

Our health, our care, our say – One year on

Making it Happen – The Third Sector

Event report, actions and next steps

DH INFORMATION READER BOX	
Policy	Estates
HR / Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working
Document Purpose	For Information
ROCR Ref:	Gateway Ref: 8294
Title	Our health, our care, our say - one year on. Making it Happen - the Third Sector
Author	DH
Publication Date	30 May 2007
Target Audience	PCT CEs, Local Authority CEs, Directors of Adult SSs, Directors of Children's SSs, Directors of Commissioning, Voluntary Organisations, Social Enterprise Organisations
Circulation List	
Description	This report details the points raised at the event held on 12th March 2007. It includes points raised in workshop session discussions and the final plenary session, and also gives a brief description of current and future departmental work in these areas.
Cross Ref	Our health, our care, our say: a new direction for community services Commissioning Framework for Health and Well-being
Superseded Docs	
Action Required	N/A
Timing	N/A
Contact Details	Michael West Care closer to home policy team Richmond House 79 Whitehall London SW1A 2NS Tel. (020) 7210 5040
For Recipient's Use	

Contents

Foreword	4
Introduction	5
Workshop notes - Direct Payments and Individual Budgets	6
Workshop notes – The social enterprise model	9
Workshop notes – Caring for people with long-term needs	11
Workshop notes – Smaller third sector organisations	13
Notes from afternoon plenary session – identifying opportunities, removing barriers	16
ANNEX A – Slide presentations - the commissioning environment (morning plenary session)	
ANNEX B – Slide presentation – Direct Payments and Individual Budgets	
ANNEX C – Slide presentations – The social enterprise model	
ANNEX D – Slide presentation – Caring for people with long-term needs	
ANNEX E – Slide presentations – Smaller third sector organisations	

Foreword

This report captures the issues and challenges facing the third sector in the context of delivering the strategic aims set out, just over one year ago, in the White Paper *'Our health, our care, our say'*.

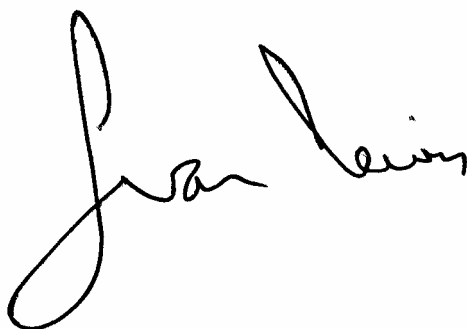
The White Paper identified greater third sector involvement, in both commissioning and service provision, as a key factor in realising its goals of improving health and well-being and giving people more choice, a stronger voice, and better access to a wide range of community services. It recognised that third sector organisations have a wealth of knowledge and experience, of both health and social care services and local service user needs, which have the potential to translate into provision of the kind of high-quality, user-focused services which the White Paper envisages.

This report also follows the publication of the *'Commissioning Framework for Health and Well-being'*. The framework addresses many of the issues and actions identified by the Third Sector Commissioning Task Force in their report *'No excuse. Embrace partnership now. Step towards change!'* This set the Department, and others, a number of challenging tasks with the aim of producing a much-strengthened third sector.

This document provides a timely reminder, not only of the issues affecting the sector, but also that there is still much to do if we are to achieve the true partnership of equals between the public and third sector to which we all aspire. The Department's leadership – taking the right approach at national level to address key issues – will be vital to meeting this challenge.

We are doing this through the establishment of a formal programme delivery board - which I chair - consisting of and led by senior departmental officials, and complemented by non-DH members. The board will ensure that the Department is held accountable for its actions, and will be able to 'reality-check' some of the discussions and outcomes.

The Board will be complemented by an external 'sounding board' and a programme of NSPF Learning Events, thereby ensuring that we continue an open and transparent dialogue with the third sector. Together, these arrangements provide an important mechanism for meeting the challenge of embedding the sector, in all its diversity, into the Department's programmes going forward, and through which to address the issues and challenges highlighted in this report.

A handwritten signature in black ink, appearing to read 'Ivan Lewis'. The signature is fluid and cursive, with a large initial 'I' and a long, sweeping underline.

IVAN LEWIS

Introduction

“Making the Happen – The Third Sector” was held on 12th March 2007, forming one of a range of events marking one year since publication of the White Paper *Our health, our care, our say*. The event provided an opportunity for representatives of third sector organisations, of all sizes, to discuss the key issues facing the sector, both with each other and with senior officials from the Department of Health. The day included a plenary session on commissioning, along with workshops on Direct Payments and Individual Budgets, the social enterprise model and caring for people with long term needs. There was also a session aimed at specifically addressing the issues affecting smaller third sector organisations.

This report details the points raised at the event, including both notes taken from workshop session discussions and delegates’ points from the final plenary sessions. The slides used in both the morning plenary session on commissioning and in the workshop sessions are enclosed as annexes.

Delegates and speakers were given an opportunity to comment on a draft of the report, in order to ensure that it provides an accurate record of the points made on the day. We are grateful to all who contributed.

Action and next steps:

The report also contains details of work being done, by both the Department and other organisations, to address some of these points. These are intended as a brief indication of current and future activity, as well as pointing the way to other resources which are available to assist the sector in developing their role in relation to commissioning and service provision. This information is included in blue boxes at the end of each section.

Local action and joint working:

As well as work underway nationally, many of the barriers to increased third sector involvement in health and social care services can be resolved by effective joint work working at local level. We therefore hope that the issues identified in the report will prompt action, by both commissioners and third sector organisations, at local level.

Case study examples demonstrating how effective commissioning by statutory and NHS organisations working jointly with third sector organisations can lead to a more innovative and dynamic health and social care service, better designed to meet users needs, can be found in the NSPF publication “Making Partnerships Work: Examples of Good Practice”

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072998

Direct Payments and Individual Budgets

Copies of the slide presentations used in this workshop are included at **ANNEX B**

- There was a general welcome for Direct Payments but there was some concern over commissioning of services. Local needs could clash with the strategic vision that commissioners would need to take – how could Individual Budgets and Direct Payments commissioning be correlated?
- Some de-commissioning of services would occur, as these services did not fit the needs of users. However, as Individual Budgets and Direct Payments grow, commissioning will need to be smarter. There should be a move away from spot purchasing, to challenge the services provided by building levels of personalisation.
- The intention is for everyone to have a notional Individual Budget, and not everyone would move to Direct Payments.
- There was some concern over how you can rationalise choices in this area for mental health users. There was also concern about providing Individual Budgets in a residential care setting.
- Outcomes should be the starting point for Individual Budgets; intelligent commissioning and increased take up would follow on from this. Decisions should be based on the outcomes across care planning from the White Paper. Planning is underway now around outcomes, and more thought was being given on this for the 2008/09 planning round. The aim is to have a common set of outcomes at all levels, including performance assessments mentioned in the recent Communities and Local Government White Paper *Strong and Prosperous Communities*.
- Support plans need to be tightly focussed on individuals. As part of the Individual Budgets on-going evaluation, outcome comparisons will be made for individuals not holding an Individual Budget. Detailed research is needed for commissioning to ensure levels of service match the needs of users.
- Individual Budgets are about giving people what they want. Providers need research – gathering information by clever commissioning is the key.
- The problem for many people who take up an Individual Budget is that they are unaware of what is available. Advocacy and brokerage services should play an important part here and the funding and development of this service should not be forgotten. Care managers can develop advocacy skills (as shown in Individual Budget pilot sites) but work is needed to develop this skill and it will vary across the country. The potential for a conflict of interest exists where providers are also advocates.
- There are no targets for take-up rates for Individual Budgets although there is a strong push to increase the uptake of Direct Payments. The evaluation of the individual budget pilots in

spring 2008 will give a clearer picture of these services and support the decision about whether or not to roll out in this form.

- A care user spoke of her experience and felt that her original care package was like going back to infancy – Direct Payments transformed her life. Although she was happy with Direct Payments, she was offered an Individual Budget. Although sceptical at first, she was impressed that the first question in the Individual Budget assessment was around what was important to her – not what care she needed. Her major aim was to stay out of hospital and control of her own budget has enabled her to do this. If you give people control, they are able to use the money in ways which are of greatest benefit to them.
- The importance of support behind Direct Payments and Individual Budgets was emphasised.
- In an IB pilot project in Essex care users have become peer mentors - helping spread the benefits of Individual Budgets. If providers work with users to secure best outcomes, the user can talk direct to them, thereby reducing bureaucracy. Older people may not want to be budget holders and may prefer providers to carry out this role for them.
- There is an opportunity to develop the services of providers, as well as the market in which they operate. Traditionally, providers would carry out shopping for a user – in the future, the providers may look to help the user go shopping instead through smart use of Direct Payments.
- Direct Payments should meet the needs of the care user, not be clawed back by the local authority. In principle, Direct Payments and Individual Budgets should be cost neutral.
- With mental health services there may be a conflict between low-level needs and urgent care packages. Six-month, rather than yearly reviews, were suggested to overcome this. The key with all Individual Budgets is flexibility.
- Spring 2008 is the due evaluation date, but the personalisation agenda is now. Individual Budgets and direct payments are mechanisms to help deliver this personalisation of services. 30% of service users are self-funders and there is no reason that providers cannot develop their services to fill this potential market as well as meeting the needs of those receiving statutory services.

It is important that we have effective commissioning which is based on a wider perspective of the needs of the local population. The Commissioning framework for health and well-being supports this approach and explains the importance of undertaking a Joint Strategic Needs Assessment across local health service commissioners and local authority partners.

There is an important role for local authorities in creating a climate where providers want to operate - providing the range and diversity of service provision that will offer real choice and flexibility to those using services. It is also important to remember that this approach will also help to meet the needs of those people who fund their own care and support needs.

Work is currently in hand to identify ways to support local councils in offering direct payments and a toolkit will be launched later in May.

We are continuing work on support brokerage and advocacy through the Individual Budget Pilot sites and are currently looking at the extent and role of user-led organisations to support the further development of personalised services and peer support.

For more information about this work please contact: IBPILOTS@dh.gsi.gov.uk

The Social Enterprise Model

Copies of the slide presentations used in this workshop are included at **ANNEX C**

- The presentation explained the principals of social enterprise, and outlined the work of the Social Enterprise Unit. This included the social enterprise pathfinders, announced in January, 2006. During the presentations a number of general points were raised as follows:
- There was a question about what type of support would be available for social enterprise pathfinders.
- It was pointed out that it is sometimes difficult for people such as those at Business Link to understand social enterprise. Would such advisors be up to speed on the transition from the public sector to social enterprise?
- The resource pack – “Welcoming Social Enterprise into health and social care - a resource pack for social enterprise providers and commissioners” is available via DH website www.dh.gov.uk/socialenterprise.
- Local authorities should be included in social enterprise work.
- We should avoid carving social enterprise out from the wider third sector- all of the third sector should be seen as socially enterprising. To maintain community involvement in a social enterprise, the process is vital. Different areas will need different processes of involvement.
- Social enterprise lends itself more readily to replication in other settings / areas rather than a growth model where a particular social enterprise expands its scope / territory.
- There is potential for social enterprise and the third sector to collaborate more (eg- around back office support, bringing learning about efficiency together, access to social enterprise support).
- Level of support for work on health issues varies across different Regional Development Agencies.
- Investment- needs a balance of equity and capital. A speedy and non-bureaucratic process is required.
- There is a need to educate commissioners about third sector opportunities. There should be mutual understanding based on needs, converted to outcomes. Commissioners need to be prepared to take risks.

The Social Enterprise Unit at the DH was created “... to promote a vibrant social enterprise sector in health and social care” – its main aims are to:

- Support the development of social enterprise business model
- Open up marketing and commissioning to social enterprises

- Encourage new entrants to social enterprise
- Champion the value of social enterprise

Currently its objectives are:

- Providing support and information eg a resource pack and website
- Setting up a social enterprise investment fund from April 2007
- Identifying and working with social enterprise pathfinders

More information about the Department's social enterprise work can be found at:
<http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Commissioning/Socialenterprise/index.htm>

For further information contact social.enterprise@dh.gsi.gov.uk

Caring for people with long-term needs

Copies of the slide presentations used in this workshop are included at **ANNEX D**

- Growing numbers of older people and the increasing needs of people with long-term conditions (LTCs) are having a big impact on NHS and Social Care resources. The White Paper explores ways of delivering services in new and different ways, including more self-care.
- The ambition of commissioners and current service providers to shift more care into the community and to give people more say in their care needs to be delivered. Third sector has a crucial role in driving change and putting people and their families first.
- Many people with more complex LTCs need and want care plans. Care plans need to show what services are available; where people can get good advice to help them manage their condition; and where they can get access to specialist support when they need it.
- Pilots were underway to support change in areas such as information prescription pilots; the establishment of a community interest company for the expert patients programme; start of an expert carers programme; individual budgets and an end of life strategy.
- Commissioners need to understand that getting out-and-about and helping people to socialise can have a major impact on people's health and well-being. People with LTCs live constrained lives and PCTs need to be more driven by the health and well-being of patients.
- Good work is taking place in some parts of the country. In Hampshire Good Neighbour schemes with GPs, Health Visitors, social workers and the voluntary sector were sign-posting the other health and social care services.
- Need for stability in funding. Third sector was innovative, but living on a knife-edge. There were concerns that PCT would often only commit to one year, there was an appreciation that funding was never going to be long term, but 3 year funding cycles were considered important.
- More needed to be done on prevention and to get in earlier to treat chronic disease to slow down or prevent progression.
- A more informed public debate is needed about service change. The public are cynical about change because they are often not fully informed about service gain and only see service loss.
- A culture change will be required for GPs to use their practice based commissioning (PbC) resources for interventions other than medical care. The Department may need to work with PCTs and GPs to address this. There were also questions around possible PbC contracting models for third sector services (for example, would GPs commission direct with the third

Making it Happen – The Third Sector

sector, or would contracts be held by the PCT?)

- David Colin-Thomé suggested that a workshop was held to really explore how the third sector could be more fully utilised to drive through improved services for people with LTCs, and how people and third sector organisations could be a stronger voice for change.

As a result of these discussions, the Department will be hosting a workshop on third sector involvement in caring for people with long-term needs.

This event work through the issues raised during this workshop, with particular focus on how Third sector providers to realise the benefits of practice based commissioning. It will be run by David Colin-Thomé, National Clinical Director for Primary Care.

This event is planned for summer 2007, and will be in collaboration with the National Strategic Partnership Forum (NSPF).

For more information about NSPF Learning Events please contact vcsmail@dh.qsi.gov.uk

Smaller Third Sector Organisations

Copies of the slide presentations used in this workshop are included at **ANNEX E**

- Commissioners must recognise that the majority of VCS organisations are small, local bodies which are not used to the commissioning and contracting process.
- Small organisations in the sector are often fiercely independent. This sometimes acts as a barrier to partnership working between organisations/providers and partnership bids for contracts, as smaller organisations they fear they will be taken over by their larger partners.
- Commissioners need to recognise that third sector services are not a cheap option.
- Short-term funding is a major threat to the work of smaller third sector organisations, particularly smaller ones. Short-term funding also makes it difficult for organisations to retain staff. There is a serious risk that some organisations may fold before fully developed commissioning plans are in place. Transition funding could keep organisations going in the mean time.
- A wholesale shift from grants to contracts for third sector organisations risks depriving some smaller organisation of vital working capital. The extra costs associated with making a tender need to be recognised by commissioners and reflected in market development strategies.
- Services commissioned from third sector are more likely to be cut when funding becomes tight. PCTs and LAs are more likely to retain the services of those with whom they have legally-binding contracts. The sector needs to better demonstrate its value and impact on delivery or strategic outcomes to commissioners.
- Ring fencing money for the voluntary sector would prevent some funding problems.
- The report of the third sector commissioning task force identified a number of barriers to effective commissioning from third sector organisations. The recently-published commissioning framework for health and well-being addresses these barriers. However, the proof will be in how this impacts on commissioners' behaviour.
- PCT and LA funding for social enterprise is taking money away from the traditional voluntary sector model.
- Smaller organisations will benefit from the new commissioning framework – but only if we get it right. The framework is currently out for consultation. Smaller organisations should take advantage of this opportunity to shape the final version.
- There is concern that the new commissioning model will primarily benefit large organisations – as they have the staff time to work on contracts. The complex process of tendering and contracting for services is a potential barrier to smaller organisations entering the market if application of the proposed model is not sensitive and proportionate. This is

not a model they are used to – it does not feel ‘real’ to them. Smaller organisations should be given support to help them with the contracting process.

- Some delegates were concerned that the commissioning framework will suit the large national providers, and that structures will be put in place to assist small, local providers, meaning that it is the *smaller national providers* which are most likely miss out.
- There were concerns that the Department is not engaging sufficiently with smaller providers. The NCVO provider network might be a useful vehicle for this communication in future.
- Smaller organisations often do not receive information and communications from the Department and from local commissioners. Improving communications and information sharing is a vital prerequisite to increased involvement.
- Commissioners need to understand third sector providers in their area. Third sector organisations can help with this by ensuring that commissioners understand what they have to offer. Direct access to commissioners – preferably face to face - would greatly assist with this, but is difficult to get at present. Commissioners need stronger market and community engagement strategies. The third sector need stronger commissioner engagement strategies.
- Increasing mutual understanding between statutory and third sector organisations can be done in a number of ways, for example through staff secondments. Secondment of staff to third sector organisations is also a way of providing support to third sector organisations without the need for formal contracting.
- Intermediary bodies could broker relationships between commissioners and small providers. Some umbrella organisation (such as LMCA) already do this. In many areas however, intermediary bodies need to be promoted and require long-term investment. Local authorities could help by fostering local partnerships within the third sector.
- It must be remembered however that intermediary bodies / umbrella organisations are rarely able to represent all of their members’ diverse views. It is therefore vital that smaller third sector organisations also have direct access to local commissioners.
- When working with statutory or independent sector organisations, VCS bodies are often not treated as equals, because of their dependency on income from the public sector and/or charitable donation.
- Partnerships and consortia of small organisations may make them more visible to commissioners and enable them to tender for larger contracts. However, there was also concern that commissioners do not have the necessary skills to handle partnership tenders.

Third Sector and Social Enterprise Delivery Board, which met for the first time on 25 April, will provide high-level accountability for ensuring that the cross-cutting issues affecting third sector organisations, including small organisations, are taken into account across relevant departmental programmes, including those affecting small organisations.

The Department is producing a guide for third sector providers on being commissioned by the NHS.

The Department is also planning to arrange a workshop to explore development of stronger mutual understanding between commissioners and the third sector.

For more information about this work, please contact: thirdsector@dh.gsi.gov.uk

Plenary session – Identifying Opportunities, Removing Barriers

During this session delegates were asked to identify and write down the one action which would make the most difference to their organisation. These priorities were then fed back to the group and discussed. The points written down and raised in this session have been grouped by subject and are listed below.

The commissioning relationship:

- DH commissioners and the third sector need to better understand each other's values, risks and needs. A key part of this is for commissioners to understand the finance and culture of third sector organisations. As a first step towards this, commissioners should 'get to know' third sector organisations, of all sizes, to understand how they work.
- At local level, all organisations should recognise and understand each other's potential and actual contribution to services.
- Commissioners need to understand the third sector and be open to allowing it to help shape services. Ultimately, a better understanding between the sectors will lead to a better working relationship.
- Involving the voluntary sector in commissioning at local level will lead to better mutual understanding between commissioners and the sector.
- Local communities need to understand the commissioning process. This will ensure that they can fully participate in the commissioning debate.
- A mature relationship between commissioners and third sector providers will help to ensure that commissioning is about quality and not just costs.
- Partnerships with the third sector should be consistent with the principles of equality, trust, respect and transparency.
- A secondment / exchange programme between the public and third sectors would increase understanding.
- Commissioners need a solid understanding of community need, which they can then convert into outcome-based commissioning plans.
- Business skills in the third sector need to be improved.

- Commissioners should be prepared to take risks – the third sector provides innovative services that can have a potential impact on the delivery of strategic outcomes.

The Commissioning Framework for Health and Well-being has been designed to foster a good relationship between commissioners and third sector providers. All current and potential providers will be encouraged to enter and operate in the health and well-being arenas, and commissioners likewise encouraged to make best use commissioning to make the most of the expertise available within the third sector.

The framework is out for consultation until 29 May 2007. Third sector organisations are encouraged to give their views on the document by responding to the consultation via www.commissioning.csip.org.uk.

More information on the framework is available at www.commissioning.csip.org.uk

The new Third Sector and Social Enterprise Delivery Board has identified the sector's need to engage with commissioners positively and confidently as a key priority to be addressed. The Department will explore with the sector what needs to be done, and by whom, to enhance the sector's business skills.

Contracting issues as part of the commissioning process:

- There are many different contract types and processes – need more co-ordination between public sector organisations to simplify this.
- Policies need to be consistent over a longer period to give stability to the planning process.
- Commissioning, and within this contracting, need to be as straightforward as possible, so as not to prevent access to smaller with limited resources. Smaller organisations need support to understand contracting (including practice based commissioning) to enable them to tender for services.
- The contracting process should be proportionate and flexible, with more complex arrangement limited only to large contracts.
- There need to be incentives within contracting to promote innovation and choice.
- Commissioned services should meet population need. Full cost recovery should apply.
- Children's services could be used as a model of good third sector commissioning.

The Department has recently commenced work on developing a new national contractual framework for out-of-hospital services. The work is being co-ordinated by a steering group within the Department, and will be supported by an external stakeholder reference group. The third sector will be represented on the reference group by the NHS Confederation's third sector affiliates network. We will also engage directly with individual third sector bodies to contribute to this work.

The intention is to develop contractual models, consult on them by the autumn, and introduce them as interim contracts in 2008/09.

For more information about this work, please contact: anthony.kealy@dh.gsi.gov.uk

Funding:

- Transition funding will prevent small organisations going out of business before the new commissioning plans are fully developed.
- Most current funding is too short term. It should ideally be 5 years or longer.

Short-term funding creates instability for smaller providers. Funding should be long-term and linked to delivery of strategic outcomes.

- Commissioning should be based on full cost recovery and long-term stability for the sector.
- The Compact should be enforceable.
- There should be ring-fenced funding for the third sector.
- More should be invested in building third sector capacity – for example through the social enterprise fund.
- Funding should be made available to allow excluded groups to participate in the health and well-being agenda.
- Communities should be given their own budgets to buy health and social care.
- Patients should be given budgets to buy healthcare – similar to IBs for social care.
- Funding should follow individuals no matter which area (LA or PCT) they move to.

Given that health and social care services are commissioned and provided locally, it would not be appropriate for transition funding for third sector services to be provided centrally. However, PCTs and local authorities may wish to review their local arrangements, subject to affordability.

The Commissioning Framework for Health and Well-being has a specific focus on commissioning for outcomes. It does not prescribe funding mechanisms. Specifically, it is not the case that grant funding will no longer be an option for funding local services or for supporting the sector's participation in the commissioning process more widely. Funding mechanisms are for local determination, based on the specific circumstances of the service.

The aim the Commissioning Framework for Health and Well-being is to create a commissioning environment which provides a fair playing field for a diverse range of providers, including third sector providers. Ringfencing money from commissioning budgets

for any particular provider group, including the third sector, would be against the principles of competitive neutrality and local determination of local priorities.

A £73million Social Enterprise Fund, announced by the Department in January, will go towards supporting and encouraging the development of social enterprises in health and social care.

Integration of health and well-being and the shift to prevention:

- There should be a recognition that health is a relatively minor component of well-being. Service focus should shift to well-being in a broader sense.
- Health and social care should have a well-formulated, agreed joint agenda which is realised through true partnership working. Health and social care should be seen as a continuum, and statutory responsibilities should be integrated.
- Integration of health and social care should be at the level of culture, finance and accountability.
- There should be a holistic basis for the commissioning of adult services (similar to Every Child Matters).
- There should also be clarity about the shift of resources from acute to community care.
- There should be sustainable funding for well-being programmes as part of a clear integrated commissioning strategy across health, social care and other areas.
- There needs to be a realistic understanding of the costs and time delays involved in moving from an acute to a preventative care model.
- Changes that affect service users should be carried out at a pace to suit them – not the system.

Since 1st May 2007, a team within the Department has been established to focus on issues in relation to shifting care closer to home. They will work with others across the Department on areas including encouraging a focus on well-being and on integrating health and social care services.

At local level, service integration and the shift to prevention is likely to be a top priority for local health services in the coming year. The NHS Operating Framework for 2007/8 (para 3.11-12) states that PCTs should be working to take forward the shift of care into community settings, and that this includes promoting health, well-being and independence, with stronger local services and support to reduce the prevalence of physical and mental illness.

We are strengthening local partnership working by legislating to require LAs and PCTs to produce a *Joint Strategic Needs Assessment* of the health and social care needs of their local population. This will ensure local partners have a shared understanding of the needs of their locality, enabling them to agree more effective long-term health and well-being priorities.

PCTs and local authorities are also working together through Local Area Agreements (LAAs) to commission a variety of health and well-being outcomes. Projects include promoting exercise as part of a healthy lifestyle, preventing injury and hospital admission resulting from falls, and supporting older people to continue living in their own homes. Some LAAs also have shared accountability and funding arrangements. More information on LAAs can be found on local authority websites.

The Commissioning Framework for Health and Well-being aims to re-focus commissioning away from services for ill health, towards services which promote an integrated vision of good health, well-being and independence. The framework is out for consultation until 29 May 2007.

More information on the Framework, and an opportunities to respond to the consultation, are available at www.commissioning.csip.org.uk

Other points:

- The evidence base around the benefits of third sector involvement should be developed.
- Smaller organisations are fiercely independent. This inhibits partnership for fear of takeovers.
- Local communities should be able to hold commissioners to account for delivering for local need.
- Policymakers and commissioners should prioritise homelessness.
- There should be access to a good district nursing service, 24 hours a day, 7 days a week.
- Commissioning should recognise marginal groups and professional barriers. It should be used to provide integrated delivery and support.
- Professional barriers to integration need to be overcome.
- Health services should be given over to local political control.
- PCTs should fully engage with strategic partnerships.
- Commissioners need to recognise women as a distinct group within larger contracts. This will also encourage larger organisations to develop partnerships with local women's organisations.
- DH should produce guidelines on equality in procurement to ensure that VCS procurement does not exclude women's organisations and other marginalised groups.
- Put some muscle behind commissioning for long-term conditions, and use the NSF for long-term neurological conditions as an example.

Annexes – Slide Presentations:

Slide presentations used during this event are available as annexes to this document.

These presentations are available to download, in PowerPoint form, from www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075941