supply of public services
- To strengthen accountability to local people
- To open up government to public scrutiny

Reducing Bureaucracy

The Bill has many measures included that remove or reduce the target culture that has developed in local government. It also changes the profile of partnership working in local areas dramatically, leaving how collaborative working is facilitated to local discretion.

The Bill removes any responsibility from Government to assess and monitor performance of local authorities and also the requirement for Local Strategic Partnerships, such as the ESP. Bureaucracy and red tape is cut dramatically through the abolition of Local Area Agreements (LAAs) and Comprehensive Area Assessments (CAAs).

With the abolition of Regional Development Agencies (RDAs) such as the London Development Agency, there will be greater emphasis on local plans and strategies such as The Sustainable Community Strategy. All regional strategies are to be abolished including Spatial Strategies for planning, which will give Councils back ultimate control of what happens within the borough boundaries.

The Standards Board currently in operation for the monitoring of councillor's behaviour will also be abolished and monitoring of the council will be in the hands of local people. Councils will also be given the power to return to governance systems from before 2000 if they wish. This would mean Councils could move back to the committee system and away from the cabinet model of governance if they so wish.

Empowering Communities

The Bill will give councils a New Power of Competence, which means they can do anything as long as it is legal. This will allow councils freedom to innovate if it's in the local interest. Partnership work will be one of the things used by councils to demonstrate competence, although this will be measured through the ballot box, as the Audit Commission is being abolished.

Community Right to Buy will be a new power introduced through the law. The Bill will require local authorities to maintain a list of assets in their area which have community value, these could include post offices, village shops, and local pubs, community centres, open spaces, parks etc even if they are owned privately. Communities will be able to nominate assets which they believe should be included in such a list. If the asset is to be sold, the community must be given time to develop a business case as a potential bidder.

Community Right to Challenge will be another new provision in law. Where people are not happy with a public service they have the right to challenge if they think they can do it better. Community is defined as a voluntary or community body, or a body of persons or a trust which is established for charitable purposes, as well as parish councils. When considering a challenge, the local authority must consider whether accepting it would promote or improve the social, economic or environmental well being of the authority's area.

Voluntary and community groups need to be cautious of this new power, as it will not automatically mean that the challenging group will have automatic rights to run the service if the challenge is accepted. A formal tendering process will have to be run, where the group will have equal right to bid against other providers, in line with standard procurement practice.

The Bill also introduces massive reform of the planning system to allow communities to have more control of their local area. The Bill introduces the right for communities to shape their local areas by creating a "**Neighbourhood Planning Authority**" (NPA). The NPA could be based on existing neighbourhood forums and once created will operate for 5 years. The idea here is to empower communities to have more control over the physical and social fabric of their neighbourhood.

Local Control of Public Finance

As well as the current freeze on council tax for the next two years, The Bill proposes further reforms by introducing **Council Tax Referendums**. There will be no more Central Government council tax caps, instead local people will be given the power to veto council tax rises if they are above a threshold set by Government. Referendums can be called to vote on tax rises, if the residents feel the rises are unacceptable.

Councils will also be empowered to offer **Business Rate Discounts**, so they can respond to issues from local business and help stimulate neighbourhoods.

Current planning legislation introduced a new charge on developments called the **Community Infrastructure Levy**. This replaces the old the Section 106 agreements between the council and developers. Under the new bill councils will be required to invest planning gain back into the area from which it was raised and not disperse the benefits across the borough.

In an extension of Enfield Council's ward based community funding, The Bill introduces **Community Budgeting** from 2013. Communities will be able to pool different sources of public funding to tackle cross cutting or common themes in their neighbourhood, known as 'place-based' budgets.

Diversify the Supply of Public Services

As a result of the Community Right to Challenge the Government believes there will be a diversification of suppliers in the delivery of public services. Linked to the Community Right to Buy, the ambition is that communities will take over local buildings and services and run them themselves. This approach is at the heart of the Big Society agenda and could see an erosion of the role of local government in meeting people's needs.

Although not specifically in the decentralisation and Localism Bill, the diversification in supply of public services is also embedded in other legislation currently going through Parliament. The changes to education will allow **Free Schools** run by parents or teachers to be developed and in the affluent boroughs in London, some have already been approved.

Another new piece of legislation also introduces **New Rights to Provide** where public sector staff can propose to take over and run their services through social enterprises or mutuals and contract back their services to the local authority or NHS. The Government has allocated £10m so far support this initiative and there a series of pilots around the country called Mutual Pathfinders.

London has four pathfinders piloting the new approach to delivering public services.

- I. Hammersmith and Fulham Children's Services exploring new models of delivery with staff, possible commercial partners and neighbouring local authorities
- II. The Lambeth Resource Centre exploring options for coproducing services with employees, service users and third sector organisations to provide rehabilitation support for people with physical and sensory impairment
- III. The Royal Borough of Kensington and Chelsea working with employees to examine the potential for different models of employee led youth support services

- IV. Westminster City Council working with employees in Children's Services and neighbouring local authorities to move towards creating an arms-length mutual organisation

Government Scrutiny

In order to make central and local government more transparent and accountable, all Government spending over £25,000 will have to be published by April 2011. All Council spending of £500 or more will also have to be published from April, as well as a raft of measures to increase transparency on contracts, salaries and staffing.

Accountability to Local People

Referendums seem to be the key approach to increasing influence and empowering local people through this legislation. The Bill gives new powers to instigate a referendum by local residents, a local authority must hold a referendum if they receive a petition to do so which is signed by 5% of electors. The people signing the petition must be on the electoral register and live within the borough boundaries. The duty is not absolute, the local authority will determine whether the matter is relevant to the local area and can reject requests.

Implications for London Civil Society Organisations

Localism offers real opportunity to organisations embedded in neighbourhoods and working with communities of geography/place. As commissioned services reduce, there will be an important role for voluntary and community organisations to help fill the gap.

Direct Providers

1. The localism and Big Society agendas will mean a greater drive for capturing the social capital in communities through engaging more volunteers to help others. Locality has been awarded the contract to roll out Big Society across the country and will be recruiting Senior Community Organisers and Community Organisers during 2011/12. It would be positive and constructive if existing groups engaged with these Organisers to ensure there is no duplication of activity and encourage positive partnership working.
2. The proposed register of assets of value to the community could be a real way of voluntary and community organisations getting the buildings they use for delivery i.e. community centres, church halls etc some level of protection and security.
3. The ambition to diversify the supply of public services should work in the best interest of voluntary and community sector providers. However, as standard procurement rules will apply this is likely to exclude small organisations from playing a part unless they work in collaboration with others. It must be noted that in a tendering process all partners must meet the Pre-Qualifying Questionnaire (PQQ) or Business Questionnaire that forms the first part of the process. It would be advantageous therefore for all groups to get a copy of their borough's PQQ and gradually work towards meeting these standards in readiness.

Strategic Organisations

1. The localism and Big Society agenda is likely to direct the work of strategic organisations to community development and volunteer recruitment activity. If the social capital in our communities is to be maximised, there will need to be work that helps voluntary and community organisations engage better with broader communities and understand how to recruit and support more volunteers in their direct service delivery.
2. The lobbying and campaigning function for strategic organisations is likely to also see a massive impact as a result of funding changes and the drive for a local voice of communities. This will pose a challenge for regional and national organisations in focusing their activity to have the most impact and influence.
3. With so much structural and policy change in this field, frontline organisations will need information, advice and support in understanding how to best use the right to challenge, right to buy, and how to play a part in the right to provider in partnership with public sector employees.

Recommendations

The cuts in public sector finance and the realignment of statutory agencies and their roles over the next two years will affect all voluntary and community organisations that have a relationship (funding or otherwise) with the statutory sector.

1. Both strategic and frontline organisations need to work with their committees to explore, consider and identify a strategic way forward for their organisations. This report could act as a framework for discussions and to consider the sustainability of organisations in light of the changes.
2. The increased importance of the Health and Well-being Boards with a HealthWatch representative changes the profile of influence in health and social care at borough level. The one representative will have to be the voice of patients, service users and the wider public and in some cases an advocate for the voluntary sector. It will therefore be vital that both frontline and strategic organisations engage with their new HealthWatch to ensure this is enabled.
3. Those organisations working in the health field will have to devote energy and time to positively engage with the new Clinical Commissioning Consortia. This will take time and is unlikely to result in quick wins.
4. In those boroughs that are actively supporting the Right to Provide for public sector employees, there may be opportunities for these new mutual organisations to involve voluntary sector organisations on their boards. Therefore organisations need to keep an eye on developments and identify possible opportunities, if they would be advantageous for your organisation or beneficiaries.
5. The personalisation of health, social care and some children's services will require voluntary organisations to be ready to realign their income profile to selling to individuals. This will involve unit costing all interventions, developing a marketing strategy, building relationships with brokers, getting a presence on brokerage websites and ensuring you have the cash reserves to move to payment on results/delivery.

6. For those organisations wishing to secure contracts, these will be of a larger scale and sometimes cross borough. Collaborative and consortium working may be required, especially for smaller groups if they wish to be successful in this arena. In order to be successful you need to consider the following: -
 - Are you PQQ ready?
 - Have you got partners or other organisations where consortium working may increase your chances of success in the commissioning processes?
 - Are you happy to work collaboratively or do you want to go it alone?
 - Do you need to review and amend your governing document?
7. Consider how you engage and work with volunteers to achieve your mission. With less funding in the system from both statutory and independent funders, building a strong volunteer base will become more critical.
8. Strategic organisations need to align their activities to the new environment and consider their sustainability and mode of operation. This may require charging for some support services or operating more on neighbourhoods to have the most impact.

Readiness Checklist

To help organisations in London, LSx have developed a simple checklist to assist organisations assess their readiness for the potential changes.

General for Strategic and Direct Providing Organisations		
		Tick
1.	Has your board or committee devoted time to considering the changes and how they impact on your sustainability?	
2.	Has your organisation developed a strategic/business plan so you ready for the changes and no reactive?	
3.	Has your board and staff team got the right skills and knowledge to be able to respond appropriately to new environment and changes in business approach?	

Health and Social Care Changes		
		Tick
4.	Have you engaged with LINK and the transitional HealthWatch arrangements to ensure the voice of your service users and your organisations are adequately represented on the Health and Well-being Board?	
5.	Are you clear of the development for the Clinical Commissioning Consortia for your area?	
6.	Are you aware of any public sector staff looking to create a mutual to deliver public services locally?	
7.	Do you want to play a role in any public sector staff mutuals for service delivery?	
8.	Have you costed your services in readiness for personal budgets and selling to individuals?	
9.	Have you got a clear marketing strategy for your services so you are able to secure business by selling?	
10.	If you are going to tender for services are you PQQ ready?	
11.	Are you part of consortia and partnerships so your organisation is best placed when tender opportunities arise?	
12.	Have you reviewed your governing document to ensure you are able to sell services and possibly cover a larger geographical area?	

Big Society and Localism		
		Tick
13.	Have you got a big enough volunteer base to sustain activity in the event of cuts in funding?	
14.	Have you explored how you could deliver services more in neighbourhoods and be a part of local communities?	

Strategic Organisations		
		Tick
15.	Are you clear of support requirements of your members and how they can be met in the future?	
16.	Have you considered your delivery model and whether it is local, regional or bigger?	
17.	Have you assessed how you will influence policy in light of the changing profile of agencies in London?	