No excuses. Embrace partnership now. Step towards change!

Report of the Third Sector Commissioning Task Force

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Preface

A year ago Ministers established the Third Sector Commissioning Task Force, to address the practical obstacles to the third sector fulfilling its potential as a mainstream provider of health and social care services. The challenge, at that time, was as much about raising the profile and credibility of third sector providers in the context of service reform, as about delivering solutions to the problems they faced in their existing relationships with PCTs and local authorities.

Since then, *'Our health, our care, our say: a new direction for community services'*[1] has acknowledged that delivering health and social care services is no longer the preserve of the public sector, and that third sector as well as private providers have a valuable role to play in shifting the balance of provision closer to where people live, and the type of responsive services people want. To achieve the vision for more innovative and dynamic health and social care services, we need stronger and more effective commissioning, by PCTs, practice based commissioners and local authorities, underpinned by more efficient and streamlined regulation and accreditation of the multiplicity of providers within a much more diverse provider market.

It is not just the responsibility of commissioners to drive the transformational change required for innovative new models of provision involving third sector providers to become a mainstream option. Third sector organisations also need to demonstrate to commissioners their potential to deliver services, and communicate their unique selling points in the context of the Government's vision for more flexible and responsive services.

The Task Force has succeeded, where other initiatives have failed, in putting the third sector at the heart of the health and social care reform agenda. It has brought into sharp relief some of the barriers to third sector participation that <u>must be tackled</u> if the third sector is to become an equal partner in delivering services. Its conclusions, and the commitments that spring from them, pose fundamental challenges to Ministers, the Department of Health, the NHS and local authorities, if they are to establish a genuine partnership with the sector that works to the mutual advantage of commissioners, providers and service users.

Our conclusion is that a partnership approach, based on mutual trust and understanding between organisations concerned, with commissioning and delivering services that people want and value will be achieved by improved communication and changed behaviour. Our challenge to you all is, therefore, to read this short report, to reflect on its conclusions and commitments and to send us your responses. But more than that. It is to consider how you and your organisation can embrace the reform agenda and make a real difference and improve the health and well-being of the nation. It's time to get on with it!

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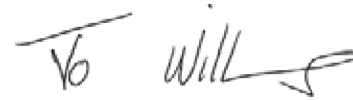
[1] 'Our health, our care, our say: a new direction for community services', http://www.dh.gov.uk/assetroot/04/12/74/59/04127459.pdf

We now look forward to the beginning of the most exciting phase of the Task Force's work, as we seek to bring its messages to life within the wider reform programme.

Ivan Lewis MP
Parliamentary Secretary (Care Services)



Jo Williams
Chief Executive, Mencap

The undersigned endorse the vision of partnership between the public and third sectors set out in this report, and are committed to making it a reality by helping to address its conclusions and commitments:

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VCS Champion, Department for Communities and Local Government

Tim Byles, CBE
Local Government National Procurement Champion

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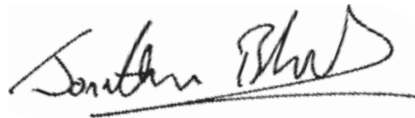

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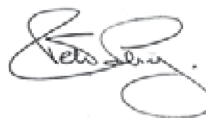

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Introduction

1. This report sets out the conclusions and recommendations from the *Third Sector Commissioning Task Force*[2], set up by Ministers in July 2005 to:

   a. promote a sound commercial relationship between public sector commissioners of health and social care services, and the third sector as providers of those services

   b. help to remove barriers to entry for all providers of health and social care services, and

   c. promote equality of access for all types of third sector organisations, compared with providers from other sectors, in the public provision of public sector health and social care services

2. The *third sector* is a vital element of the rich diversity of our society. This work has focused on their role as providers within health and social care, although we do of course recognise the sector's valuable role as advocate for groups in society with specific needs, and for its role in supporting and facilitating people to volunteer. *'Third sector'* describes the range of organisations, which occupy the space between the State and the private sector. These include small local community and voluntary groups, registered charities both large and small, foundations, trusts and the growing number of social enterprises[3] and co-operatives. Third sector organisations share common characteristics in the social, environmental or cultural objectives they pursue, their independence from government, and the reinvestment of surpluses for those same objectives.

3. The Department of Health's provisional estimate is that there are currently over 26,000 third sector organisations delivering health and social care services in England, with a combined annual income in excess of £13bn. They vary considerably in size: the largest two per cent of organisations account for over a quarter of the sector's income whilst nearly half have an annual income of less than £50,000.

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[2] See Appendix B

[3] A social enterprise is a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners.

4. The Task Force forms a key part of the Government's broader approach to ensuring the third sector can play a full role in public services reform across the range of service areas[4], particularly health and social care reform. This report specifically focuses on:

   a. the White Paper *'Our health, our, care, our say – a new direction for community services'*[5], that envisages a new strategic direction for the care and support services that people use in their local communities that:

   - Puts people more in control of their own health and care – with their actions and choices driving improvement
   - Enables and supports health, independence and well-being – building on the programme for health improvement set out in *Choosing Health,* and
   - Provides rapid and convenient access to high-quality, cost-effective care – meaning a shift in the balance of provision and how local services are provided, and

   b. *'Health System Reform in England'*[6] describes the framework for reform of the NHS in England. It summarises the initiatives already in place, explains how the reforms are mutually reinforcing - embedding the right balance of incentives, transparency, plurality of providers and patient choice – and sets out a programme of further development for 2006.

5. These two documents articulate a vision of more choice and a stronger voice for patients combined with a more diverse range of providers, with more freedom to innovate and improve services. System reform provides the mechanisms and levers to deliver the shift in how services are provided.

6. The Task Force has given voice to third sector perspectives in the context of the wider system reform programme, and has succeeded in putting the third sector on the health and social care reform map. It has highlighted the key potential contradictions between the rhetoric and reality of service reform and partnership with the third sector. In turn, its conclusions and outputs express the key challenges for Government, the public sector in health and social care, and the third sector, that must be addressed through culture and behaviour change[7].

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[4] http://www.cabinetoffice.gov.uk/thirdsector/

[5] Our health, our care, our say: a new direction for community services, http://www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf

[6] Health reform in England: Update and next steps, http://www.dh.gov.uk/assetRoot/04/12/47/27/04124727.pdf

[7] Details of the Task Force Working Groups and their respective outputs are contained within the companion document 'Third Sector Commissioning Task Force, Part II: Outputs and implementation

Vision – where are we heading?

7. Reforms to health care are moving the NHS away from its traditional model of service provision towards a new vision for provision in the health and social care system. The provider 'market' will become increasingly plural and diverse. Different organisations will contribute their different strengths – public service values, strong governance and accountability from the public sector, commercial discipline and customer focus from the private sector and the unique strengths of the third sector embodied in its independence from government and shareholders, and its focus on service users and innovation to respond to their needs.

8. Providers will be more flexible, innovative and responsive to the changing needs of patients, service users and carers, and commissioners. As far as the individual service user is concerned, the quality of care will matter more than which organisation provides it. Standards will be assured through providers being subject to independent review and inspection. Increasingly, the focus of commissioning should be on achieving positive outcomes for service users as well as value for money for tax payers.

9. The balance of provision will shift. More care will be provided closer to home. Hospital services will increasingly be provided within communities. This will challenge the old distinctions between primary, community and secondary care, as well as health and social care. There will be new opportunities for innovative providers from any sector to meet the needs of users – competing as well as cooperating for the benefit of patients and users.

10. In this context, the Task Force envisages a mature and equitable relationship between public sector commissioners of health and social care services and the third sector. The relationship must help secure the design of user-centred services to meet locally identified need and their delivery through a diverse range of type and size of providers. All providers must be able to compete for and deliver contracts on a fair and equal footing. Within a diverse and complex third sector, this can only be achieved through:

    a. **systematic involvement of health and social care service users at all stages of the commissioning process**

    b. **expert knowledge and capability among health and social care commissioners**

    c. **understanding among commissioners about the third sector, and its potential to add value to needs assessment, strategic planning, and to empowerment of service users and community capacity building, as well as the delivery of services**

    d. **principles and practice for commissioning and contracting that recognise and value the full range of providers, including those from the third sector, as equal partners in delivery,**

e. allowing longer term contracts, in the right circumstances, 'full cost recovery' and the fair balance of financial risk between commissioners and providers

f. streamlined system management regulation (including licensing and accreditation) of health and social care providers that is proportionate, promotes greater coordination between regulators and commissioners and provides equivalence for similar providers, regardless of sector

g. third sector providers that are able to shape their behaviour and governance to address the challenges of accountability in a regulated business environment, and

h. support for new providers entering the market (for example through Futurebuilders England and/or a Department of Health Social Enterprise Fund).

Issues – what needs to change?

Obstacles to a sound commercial relationship

11. The barriers to partnership between public and third sectors have been well rehearsed over the past years as a result of work by the government and the sector, including the Treasury 2002 Cross Cutting Review on the role of the voluntary sector in service delivery, Sir Peter Gershon's 2002 review of Public Sector Efficiency, Acevo's *Surer Funding* report, and the 2005 NAO Report '*Working with the Third Sector*'. To inform and focus the Task Force, an initial Working Group co-chaired by Victor Adebowale and Ken Anderson produced a bespoke statement of the obstacles to a sound commercial relationship, as they were perceived in the context of the health and social care environment.

12. This statement, 'Views from the Market'[8], structured around three of the dimensions or phases of the commissioning process – Planning (Commissioning), Purchasing (Procurement) and Monitoring (Contract management), (set out in more detail at Appendix A) – articulates and defines the issues, and provided the framework for prioritising the development of solutions to the critical barriers to cost effective commissioning in health and social care:

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[8] www.dh.gov.uk/stakeholders

Critical barriers to cost effective commissioning

Planning (commissioning)

- Variable skills and capabilities among commissioners

– commissioners focusing on individual contracts rather than local, regional or national markets

– limited understanding of third sector market, investment mechanisms and options

- Limited user and provider involvement in planning

– active involvement limited

– perception that involving potential third sector in service planning would constitute a conflict of interest

- Inconsistent processes across health and social care

– variation in commissioning regimes, timetables and budget setting

- Procurement process seen a more important than planning

– limited attention given to identifying the needs of users and procuring services which address them

– difficulty in ensuring that services are values driven

- Failure to map requirement against workforce capacity and capability

– limited forward planning for the skills required as local demographics change

– limited joint workforce development constrains potential for greater consistency - and complementary local solutions

Purchasing (procurement)

- Procurement process does not allow for diversity of providers

– predisposition towards known providers

- administrative cost of procurement processes prohibitive to small organisations

- Overheads not being included as part of contract pricing (‘full-cost recovery’)

– limited understanding of the rationale for ‘full cost recovery’, or the impact and risk when it fails to be addressed

– assumption that third sector providers can use charitable income to fill funding gaps

- Short-term contracts

– stifling providers’ planning and investment in service development
– impeding generation of capital

Monitoring (contract management)

- Poor liaison between commissioners and contract managers
- Disproportionate and inconsistent demands of multiple regulators

– different bodies require different information and formats

– reporting requirements disproportionate to the size of contracts

- Users not involved in monitoring and feedback

– lost opportunity to create a ‘virtuous circle’

Priorities

13. For the Task Force to be successful, it needed to be pragmatic about the extent to which it alone would be able to bring about transformational change within the twelve-month period. It therefore focused its efforts on what it was realistic to achieve in the context of NHS and local government reform:

    a. putting the 'stakes in the ground' that would articulate the third sector's role as a key partner in planning and delivering health and social care services

    b. describing the characteristics of the commissioning and contracting environment within which the third sector would be able to operate most effectively

    c. identifying areas of service where there was evidence of potential for the third sector to play a greater role

    – thereby influencing and contributing to existing and ongoing reform programmes.

14. Working through three distinct but related workstreams, the substantive work of the Task Force focused on the achievement of timely, relevant and realistic products and outputs to support the pragmatic aim of putting the third sector on the health and social care reform map. Inevitably, it has not been possible to involve everyone with a stake in the transformation that the Task Force is aiming to influence, although the thinking of the Task Force has been informed by a range of organisations, large and small, that have contributed through its working groups. The work was undertaken in the following priority areas:

    - Influencing the development of greater expertise amongst commissioners across health and social care and increasing their knowledge of the third sector, sharing experiences of involving users and patients to inform improvements in practice, and improving third sector organisations' understanding of and engagement in the commissioning process

    - Designing a procurement and contracting framework applicable within health and social care that helps to secure greater consistency and a fair playing field for all providers, including third sector, and greater consistency

    - Informing the development of regulation across health and social care with a view to a more streamlined system for regulation, accreditation and monitoring that minimises the administrative burden on third sector providers

15. The dynamic nature of the reform programme is such that the frame of reference for the Task Force's agenda is now much clearer and specific opportunities, that might not have been explicit a year ago, have now crystallised. It is now possible to position the Task Force's agenda and conclusions in the context of a more detailed framework for change in the wider system of which the third sector is now acknowledged as an integral part.

16. **This represents a window of opportunity, for commissioners and providers, that must not be missed.** The conclusions and recommendations set out below are therefore framed in terms of those areas of the system reform programme where they will be addressed. They reflect a bold vision for how the delivery of policy, and relationships between a wide range of stakeholders, must develop if patients and users are to be served by flexible and responsive health and social care services that achieve their full potential. Details of the Task Force Working Groups and their respective outputs are contained within the companion document *'Report of the Third Sector Commissioning Task Force: Part II – Outputs and implementation'*[9].

17. This report is intended to feed the broader process of health and social care reform over the coming months – informing the development of commissioning, commissioners, providers, system management and regulation in a rapidly changing environment as they begin to impact from April 2007. Further work from the Task Force may be needed to consider how the third sector can be enabled with new commissioning regimes as system reform progresses.

18. **Culture and behavioural change are, of course, the biggest challenges of all, and must be recognised and embraced as critical and integral to the success of the ongoing reform programme.** To exploit the potential for innovation and seize the opportunities presented by service reform, commissioners and providers must step out of their respective 'comfort zones' and collaborate to develop genuine diversity of provision and support new providers entering the market. This is the key challenge for all concerned, and ultimate success will be determined by the extent to which everyone embraces change and the opportunities that it offers for the benefit of patients, service users and carers.

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[9] www.dh.gov.uk/stakeholders

Conclusions and commitments

General conclusion

19. The Task Force represent the results of a single year's work, and should not be regarded as the end of the story. The challenge ahead is ensure third sector perspectives are reflected among the set of 'first order' questions in the future rather than the retrospective footnote to policy development they have tended to be in the past. To capitalise on the Task Force's success, the third sector must be 'hard-wired' into the ongoing reform programmes - systematically examining them in terms of whether they increase or limit the scope for greater plurality, and to ensure they introduce no unintended barriers to third sector engagement. **The critical goal is more responsive services that deliver better outcomes for people.**

20. It is the vision for a diverse provider market, and provider development, that will drive this. However, the mechanisms for increasing diversity of provision rests firmly with the development of commissioning, and the wider demand side reforms in the NHS. **Commissioners, in particular, will need to consider the impact of our conclusions on their practice and behaviour, as they are reflected in new commissioning frameworks. Third sector organisations also need to consider the messages for them about the need to demonstrate their potential to deliver services to commissioners.**

21. The vision, and the 'route map' for achieving it, is now clear. Lack of action to address the barriers to third sector participation can no longer be justified. The following paragraphs outline our conclusions, along with commitments where we consider further action is needed – which the Department of Health has agreed to consider through debate and feedback from across the public and third sectors. **In this context, commissioners and providers should consider what behavioural change is required to make them a reality.**

Commitment 1: We, the Task Force, have agreed that our conclusions, outputs and commitments will be actively pursued in the context of the ongoing system reform programme, and working with partners across national and local government. This will be reflected in a delivery plan and the formal programme governance arrangements underpinning the delivery of system reform, including:

i. continuous involvement of the third sector in policy development,

ii. evidence of impact within policy guidance and key statements on system reform, and

iii. third sector involvement in the system reform programme through membership of its reference groups.

Commitment 2: This report should be regarded as the start of an ongoing process rather than an end point. To ensure progress, there will be a formal review of progress and follow-up report by the April 2007.

Planning and commissioning

22. **Conclusion:** Involvement of service users at the planning stage of the commissioning process are critical to its ultimate success in securing high-quality, value for money, responsive and innovative services that address the needs and wants of service users. It also has the power to empower users and build community as well as personal capacity. Many third sector organisations will have clear and well-grounded views on how best to achieve the outcomes for service users sought by commissioners, and how resources can be used most effectively. They should systematically be involved in needs assessment, priority setting and service design – **although commissioners and the sector also need to recognise that involving third sector organisations is not a proxy for engaging local communities and service users themselves.**

23. All this will involve culture change within both the public and third sectors. Local partners will need to build on the work already carried out through Local Strategic Partnerships, Local Area Agreements and local compacts, which provide mechanisms through which to secure third sector engagement in commissioning. Successful community engagement projects, such as the Action Diabetes programme run by Dr Foster and Slough PCT and the Connected Care project run by Turning Point and Hartlepool PCT, provide examples of how to conduct dialogue with groups of users as distinct from groups for users.

Commitment 3: The key principles and recommendations set out in the Task Force output '*Recommendations from a service user perspective on good practice in commissioning*' [10] will be used to inform the Health System Reform Commissioning Framework, due to be published in Summer 2006 and equivalent frameworks that inform local government commissioning.

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[10] Contained within the companion document 'Report of the Third Sector Commissioning Task Force: Part II – Outputs and implementation'

Connected Care

Connected Care provides an example of commissioning and delivering responsive services in the poorest neighbourhoods, with the potential to bridge the gap between health and social care, ensuring that local communities are directly influencing and assisting in the redesign of services. The first pilot of Connected Care centre is taking place in the Owton ward in Hartlepool, which is recognised as one of the most seriously deprived areas in the country.

Commissioning Connected Care starts from the needs of individuals living in the local community. Time and resources are invested in communicating and engaging with that local community to ensure their views are properly heard and in order to understand their needs better.

At the heart of the process is the Connected Care audit that enables the local community to identify their needs and to plan and deliver appropriate Connected Care services around them. This informs the development of holistic, community-led services that directly address the full breadth, depth and complexity of peoples' needs, bringing together health and social care services as well as housing, education, employment, community safety and transport to provide a wide range of support that covers both universal services and more targeted provision for those with specific needs.

Commitment 4: The planned consultation on the principles set out in the health Commissioning Framework provides an opportunity for stakeholders to feed directly into the ongoing development of the commissioning framework. Specifically, it will inform development of the *'Commissioning Health and Wellbeing'* framework, planned for publication in December 2006. Discussion, debate and feedback about the Task Force report will be key to informing this process.

24. **Conclusion:** Engagement of the third sector (as well as other stakeholders and provider groups) is also essential to the development of service models that are robust and realistic, and a critical element of market development. Commissioners need to understand more clearly the third sector, the organisations within it, their structure, governance and financial regimes, as well as their role in the commissioning process. Local authorities should also consider reviewing their commissioning practice in the light of the principles described in the Task Force output *'A guide on how to commission from 3rd sector organisations'*[11].

Commitment 5: The Department of Health will disseminate to commissioners of health and social care the key messages within *'A guide on how to commission from 3rd sector organisations'*. This output will also be used to inform the Health System Reform Commissioning Framework, due to be published in Summer 2006 and guidance to support its implementation.

Commitment 6: There should be strong third sector involvement in the development of PCTs and practice based commissioners. The Department of Health will consider and use the recommendations from a service user perspective and the guide on how to commission from third sector organisations to inform its ongoing PCT development programme.

25. **Conclusion:** For third sector providers to realise their full potential as part of the mainstream, as well as shaping their behaviour and governance to address the challenges of accountability in a regulated business environment, they need robust strategies for communicating and marketing their unique selling points to commissioners in the context of the Government's vision for more flexible and responsive health and social care services.

26. All public procurement must be conducted in line with domestic value for money policy and the European Union (EU) procurement rules. Third sector organisations need to understand more clearly the commissioning environment in the NHS and local government in order to shape their behaviour and succeed in an increasingly diverse provider market. Specifically, there are critical points in the commissioning cycle where they need to engage. They should play close attention to NHS Commissioning Framework, when it is published for consultation later this summer, and note the processes that will inform development of the PCT prospectus so they understand when and where the opportunities lie to engage PCTs as commissioners.

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[11] Contained within the companion document 'Report of the Third Sector Commissioning Task Force: Part II – Outputs and implementation'

Commitment 7: Working with the sector, the Department of Health will, disseminate to third sector stakeholders and providers, Task Force output *'Enabling success for third sector providers in the new health and social care commissioning environment'*[12]. The forthcoming consultation on the health Commissioning Framework provides an opportunity for stakeholders to feed directly into the development of the *'Commissioning Health and Wellbeing' framework, planned for publication in December 2006.*

Commitment 8: The Task Force will work with third sector organisations and providers to consider how they, individually or collectively, could help to improve commissioners' understanding of the potential role for third sector organisations, including those who choose to provide services, in improving the delivery of user experience and public health outcomes.

[12] Contained within the companion document 'Report of the Third Sector Commissioning Task Force: Part II – Outputs and implementation

I CAN, the charity that helps children communicate, works through Children's Services to develop the communication skills of young children with speech-related disabilities. Communication development underpins every child's ability to learn and build relationships, so this work is of fundamental benefit for the future.

I CAN acts as a catalyst between health and education. With local NHS and LEA partners it has developed a national network of I CAN Early Years Centres which not only meet the needs of young children with severe speech and language impairments, but also do so in productive, inclusive settings, while reducing pressure on therapy waiting lists. Without this early detection and intervention, some of these children would reach school age without even speaking their first words.

There are now 18 centres across the UK, providing direct support for approximately 500 children and indirect support for a further 10,250.

The next phase of Early Talk is systematic and evidence-based approach to support the communication development of all pre-school children. Working with statutory sector partners, I CAN is developing authority-wide Early Talk programmes in up to 56 local authorities across the UK. The first of these are Brighton, Wigan, Pembrokeshire and North Tyneside.

27. **Conclusion:** To exploit fully the third sector's potential to provide high quality, value for money, responsive and innovative services, Government, NHS and local government commissioners of health and social care need a clearer understanding of the role of the third sector in the provider market. They also need to understand more clearly the scale of existing and potential third sector contribution to health and social care provision. Local government already has valuable experience of market intelligence and development that could usefully be shared with local NHS partners and are encouraged to use their existing intelligence at local level, to share with local NHS partners and inform joined-up strategic market development locally.

Commitment 9: The Department of Health will use the Task Force's output *'Commissioner thoughts on the role of the third sector'* [13] along with the outputs from its initial third sector market mapping survey to begin to develop a coherent high-level view of how commissioners' current and potential expectations match with third sector providers' current and potential capacity to deliver services.

Commitment 10: The Department of Health will use the intelligence from its initial third sector market mapping survey to demonstrate to commissioners the scale of existing and potential availability of third sector capacity. The Department and commissioners should use this survey of the third sector to inform any market development activity, nationally, regionally or locally, and to contribute to the broader development of thinking about commissioning and provider development.

Commitment 11: The Department of Health, working with its national and local partners, will gather and disseminate examples of good practice in commissioning and market development, and use them to inform its PCT development programme.

Rethink was commissioned by Stockport MBC/Pennine Care NHS Trust in 2005 to review Mental Health Day Services in the Borough. This involved consultation with service users and carers, other local providers from all sectors, and also engaging agencies such as local colleges, faith organisations, and leisure services.

Rethink incorporated best practise from across the country and our own research with IPPR as set out in "Mental Health into the Mainstream". The recommendations included the decommissioning of some statutory services and the commissioning of a socially inclusive Wellbeing Centre in Stockport which was subsequently put out to competitive tender to the third sector.

The MBC & Trust were so satisfied with this work that 2 other Boroughs have now commissioned similar reviews to redevelop their commissioning strategy.

[13] Contained within the companion document 'Report of the Third Sector Commissioning Task Force: Part II – Outputs and implementation'

Procurement and contracting

28. **Conclusion:** If health and social care commissioners are to procure services successfully from the full range of providers, including third sector, there needs to be a more mature approach to securing contracts. This must recognise the benefits of:

    a. providing funding stability by enabling longer term contracts, for appropriate segments of the market and in the right circumstances,

    b. reflecting a common language around cost structures and fair pricing, and

    c. fair and proportionate balance of risk with all providers.

29. The Task Force outputs *'Proposed model contract for provision of social care services'* and *'Proposed model contract: Guidance note'* [14] provide a potential basis – for relevant service segments – for improved, more mature contracting between commissioners and providers. Clarity and standardisation are important for all parties. Templates for national contracts will be introduced by the Department of Health.

Commitment 12: To learn more about its benefits and challenges, and ensure fitness-for-purpose, the Department will review the *'Proposed model contract'*, working with national and local partners, to inform the development of the portfolio of national templates contracts, with a view to it being made available across health and social care by December 2006 and promoted as good practice.

Regulation, accreditation and monitoring

30. **Conclusion:** To achieve the Government's vision for reformed health and social care service delivery, there needs to be rationalisation and simplification of the present complex pattern of multiple scrutiny by both formal regulators and commissioners of services. Regulation, licensing and accreditation of health and social care providers needs to be equitable, proportionate, risk-based and streamlined, so that it optimises the overall inspection and monitoring burden proportionate to the balance of users', providers', commissioners' and regulators' needs.

[14] Contained within the companion document 'Report of the Third Sector Commissioning Task Force: Part II – Outputs and implementation'

Commitment 13: The Department of Health will use Task Force output '*Suggested additional principles of good regulation*'[15] to inform its programme for designing a new system for managing and regulating health and social care.

31. **Conclusion:** Health and social care providers are subject to a wide spectrum of regulation including charity law and housing. As a mechanism to enact the proposed principles, we have considered the potential either for the creation of a separate concordat for social care, or the broadening of the existing health and social care concordat to include regulators of social care providers not currently represented.

Commitment 14: The Department of Health will consider these potential outcomes in the context of its programme for designing a new system for regulating health and social care.

32. **Conclusion:** The Healthcare Commission (HC) and Commission for Social Care Inspection (CSCI) have already made considerable progress towards more streamlined, cost effective regulation and remain committed to ongoing modernisation and development (both with each other and with other regulators such as the Housing Corporation and the Audit Commission). Accreditation and passporting schemes already in existence offer a sound basis for further investigation and consideration in order to establish possible models and mechanisms for effective application across health and social care. This is a complex area and a range of examples of accreditation schemes operating in different sectors across the UK is set out and discussed in Task Force output *'Accreditation, Passporting and Umbrella Bodies – a paper for discussion'*[16].

33. The acquA case study provides a good example of how third sector organisations can effectively organise and develop themselves to meet the more rigorous demands of entering into contractual relationships with public sector providers for the delivery of health and social care services.

Commitment 15: The Department of Health will use the Task Force outputs to inform its programme for developing effective system management and regulation as part of its Health System Reform programme, and ensure the new regulation regime reflects the perspectives of users as well as third sector stakeholders and providers through their direct involvement.

[15] Contained within the companion document 'Report of the Third Sector Commissioning Task Force: Part II – Outputs and implementation'
[16] Contained within the companion document 'Report of the Third Sector Commissioning Task Force: Part II - Outputs and implementation

acquA (Acquiring Accreditation) is a trademark owned by The Alliance Herefordshire a support organisation for third sector health and social care providers

A comprehensive accreditation framework that provides third sector organisations with a kite-mark of good practice to confirm their fitness for purpose for delivering services. It provides the assurance of high standards within a framework that combines learning and improvement with rigorous, objective assessment.

Organisations earning the kite-mark are included on a Register of Approved Providers, owned and administered by the sector; and recognised by public sector commissioners.

Commitment 16: Discussion, debate and feedback about the Task Force report will be key to informing any consultation on system management and regulation.

Moving forward

34. The Task Force set out with the ambitious aim of putting the building blocks in place to transform the working and business relationship between public sector commissioners of health and social care and the third sector as providers of those services. In doing so, the objective was to help to remove barriers to entry for all potential providers of health and social care services, and promote equality of access for all types of third sector organisations, compared with providers from other sectors. The commitments describe a series of actions whose implementation would signal a step-change in nurturing the third sector's role as a key partner in public service delivery.

35. The Task Force has put the third sector firmly on the map, as far as strategic policy and delivery are concerned. But that is not the end of the story. It would premature to assume that in itself, the Task Force's work will deliver the aspirations for greater third sector involvement in the delivery of mainstream services. The Task Force will be maintained to ensuring our conclusions, outputs and recommendations are firmly embedded and rooted within the ongoing system reform programme. **Achieving this requires changes in behaviour and culture within Government, NHS and local government commissioners of health and social care, and the Third Sector, and these will be challenging for all concerned.**

36. The key to this will be continued transparent and open dialogue as the way to do business. This will be maintained, at national level, through the NSPF and ongoing work of the Task Force itself.

What will happen next?

37. This report will now be considered further by the Department of Health through dissemination and debate with stakeholders across the public and third sectors. Particular care will be taken to reach small local voluntary and community groups and social enterprises, to ensure that the barriers and solutions identified here address the critical barriers, as they are perceived at the community level. Feedback from all quarters is encouraged and welcomed.

38. Public, VCS and social enterprise partners in local compacts should consider the messages in this report in terms of how they can add value to the development of relationships locally and feed back their views about the benefits and limitations of its content by sending them to ThirdSector@dh.gsi.gov.uk by the end October 2006.

39. The NSPF and Department of Health will actively seek views about the issues addressed in the report through NSPF-hosted joint learning events during the summer and autumn of this year, focused on the issues set out in this report.

40. The Department will be consulting in the summer about the initial products of its system reform programme, specifically around commissioning and contracting. Third sector stakeholders should actively participate and feed in views to this consultation exercise.

41. This consultation exercise, as well as feedback regarding this report, will feed directly into the ongoing development of the System Reform programme, and specifically, the commissioning framework. In particular, they will be used to inform development of the *'Commissioning Health and Wellbeing'* framework, planned for publication in December 2006.

42. Department of Health will test out the draft Model Contract for Social Care Services, to inform the development of a portfolio of national contracts templates by December 2006.

43. The Department of Health's Social Enterprise Unit will support social enterprises to involve staff and service users in designing and delivering services which better fit patients and service users needs, and will implement the commitment made in 'Our health, our care, our say' to set up an investment fund for social enterprise, to help with set up costs, from April 2007.

44. Working with the National Strategic Partnership Forum, the Task Force will conduct a review of progress and produce a follow-up report by April 2007.

45. In the time that has been available, there is a range of issues that the Task Force has been unable to address so far which nevertheless warrant further consideration. In particular, it is important to acknowledge that its deliberations have focused on commissioning by local authorities and PCTs, and have specifically not considered the implications of and for Practice Based Commissioning, Direct Payment, Individual Budgets or Payment by Results. The Task Force will look at these in the next phase of its work.

In Control and Individual Budgets

'In Control' is a new way of delivering social care that puts the person at the centre of all the processes. Following an assessment of the individual's support needs, a budget is agreed and a plan developed. The budget is then transferred to the individual concerned, or to an agent chosen by them to act on their behalf. The budget is used to purchase services that are tailored to the person's individual needs.

This is Celia's story. Celia was originally in residential school. But things weren't going well and she wanted to be more independent. With the help of her family and 'In Control' her life has been transformed. She has a dedicated staff team and keeps them all busy.

Celia is now very happy in her flat. She loves her life and, although she still presents challenges to others fairly regularly, in just a year her life has improved out of all recognition.

46. Two other important examples are – how to ensure that very small scale third sector organisations that provide enormously valuable work supported though grant aid continue to be valued in an increasingly 'commercial' environment, and joint strategic development of the health and social care workforce, along with related issues around terms and conditions. The Department of Health is also reviewing its own grant giving.
47. Those feeding back their views about the content of this report are encouraged to identify any other issues warranting further consideration.

Appendix A

Third Sector Commissioning Task Force

Process Definitions

Definitions	• Determining priorities. Priorities are frequently set at least in part at national level by target setting as well as less prescriptive methodologies. Local commissioners need to respond to these priorities, adapt them to local circumstances and set further local priorities as necessary. • Identifying need. This involves assessment of factors such as local demographics, epidemiology and historic service utilisation, in order to identify the pattern of service that will respond to a population's needs. • Providers and capacity. Possibilities for service provision include the scope to provide services "in-house" and the options for purchasing services from external providers, public or private. Commissioners need to consider this strategically and plan for future as well as current requirements.	• Deciding which services should be undertaken in-house and which should be contracted from other providers (or when a balance is required). • Identifying which providers services should be contracted from. Delivering a local service and maintaining the availability of capacity in the future. In other cases, and around the margins of capacity needs, there will be more alternatives. Commissioners will need to identify providers based on factors including quality, convenience and value for money.	• Delivery. At the most basic level, contract management arrangements need to be put in place to demonstrate to commissioners that the services that have been commissioned are actually being delivered (and allow action to be taken otherwise). • Volumes. Commissioners need to understand how the volumes of care that are being delivered and the extent of patients' needs that have been identified. This will feed back into the way that commissioners plan to meet needs and will also allow the question of whether contractual incentives are operating as planned to be assessed.

	Planning (Commissioning)	Purchasing (Procurement)	Monitoring (Contract management)
Definitions	• Budget. Commissioners need to critically assess whether they have sufficient resources to meet identified needs and priorities in light of the options for service provision. Commissioners need to reassess and challenge priorities if this appears not to be the case, and review on an on-going basis.	• Designing and negotiating appropriate contractual relationships with third party providers. These need to reflect appropriate incentives (for delivery, utilisation, and quality), to allocate risks effectively, specify exactly what is being provided and clarify ownership of functions as necessary. • Putting in place appropriate governance arrangements covering incentives, risk allocation, ownership and accountability, in lieu of a contractual relationship where services are delivered internally.	• Clinical quality. This can be partially assessed through regulatory bodies confirming compliance with publishes regulatory standards and taking action where they are not achieved. But there is also a role for local commissioners in promoting, monitoring and participating in local clinical governance and clinical audit and assessing quality through techniques such as outcome assessments. • Patient satisfaction. Patients' views on healthcare services can provide valuable information on how providers are meeting their needs in a range of areas, and in particular, whether a high quality patient experience is being provided.

Appendix B

Task Force membership, aims, objectives, principles and terms of reference, October 2005

A Ministerial Task Force to strengthen the commercial relationship between the Third Sector and the public sector co-chaired by PS(CS) and Jo Williams, Chief Executive of Mencap. To achieve its aims the Task Force will make use of specialist Working Groups to deliver detailed packages of work that will report through a Project Board to the Task Force. The Task Force itself will determine strategy and scrutinise the work of the project and Working Groups to achieve that strategy.

Co-chairs	
Liam Byrne and then Ivan Lewis (Parliamentary Secretary for Care Services)	Jo Williams (Chief Executive, Mencap)

Third Sector Members

John Low (RNID)

Cliff Prior (Rethink)

Virginia Beardshaw (ICAN)

Stephen Burke (Counsel and Care)

Stephen Collinson (Sue Ryder Care)

Victor Adebowale (Turning Point)

Clare Tickell (NCH)

Tom Hughes-Hallett (Marie Curie Cancer Care)

Jonathan Bland (Social Enterprise Coalition)

DH Members

Ken Anderson (Commercial Director)

Flora Goldhill (Head of UE&I and Chair of Task Force Project Board)

Antony Sheehan (Care Services Director)

Una O'Brien (Head of Policy Development)

OGDs and Local Government

Mark Upton (ODPM, Local Government Directorate)

Elaine McHale (Director of Social Services, Wakefield)

Richard Clarke (Office of the Third Sector, Cabinet Office)

Anne Jackson (DFES)

Catherine McLeod (DTI)

Jeni Bremner (LGA)

Others

Gill Morgan (NHS Confederation)

Melinda Letts (NSPF)

Richard Gutch (Futurebuilders)

David Walden (CSCI)

Jane Campbell (DRC)

High Level Objectives	The Task Force will: □ promote a sound commercial relationship between the Third Sector and the public sector □ help to remove barriers to entry for all providers □ promote equality of access for all types of Third Sector organisations in the provision of health and social care services
Specific objectives	□ Minimise transaction costs for the Third Sector □ Promote the commissioning of NHS and social care services from the Third Sector, to deliver a plurality of provision that better meets the needs of people using the services □ Ensure best value for money in the way the sector operates in providing services commissioned by the NHS and social care □ Encourage innovation in the way services are provided to meet patient needs and wants □ Reduce the time the NHS and social care commissioners take in procuring services from the sector □ Increase transparency and accountability in NHS and social care procurement and funding processes
General principles	The following general principles will underpin the work of the Task Force: □ The fundamental principle of the Task Force is to improve the well-being of users through improved services and greater responsiveness □ The Task Force is seeking to enhance the desirable characteristics of the Third Sector; user focus and relationship to communities, innovation and responsiveness □ Recognising the Third Sector already provides health and social care services and the need to avoid any unintended consequences of actions taken
Terms of reference	□ Develop strategies to achieve the Task Force aims and objectives □ Commission project and Working Groups to define specific products and outcomes and produce them within agreed timescales □ Approve specifications for deliverables □ Approve delivered products □ Assess market intelligence on the sector's current and latent service provision capabilities □ Approve all communications made on behalf of the Task Force
Timescales	The Task Force is expected to take one year to deliver

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