Engaging the Voluntary Sector to Address Health Inequalities

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Preface

By Councillor Deirdre Alden

Chairman Health Overview & Scrutiny Committee

Over the last twelve years much has been said about how the relationship between funding organisations and the voluntary sector is set to undergo a fundamental change. There is also a greatly increased recognition of the health inequalities within our society and the disadvantage this poses for the most vulnerable people in our communities. The intention to commission services from the voluntary and community sector to address these health inequalities has been the subject of a number of Government policy documents and has received a substantial amount of media attention. The Birmingham City Council Health Overview and Scrutiny Committee decided to undertake this review to gauge the extent to which this general policy has changed the experience of those who deliver services and more importantly the people that receive them day to day.

The general impression given to the Committee was one that, as yet, insufficient work has been done to develop the capacity of the voluntary and community sector to operate within this new environment. Contracts are often for extremely short durations causing uncertainty in employment and a lack of focus on service provision. There appeared to be very little evidence that contracts are awarded to voluntary sector organisations based on the need to address health inequalities. We heard evidence that work is being done to create a more coherent system of partnership between the Local Authority, health and the voluntary and community sector but as yet this was at an early stage.

I would like to thank the many voluntary and community organisations that gave up their time to come and talk to the Committee Members about their experiences. We recognise that many of the voluntary and community organisations that came to the Committee were in a difficult position in that the concerns they raised generally related to their funding organisations.

Councillor Deirdre Alden

Summary

1.1 Summary

1.1.1 The Health Overview and Scrutiny Committee found that there is a substantial national movement to change the relationship between the Statutory and Voluntary Sectors. This is evidenced through a number of reports that support utilising the sector in a more imaginative way.

1.1.2 The NHS itself has recognised the importance of increasing the range of services it supplies and ensuring that those groups of people that have the poorest health have better access to services. In order to achieve this it is accepted that services need to be delivered in a more flexible and locally responsive manner.

1.1.3 The evidence heard by the Committee indicated that the Primary Care Trusts have a commitment to change the way they commission services as well as ensuring those services reflect the health needs of the populations they serve. This can be demonstrated by the move to tendering for services and not merely funding organisations purely based on their historical relationship.

1.1.4 The Voluntary and Community Sector also needs to recognise the changing environment and adapt to provide greater evidence of need for its services. This can be done through embracing tendering processes and delivering discernable outcomes that are aligned to identified health needs.

1.1.5 A much greater spirit of partnership is needed throughout the city in terms of planning services and day to day management. The Committee heard evidence that a lack of communication between commissioning and service delivery was the norm rather than the exception.

1.1.6 The basic overarching question set out by this review was to look at how Health Bodies commission Voluntary Sector Organisations to address health inequalities. Although the Committee saw many examples of services being commissioned across the city there appeared to be little or no evidence that services were being commissioned to reduce a particular health inequality.

1.1.7 There is evidence that both the Statutory and Voluntary Sectors are working together to address the health inequalities of Birmingham's population, but at present the commitment is more theoretical than practical. The commitment also does not appear to be strategically linked to commissioning frameworks.

1.2 Methodology

1.2.1 The Committee heard evidence from a variety of sources that commission services from the Voluntary and Community sector as well as those agencies that deliver services day to day. In order to provide a contrast between statutory bodies, the Committee also heard evidence from

Birmingham City Council Adults & Communities Department (previously the Social Care and Health Department).

1.2.2   Evidence was requested from participants in order to demonstrate how services are commissioned, how service level agreements are managed and how strategic planning is developed. Evidence was requested in written form as well as further meetings in front of the full Committee and visits to organisations by officers of the Committee.

1.2.3   Through the course of the review the Committee was faced with a problem regarding its own capacity. The statutory responsibility of the Health Overview and Scrutiny Committee to respond to consultations taking place during the same period meant that there was a significant delay in gathering evidence for this review. However, the delay provided the Committee with an opportunity to ascertain whether many of the proposed changes reported by the Primary Care Trusts (PCTs) were actually reflected in the subsequent experience of the Voluntary and Community Sector.

1.2.4   Due to the prolonged timeframe of the review it was decided that the completed review would be adopted by the Health Overview and Scrutiny Committee under its powers through the Health and Social Care Act 2001 rather than being presented to a meeting of the City Council. The Committee considered the report in draft form at its meeting on the 6th September 2007. The report was circulated in November 2007 to all contributors and their comments are reflected in the report. The Health Overview and Scrutiny Committee accepted the full report at its meeting on the 11th April 2007.

1.3   Summary of Recommendations

	Recommendation	Responsibility	Completion Date
R1	That the tendering process for each PCT explicitly states that tendering organisations have a right to receive feedback if their tender is unsuccessful.	Chief Executives of PCTs	Oct 2007
R2	That the PCTs provide a report to the Health O&S Committee setting out plans for moving towards three or five-year contracting cycles with voluntary and community organisations.	Chief Executives of PCTs	Oct 2007
R3	That service level agreements stipulate a six-monthly face to face meeting between the commissioner and service provider and explicitly recognise the need for professional development of staff.	Chief Executives of PCTs	December 2007
R4	That each PCT create a preferred supplier list of Voluntary Organisations that are notified when tenders are available.	Chief Executives of PCTs	December 2007

R5	Progress towards achievement of these recommendations should be reported to the Health Overview and Scrutiny Committee on a yearly basis. The first report should be made in April 2008.	Chief Executives of PCTs	April 2008

2   Introduction

2.1   Background

2.1.1   In 2004, the Government's White Paper "Choosing Health" set out a plan for helping people to make healthy decisions about their lifestyles and promoting health and wellbeing. Through the process of promoting health and wellbeing it was anticipated that health inequalities would be reduced and better access to information and services would be provided.

2.1.2   One of the key methods outlined for reducing health inequalities is a greater reliance on the Voluntary and Community Sector to respond to local pressures. This presumes a change not only in the way that Statutory Sector Organisations commission services, but also in its capacity to commission services that adapt to local needs and provide a more robust method of delivering services.

2.1.3   Members considered that the way that the Voluntary and Community Sector has been commissioned to provide services has lacked attention but has the potential to do great good for those communities that do not exercise choice and do not have equal access to services. The Committee decided to carry out an assessment of the current situation within Birmingham's commissioning structures and to assess how these are perceived by those organisations that currently provide services. The focus was largely on services commissioned by health bodies but limited evidence was collected from Adults & Communities to provide a contrast of commissioning practices.

2.1.4   The Committee began the process by outlining the current situation as set out by the PCTs and the Birmingham Voluntary Services Council (BVSC). This was then contrasted with the Third Sector Framework being developed within Adults & Communities and the work being carried out by the Birmingham Strategic Partnership around the Voluntary Sector Compact. The final stage was to discuss the various experiences of a number of Voluntary and Community organisations.

2.1.5   The conclusions drawn from the evidence gathered were then used to create some distinct recommendations which should provide a more consistent approach to the way in which services are commissioned from the Voluntary Sector.

2.1.6   In order to ascertain how the Voluntary Sector has been utilised to address health inequalities, the Committee decided to concentrate on three distinct areas, namely:

- The process for contracting with Voluntary Organisations.
- How Voluntary Organisations' performances against health inequalities are monitored.
- Whether or not successful services receive mainstream funding.

2.1.7   The Committee believed that if effective systems are in place to address each of the three areas outlined above, then there would be a robust process for ensuring that Voluntary Sector

Organisations are being commissioned to provide services that address the most important needs of the population. Appropriate monitoring systems would also ensure that the work commissioned from the Voluntary Sector will address those disparities of service that exist within the city.

2.1.8   Before examining the evidence provided to the Committee it is important to look at how the current national situation developed. The relationship between the Voluntary and Community Sector and the state has been fundamentally entwined with the birth of the welfare state itself and it is important to recognise their comparative development.

2.2   Voluntary Action

2.2.1   In 1948 Lord Beveridge wrote "Voluntary Action", which set out an idea of the relationship between Voluntary and Private Sector Organisations and how these should relate to the state. Voluntary Action set out eight points that the state should adopt in order to make this relationship work[1]:-

- Co-operation of Public Authorities and Voluntary Agencies
- A Friendly Societies Act
- A Royal Commission on Charitable Trusts
- Re-Examination of Taxation of Voluntary Agencies
- An Enquiry as to the Physically Handicapped
- A Minister-Guardian of Voluntary Action
- Specialised Staff Training
- Continuance and Extension of Public Grants to Voluntary Agencies

2.2.2   It is interesting to note that over half a century later many of these issues are still as relevant to the relationship between the state and voluntary sectors as they were at the conclusion of the Second World War. For example, it was only in 2006 that the Office of the Third Sector was created, thus establishing a Minister of State within the Cabinet Office.

2.2.3   The first and last points, set out by Beveridge reach to the heart of the intentions of the "Choosing Health" White Paper. They also demonstrate a theme that has run through social policy for decades.

2.3   The Deakin Report

2.3.1   In 1996, "Meeting the challenge of change: Voluntary action into the 21st century" sought to provide a clear and coherent vision of the Voluntary Sector and how it could be used to provide services over the coming ten years. The report, containing 61 recommendations, was seen as a key component in the drive to reform public services and would shape the legal framework that organisations find themselves in today.

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[1] **Voluntary Action: Meeting the challenges of the 21st Century - Campbell Robb**

2.3.2   A key finding of the report recognised that new sources of funding were needed to supplement funding from statutory bodies in order to maintain the sector's independence and effective service delivery needs to be supported by a wide variety of service providers.

2.3.3   As well as the recognition that a lack of a profit motive does not mean that Voluntary Sector Organisations are inefficient, but rather that their need to make best use of scarce resources provides an equivalence to the need within private sector companies to satisfy share holders.

2.3.4   The report stated that six principles are essential to the voluntary sector. These are:-

- Public policy needs to recognise the unique qualities of voluntary action.

- Partnership must be on an equal basis.

- The role of users is crucial to the sector.

- Voluntary bodies must always be free to act as advocates.

- It must be managed professionally without deflecting from the sector's purposes and aims.

- Diversity of funding sources is one of the best guarantees of independence.

2.3.5   The Deakin report set out findings that created a distinct direction of travel for the relationship between the Statutory Sector and the Voluntary and Community Sector. The change in social policy was reflected in a number of initiatives and reports that have set out how services should be commissioned and how the Voluntary Sector is best utilised.

2.4   Cross Cutting Review

2.4.1   In 2002 HM Treasury produced "The role of the voluntary and community sector in service delivery: A Cross Cutting Review", which set out to demonstrate how Voluntary and Community Organisations can be utilised as effective vehicles of service delivery.

2.4.2   The Review began by looking at how much money is spent by the Statutory Sector within the Voluntary Sector. It was found that 16.1% of spending within the Voluntary Sector comes from the NHS, which counts for £595 million.

2.4.3   The review identified that the Voluntary and Community Sector may be able to deliver services more effectively to certain groups because their structures enable them to operate in environments wherein Statutory Bodies find it impossible. The features that Voluntary and Community Organisations demonstrate are:[2]

- Specialist knowledge, experience and/or skills. These may come through direct experience of the user perspective. Examples of this might be ex-addicts working

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[2]**HM Treasury Cross Cutting Review 2002 3.9**

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on a drug rehabilitation programme or ex-offenders working with young criminals.

- Particular ways of involving people in service delivery, whether as users or self-help/autonomous groups. An example here would be an organisation working closely with users themselves or their families and friends to plan and deliver services.

- Independence from existing and past structures/models of service. VCOs are not bound by structures or rules in the ways in which more traditional public sector agencies are. They are independent and so can try to deliver services in new and innovative ways.

- Access to the wider community without institutional baggage. Public service workers are often perceived as representatives of an authority, which certain groups have learned to mistrust. The VCS is independent of Government and therefore free to be unequivocally on the user's side.

- Freedom and flexibility from institutional pressures. The sector can offer responsive services which are user-centred as they are not driven by budgets and targets within the public sector. At best they can be flexible and innovative rather than prescriptive.

2.4.4   The commitment to full-cost recovery is set out in the review. All Voluntary and Community Organisations have costs attached to the services they provide. The review highlighted the perception that commissioning bodies are unwilling to fund these costs. It also stated that the inclusion of overhead costs within bids to provide services is legitimate and should not be opposed by funding bodies[3].

2.4.5   Streamlining access to funding is emphasised as a key concern of the sector. This had previously been highlighted with regard to regeneration funding by the Regional Co-ordination Unit (RCU) in 2001[4]. The RCU recommended that common application processes should be developed by organisations to facilitate transparency in funding. The cross cutting review recognised the worth of this recommendation but suggested that if common application processes are developed, then they should be built on existing structures.

2.4.6   The review stated that end loading of payments also poses significant risks to organisations. The practice of end loading means that an organisation will receive the majority of payments for services provided at the end of the contracted term. This poses a substantial financial risk to the contracted organisation. The risk is characterised by commissioning bodies making unrealistic

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[3] **HM Treasury Cross Cutting Review 2002 6.3**
[4] **HM Treasury Cross Cutting Review 2002 6.5**

assumptions about service levels. The report sets out that the service provider should not solely take the first part of the risk and that output levels should be set through a process of consultation and negotiation.

2.4.7   Probably the most important finding of the Review relates to the stability of the funding relationship. One-year contracts do not provide an organisation with the stability it needs to maintain standards of service delivery. This can cause problems of retaining staff, as well as diverting resources away from actual service delivery and into chasing continuation funding.

2.4.8   The review also recommended that a National Compact be made between Government and the Voluntary and Community Sector.

2.5   National Compact

2.5.1   In 1998 the National Compact was launched, setting out a framework of principles on how Government would relate to the Voluntary and Community Sector. The Compact sets out the national picture of how the relationship between Government Agencies and the Voluntary Sector works on a national level. It also illustrates how relationships work on a local level between Local Authorities, Primary Care Trusts, the emergency services and local Voluntary Organisations.

2.5.2   The Compact recognises that a healthy Voluntary Sector is an important part of democratic society and can be a key driver in policy development. Improved partnership working between the Statutory and Voluntary Sector can lead to better outcomes for the community as a whole.

2.5.3   It also sets out some commitments that organisations can expect at both local and national level. For example, the commitment to consult first, to fund the full cost of provision, the allocation of risk (e.g. payment in advance), proportionate monitoring and exit strategies (including notice of changes)[5].

2.5.4   The Compact also set out that Local Strategic Partnerships should create their own local compacts in order to recognise the local relationships between local stakeholders and the Voluntary and Community Sector. Further information regarding the Birmingham Voluntary Compact can be found in 3.7.2.

2.6   Choosing Health

2.6.1   The 2004 White Paper "Choosing Health[6]" set out the intention to promote the roles of NHS Bodies, Local Authorities and Voluntary Sector Organisations in improving health and preventing disease. The Paper sought to capitalise on the growing public interest in healthy lifestyles and illustrated ways that organisations could work together in a more systematic manner actively to

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[5] **Compact: Working Together, Better Together. Presentation**
[6] **Department of Health 2004**

promote good health, rather than the more reactive model of mainly dealing with manifested health problems that has tended to characterise health provision previously.

2.6.2   The White Paper recognises that health needs are complex and real lives do not fit neatly into the boundaries of individual organisations or Government departments.[7] In addition, Voluntary Organisations are often much better at engaging with those communities that have limited access to statutory services and which do not access traditional sources of health information. This experience can be a valuable resource for the statutory sector.

2.6.3   The White Paper sets out many examples of how health can be improved through greater partnership working and promoting choice.   An example is utilising Health Trainers to help people to make better health choices: the White Paper suggests that the Voluntary Sector could provide Health Trainers and that in general such roles should not be interpreted as a statutory function.

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[7] **Page 15 Choosing Health 2004**

3 Local Situation and Context

3.1 The Primary Care Trusts and Commissioning

3.1.1 The Committee met with representatives of each of the Primary Care Trusts in Birmingham, so that they could outline their approach to commissioning services from the Voluntary Sector. The main theme outlined by the Trusts is that services commissioned from the Voluntary Sector affect health in a wider sense. For example, funding local sporting clubs has an impact on wider health but does not approach specific health targets. This fits in with priorities set out in the "Choosing Health" White Paper but these do tend to concentrate on preventative issues.

3.1.2 There is also substantial service provision in the city by national organisations, such as Age Concern and Marie Curie Cancer Research. In many cases such organisations were preferred by the PCTs as service providers because of their specialist knowledge in a particular field. This is evidenced by the fact that substantially more investment is given to these organisations than smaller Voluntary Organisations.

3.1.3 The meetings with the Primary Care Trusts set out certain issues that appeared consistent across the city. For example, in a number of cases services were being commissioned because of an historical relationship between the Trusts and the Voluntary Sector organisation rather than a demonstrable need for the service provision or demonstrable outcomes.

3.1.4 It was explained to the Committee that funding often appeared "stop-start" because of uncertainty in commissioning budgets. This, coupled with a lack of clear exit strategies, created an uncertain environment for Voluntary Sector organisations.

3.1.5 A theme presented by each of the Trusts was that as a result of the "Choosing Health" White Paper, each is looking to change the way its commissioning function is administered. The Committee was concerned to hear that there did not appear was limited evidence that the Trusts have attempted to discuss between them how this is done in order to create a consistent experience across the city.

3.1.6 The Committee asked the PCTs if there was evidence of duplicate funding across the city and whether there was a systematic assessment of value for money. The PCTs stated there was a need for auditing to be carried out in order to ascertain which organisations were being commissioned to provide certain services and whether duplication between Health Bodies and the Local Authority existed. The Committee was reassured that through its Third Sector Framework, Birmingham City Council was developing a database of service provision which will identify cases of duplicate funding.

3.1.7 In cases where Voluntary Organisations are registered charities there is a requirement that The Charities Commission audits accounts. This process should identify cases of duplicate funding.

3.1.8   The Committee raised the issue that in many cases Voluntary Sector Organisations do not take up funding allocated under Neighbourhood Renewal Fund (NRF). It was explained that the process for securing funding was often complicated for smaller organisations. The cycle of funding does not aid organisations where they are required to make an application in April but are not notified about success until September. This leaves organisations with extremely short periods of time to spend the money which is awarded. This poses particular challenges where there is a requirement to recruit staff.

3.1.9   It was noted that PCTs were attempting to circumvent the slow NRF process by making awards out of their own budgets which could be claimed back when successful allocations were made.

3.2   Heart of Birmingham PCT

3.2.1   Heart of Birmingham PCT set out how they had looked at their commissioning function over the previous eighteen months in order to strengthen their ties with the Voluntary Sector. The Trust recognised that commissioning services from locally responsive organisations was in the interests of patients.

3.2.2   The PCT had set a baseline of £7.8 million investment in the Voluntary Sector and was looking to increase this by approximately 50% through year 2007/08. Some of the investment through Heart of Birmingham PCT is actually city-wide money where it is more efficient for one PCT to commission services. A survey of service level agreements carried out in 2005 indicated that the PCT was contracting with around 66 different organisations. This has been facilitated by nominating a health lead for each of the Health Panels that relate to the District Committees in the area covered by the PCT. Each District Committee now has a health panel that advises Councillors on how Neighbourhood Renewal Fund monies can be best spent to achieve health outcomes.

3.2.3   The Trust has also made an undertaking at board level to include the Voluntary Sector in its Local Development Plan (LDP) process. Programme leads are now asked to note in their LDP proposals whether services can be delivered by Voluntary and Community Organisations. As yet it is too soon to assess the impact of this initiative.

3.2.4   The representative of Heart of Birmingham PCT also set out how the Grants for Regeneration and Health programme worked. The programme has set aside £80,000 for a number of short-term projects which have the broad aims of tackling poverty and linking health with regeneration. The aims as set out in the guidelines developed by the Trust are that projects should:-

- Tackle poverty, social exclusion and resulting health inequalities
- Link regeneration and health
- Increase knowledge, understanding and skills
- Improve access and influence over services

3.2.5   The Trust has defined the types of organisations which are eligible for grants as those that are based within the Heart of Birmingham area that support people from socially excluded groups or communities and are a non-profit making, voluntary or community organisation, with written aims and objectives or constitution.

3.2.6   The aim of the project explicitly demonstrates a commitment to use the Voluntary and Community Sector to address health inequalities. An additional benefit is that access to funding is formalised, thus ensuring that when grants are made they are meeting the corporate priorities of the Trust. This also fulfils the commitment within the Birmingham Compact to have a single corporate gateway.

3.2.7   The Committee Members considered this to be a useful and innovative project that could pilot small local projects and address specific local issues. In addition, by restricting the available funding to organisations within the Heart of Birmingham area, the project ensures that grants are made to organisations which are locally responsive.

3.2.8   The Trust has also undertaken to move to a model of funding on a three-year cycle, unless the project is a pilot. This would mean that organisations can expect to be provided with either three year or five year contracts as a matter of course. All service level agreements should also follow a model of full cost recovery.

3.2.9   Heart of Birmingham also provided the Committee with details of a workshop they have run with the Voluntary Sector and Birmingham Voluntary Services Council to explore ways of joint working. The purpose was to explain the health priorities of the Trust and to provide an opportunity for the Sector share its ideas with the Trust.

3.3   Eastern Birmingham PCT

3.3.1   Eastern Birmingham provided the Committee with a comprehensive presentation that set out the historical position of commissioning services from the Voluntary Sector and how they are adapting their approach to reflect new priorities. The Trust set out that the five key challenges which affected how services were commissioned were:-

- Numerous funding sources (Government Grants, EU, Lottery, Charities etc.)
- Lack of clear exit strategies/pick up
- Insufficient tie-in to wider service strategies
- Crisis management of pick ups
- Short term contacting is not good for service, patients or providers

3.3.2   Eastern Birmingham stated to the Committee that the input of the Voluntary Sector was valued because of its ability to be more flexible when addressing unmet need. This provided an opportunity to pilot service provision in a way that is adaptable but also provides opportunities for innovation.

3.3.3　In the spring of 2004 Eastern Birmingham PCT formulated its own PCT-wide Voluntary Sector Compact. This document set out the Trust's commitment to how it would work with the Voluntary Sector. It committed the Trust to developing a strategic approach to funding the sector as well maintaining a transparent approach.

3.3.4　Specific measures taken by the PCT to promote more open working are regular reviews of investment, development of service strategies to set an investment framework and moving from a concept whereby bids are requested to a process of tendering.

3.3.5　The Committee was interested to note that at present there is not a formal process of explaining to organisations which are unsuccessful in a tendering process just why their tender has failed. The PCT representative acknowledged that such a process would be useful to organisations for future tendering.

3.3.6　The Trust has created a district structure which follows the Birmingham City Council district health theme panels. They have also made a commitment to agree future take up of services in advance, in order to facilitate strategic planning as well as including Voluntary Sector Organisations in service planning.

3.3.7　The Trust believes that through implementing the above they will be in a better position to address health inequalities and demonstrate compliance with performance management frameworks such as the Healthcare Commission's Annual Healthcheck.

3.3.8　A practical example of how these commitments are working in the Eastern Birmingham PCT can be seen in the strategic decision to implement Homestart services across the PCT area. Homestart provides friendship, support and advice to parents of young children. This is done through recruiting and training volunteers to go and meet parents in their own homes. The decision to implement the service across the PCT area was set out in the strategic objectives of the PCT.

3.3.9　The long-term aim of the Trust, as stated to the Committee, is that there is a move to more long-term funding models. This would provide an opportunity for services to develop with certainty and allow greater opportunities to retain staff.

3.4　South Birmingham PCT

3.4.1　South Birmingham PCT reported that they currently invest around £2.5 million per year in the Voluntary Sector. This equates to around 1-2% of an overall budget of £300 million. The Trust is seeking to invest more in the Voluntary Sector and this is linked to their overall plan to contract out the majority of its service provision. Such a move could provide a very real opportunity for development by the Voluntary and Community Sector.

3.4.2　South Birmingham PCT has not historically involved Voluntary Sector agencies in developing the commissioning process. It is now recognised that within the context of the 'Choosing Health' White Paper there is a requirement for increased partnership working. Evidence of this can be seen through needs assessments of smoking cessation services. The audits of smoking cessation

services supplied to the Committee showed how Voluntary Sector Organisations can be used to provide such services to hard to reach groups.

3.4.3   Another example of the work commissioned by South Birmingham PCT is through WorkDirections. This is a project to develop adult literacy and increase access to employment. The PCT recognises that unemployment and low literacy levels undermine health and increase health inequalities. This is an example of how a project can have an indirectly beneficial effect on the health of residents.

3.4.4   The PCT stated that in relation to capacity building of smaller organisations, it does attempt to provide assistance with tendering processes. The PCT has also worked closely with Heart of Birmingham PCT to create coherence with their commissioning process - though this has tended to concentrate on services which are commissioned across the city.

3.4.5   The Trust has recognised that the problems created by short funding cycles and is attempting to move to a model where contracts are awarded on a 2-3 year basis. It was acknowledged that considerably more work needs to be done in this area.

3.5   Birmingham Voluntary Services Council

3.5.1   Birmingham Voluntary Services Council is one of the largest Voluntary Sector support organisations in the country. It supports services through programmes of Sector Development such as training on financial management or even help in drafting constitutional articles. BVSC also represents the Voluntary and Community Sector on a number of strategic partnerships across Birmingham.

3.5.2   The Committee received evidence from BVSC that served to outline some of the local situation for the Voluntary Sector. The evidence demonstrated some of the challenges the sector is facing in an ever changing environment.

3.5.3   It was recognised that the majority of available funding is not provided for preventative work. It would also be useful for commissioning bodies to take a wider perspective of services they could commission in order to recognise some of the outcomes which would not normally be considered to have an impact on health. An example which was provided illustrated how funding for community football teams has a very real impact on health, but would not usually be interpreted as a "health" intervention.

3.5.4   BVSC highlighted the problem that in some cases Voluntary Sector organisations were receiving funding from Health Bodies because this had historically been the case. As a result of this, funding was not released to organisations that might otherwise meet demonstrable health priorities. It was suggested that the PCTs could do more to assess the organisations they funded in order to ensure the service provided was fit for purpose.

3.5.5   The Committee noted that one of the on-going problems for all Voluntary Sector organisations related to the short-term nature of funding. Although some organisations have been funded for many years, the nature of rolling year-long contracts mean that long-term planning cannot happen and that staff retention is extremely difficult. This is of particular concern where projects depend

on the knowledge of the workers which have developed them. Where there is uncertainty of continuation funding it can lead to extreme difficulties in retaining staff and therefore the underlying skills of the project.

3.5.6   The Committee sought clarification as to whether the Voluntary Sector would like to be "mainstreamed". The representative from BVSC told the Committee that the nature of the sector meant that it had good relationships with hard to reach groups that could be affected by moving to a more formalised setting.

3.5.7   The local perspective also means that the Voluntary Sector is ideally placed to inform social policy in the city. The example of the Citizens Advice Bureau was provided to illustrate an organisation which, through its work picks up a great deal of information across the city. Recent changes to funding streams mean that such organisations experience barriers to carrying out useful research and must concentrate purely on service provision.

3.5.8   In order for Voluntary Sector Organisations to develop their provider functions, it is important that consideration is given as to how their capacity is developed. BVSC has begun to provide training options for organisations to develop their finance, personnel and Information Technology functions. The Committee commented that further support was needed to help small voluntary organisations to develop effective systems to demonstrate outcomes of their work rather than the purely quantitative information which appeared to be required in existing service level agreements.

3.5.9   At present the PCTs in Birmingham have a contract with BVSC to provide a range of capacity building projects. There is a particular focus to increase the capacity of smaller Voluntary Sector organisations. BVSC stated that through supporting smaller organisations to develop their capacity, they would address some of the inherent economies of scale that larger organisations benefit from.

3.5.10   BVSC told the Committee about the Local Infrastructure Support Project. This project is a network of nine Voluntary Sector Organisations which are working together to provide a range of support and skills to other organisations. This project is intended to provide advice and training to Voluntary and Community groups to enable them obtain increased funding but also to demonstrate their outcomes.

3.5.11   The Committee queried whether a business ethos really existed in the Voluntary Sector. It was stated that it was difficult to provide an answer that encompassed the whole sector due to its diversity but, as a general rule, because organisations lack reserves to fall back on when funding dries up, thus a high degree of business awareness has developed.

3.6   Third Sector Framework

3.6.1   In addition to the evidence provided by the Primary Care Trusts the Committee received information from Adults & Communities setting out its approach to the new Third Sector Commissioning Framework.

3.6.2   This outlined how Social Care intended to create a new environment for Third Sector Commissioning by creating a citywide framework which would set out minimum standards for commissioning. Through implementing the framework it was intended to create key goals for both Birmingham City Council and the Voluntary Sector.

3.6.3   The perceived benefits for the City Council are increased value for money and greater financial control, whilst also focussing on measuring outcomes of service provision. In return, this approach would offer service providers increased clarity of the services they were expected to supply and a move to longer term funding cycles.

3.6.4   The main principles of the Framework, as set out to the Committee, are matching service provision to the Council Plan and Community Strategy priorities, enforcing the principles of the Birmingham Voluntary Sector Compact and addressing weaknesses that had been identified by previous audit processes.

3.6.5   Examples of weaknesses which had been identified are:-

- No corporate strategy for third sector/not-for-profit funding
- No clear link to corporate priorities
- Risk of duplicate funding; procedures not applied consistently
- Historic funding relationships

3.6.6   The implementation of the Framework seeks to provide clear solutions to the above weaknesses in preparation for the forthcoming Comprehensive Performance Assessment. This was of particular interest to the Committee as it demonstrated a spirit of partnership between the City Council and the Voluntary Sector which clearly met the aims of the 'Choosing Health' White Paper.

3.7   The Birmingham Compact

3.7.1   The Birmingham Voluntary Sector Compact is an agreement between the statutory and voluntary sectors that resulted from work carried out by the Birmingham Voluntary and Community Sector Commission. Although not specific to health provision in the city, it sets out a moral commitment by its signatories.

3.7.2   The Birmingham Voluntary and Community Sector Commission was set up by both BVSC and Birmingham City Council in 2000 to begin the process of exploring exactly how a Voluntary Sector Compact would work in Birmingham. In the light of key national policies it was necessary that bodies that commission services from the Voluntary Sector and the Sector itself look at how they interact.

3.7.3   The Commission set out to explore how the changing demographics of the city and changes in social policy would affect how services are provided and whether there was a common agenda that could form the basis of the Compact document.

3.7.4   Evidence was sought by the Commission through a series of area meetings across the city, visits to Voluntary and Community groups and questionnaires[8]. The Commission made its report in 2002 and recommended that the Birmingham Strategic Partnership should establish key thematic working groups to deal with specific areas. The five areas identified by the Commission were:-

- Governance
- Partnership
- Diversity and BME Issues
- Funding
- Commissioning

3.7.5   The conclusions of each of the working groups were then brought together to form the Birmingham Voluntary Sector Compact. The Birmingham Strategic Partnership Board endorsed the Compact in July 2005 with signatories such as BVSC, Eastern Birmingham PCT and Birmingham City Council endorsing the document in October 2005. Although the other PCTs did not specifically sign up to the compact they were signed up through their membership of the Birmingham Strategic Partnership.

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[8] **Making the Relationship Work: Creating a Compact. BCVSC**

3.7.6   The Compact sets out a framework of principles and values that, although not legally binding, do set out what Voluntary Sector organisations can expect when being commissioned to provide services.

3.7.7   There are certain key commitments within the document that affect the relationship between the Voluntary and Statutory sector - for example, the commitment to consult with the sector on policy development. This commitment also recognises that the sector is not cohesive, thus consultation can be a lengthy and complicated process.

3.7.8   The Compact commits the signatories to strengthening the recruitment to governing boards, to supporting capacity building across the sector and to developing a "Think Tank" to undertake a policy development role.

3.7.9   With regard to the issue of diversity and the BME community, the Compact recognises that there is not a specific BME Voluntary Sector with shared aims and objectives. This recognition is useful in order to begin categorising organisations in terms of their purpose rather than the community they are perceived to serve. The Compact also recommends that the needs of BME communities should be met through mainstream provision rather than separate projects.

3.7.10   The issue of funding cycles is addressed by the Compact encouraging partners to move to a medium-term model of three-year contracts. In addition, the contracts agreed with the sector should provide for a full-cost recovery model that is suitable for the particular circumstances in Birmingham.

3.7.11   There is also a requirement for signatories to create a single funding gateway together with a transparent commissioning process. This would ensure a commonality of experience for organisations that are commissioned to provide services as well as an understanding of how the process works.

4   The Voluntary and Community Sector

4.1   Methodology

4.1.1   In order to assess the current situation within the Voluntary and Community Sector in Birmingham the Committee heard evidence from a number of organisations which receive funding from the Primary Care Trusts. The Committee considered it was beneficial to hear evidence from organisations across a range of disciplines in order to gauge a variety of experiences.

4.1.2   Organisations that presented evidence to the Committee included:-

- MIND Birmingham
- BITA Pathways
- Servol Community Trust
- NimHE
- The Stroke Association
- The Alzheimer's Society
- Birmingham Mencap
- Age Concern
- Birmingham Drugline

4.1.3   The Committee received evidence through presentations and Committee meetings and a number of visits by officers. This provided an opportunity to gain a broad view of service provision and equate this with the reality of organisations' day-to-day situations.

4.1.4   The organisations which provided evidence supplied services that ranged through carer support, advocacy, access to employment, supported accommodation, befriending, needle exchanges and counselling. The organisations varied substantially in size and structure as well as the amount in funding that they received. The funding ranged from grants of £15,000 per annum to £1.2 million.

4.1.5   The Committee attempted to identify consistency of experience between the organisations. This was done through asking the contributors to highlight their experience of tendering, service level agreements, monitoring, mainstream funding, training and capacity building and their involvement with needs assessment and strategic planning.

4.2   Tendering

4.2.1   Many of the organisations that provided evidence to the Committee stated that they recognised that the PCTs were developing a process of tendering for contracts rather than relying on historical

allocation of funding. A concern that was frequently raised with the Committee was that the PCTs made little effort to communicate when tenders were being invited.

4.2.2   Representatives of both Birmingham Mencap and Age Concern suggested that the PCTs should develop a supplier list that could proactively approach organisations to tender for projects. Currently Birmingham-based agencies tend to find out about invitations to tender through professional journals such as Community Care.

4.2.3   The Committee was interested to note that Birmingham Mencap have found it easier to access funding through the Department of Health rather than through Birmingham PCTs. Birmingham Mencap found that the Department of Health was more responsive to funding requests and appeared to demonstrate a more "free" approach to service areas it would fund. This is illustrated through the Birmingham Mencap run employment service that is funded centrally.

4.2.4   The representative of Birmingham Mencap also stated that the organisation's experience of commissioning by Birmingham City Council Adults & Communities itself had improved dramatically over the last two years. This was evidenced through greater communication between the commissioners and Birmingham Mencap.

4.2.5   The Committee asked representatives of MIND Birmingham, Servol Community Trust and BITA Pathways if they were provided with feedback if a tender failed. Each of the organisations stated that feedback was extremely rare but would be useful when preparing future tenders.

4.3   Service Level Agreements

4.3.1   One of the most consistent issues that came through from meeting representatives of the Voluntary Sector was the quality of service level agreements.

4.3.2   A concern that was raised by both the Stroke Association and the Alzheimer's Society related to the provision of carer support programmes in South Birmingham. Both organisations stated that their service level agreements had not been updated for a number of years.

4.3.3   Where service level agreements had not been updated by South Birmingham PCT the organisations were forced to make an assumption that they were operating under previously agreed contracts. The organisations had little or no contact with the PCT and were unable to identify an individual officer within the PCT who appeared to be responsible for their service delivery.

4.3.4   South Birmingham PCT is currently assessing their level of commissioning through the Voluntary Sector. This has been carried out through requiring that agencies complete a detailed questionnaire setting out the services they provide and what specific health outcomes they achieve. Although South Birmingham PCT started this process of assessment it came to the Committee's attention that Eastern Birmingham PCT subsequently developed a similar process.

4.3.5   Many agencies completing the form were concerned that they were only given three weeks to respond and that their funding is still uncertain as a result. Organisations have been informed that service level agreements that should have been renewed in April 2006 will continue on a temporary basis until September 2006 when they will be informed of whether funding will continue.

4.3.6   Such uncertainty has caused organisations either to issue staff with redundancy notices or to ensure that their reserve funding is sufficient to cover the three month period if funding is not continued. This has caused severe difficulties in terms of staff retention.

4.3.7   Evidence supplied by the Alzheimer's Society indicated that this is not an isolated situation and that two years ago the staff who worked in their dementia service were actually issued with redundancy notices. Then, on the last day of that contract, South Birmingham PCT agreed continuation funding, thus enabling the service to continue.

4.3.8   Birmingham Drug Line stated that they have developed a good working arrangement with the Drug Action Team overseen by Heart of Birmingham PCT. The organisation has quarterly face to face review meetings and considers that it has a productive relationship with the PCT.

4.3.9   The Committee did not find one example of an organisation which had a service level agreement that was agreed to last over one year. Each organisation stated that a three- to five-year funding cycle would allow them to retain staff and develop services properly. A common issue raised with the Committee is that six months into a service level agreement, a substantial amount of staff time is devoted to negotiating the following year's funding and not service delivery. This situation does not provide value for money for the funding body. It should be noted that the Committee was only able to request this information from a very small number of the Voluntary Sector organisations within the city.

4.4   Monitoring

4.4.1   The Committee found that generally the monitoring information required by the PCT was largely quantitative. Concerns were raised by both The Stroke Association and The Alzheimer's Society that while they recognised the need to monitor the size of their respective caseloads, this did not reflect the qualitative input from the services they provide and thus there was no assessment of their outcomes.

4.4.2   The Committee heard that monitoring of service level agreements was minimal at best. In a number of cases where there had been no contact with the funding PCT, organisations were returning information on activity levels that had been set a number of years ago.

4.4.3   In each case organisations stated that they had existing systems to record their own service delivery information. A common issue raised before the Committee was that the information requested as part of service level agreements was of limited value for the PCTs, as it provided little information about the service actually delivered. This was of particular concern with regard to

addressing health inequalities, as the information contained within service level agreements does not appear to relate to health outcomes.

4.5 Needs Assessment and Strategic Planning

4.5.1 The commitment by the PCTs to include Voluntary Sector organisations in strategic planning does appear to be having some success. An example provided by Birmingham Drugline was the Adult Drug Treatment Plan 2006/07. The organisation was invited by the Drug Treatment Team to assess need and future service provision and these views were incorporated in the subsequent plan.

4.5.2 Age Concern illustrated to the Committee that as a matter of course the organisation carries out a service deficiency analysis in order to assess the need for service development. Age Concern break down their service delivery by ward and PCT area and on a regular basis identify services that are requested by their clients but are not currently available. At present this information is sent to any organisations that commission services from Age Concern. The PCTs do not have a systematic approach to using this information in the development of their Local Delivery Plans.

4.5.3 The Stroke Association is currently involved in Eastern Birmingham PCTs strategy group. At present this is the only part of the city that has begun to involve them in strategic development.

4.5.4 The Committee was disappointed that there appeared to be no demonstrable link between services that were commissioned and identified health inequalities.

4.6 Full Cost Recovery

4.6.1 The Committee was interested to find out from the organisations which provided evidence if there was a commitment, by the PCTs, to full cost recovery. The concept of full cost recovery assumes that it is legitimate for a service provider to include costs incurred in providing the service when requesting funding. For example the costs of administering the payroll of a service or depreciation of capital assets. In general it was considered that the PCTs believed that the Voluntary and Community Sector should cover its own costs.

4.6.2 The representative of Birmingham Drugline stated that the Birmingham Drug Action team are willing to reflect costs within their funding, though an area of concern for the organisation is the need to develop its accommodation. The PCT has been willing to support and finance the expansion of the service provided by Birmingham Drugline but, as staff numbers have increased, there is now a need for more office space. The Committee was interested to note that in many cases the PCTs are reluctant to incorporate certain costs which they would be required to fund if the service were provided by the statutory sector.

4.6.3 It was stated at a number of the evidence gathering meetings that funding from the PCTs needs to take into consideration training needs. It is through training that organisations can not only develop and retain their staff but also provide improvements in service delivery. It was suggested

by the representative from Birmingham Mencap, and supported by other organisations, that NHS bodies should open up their in house training courses to agencies they fund.

4.6.4   Evidence provided by Birmingham Mencap stated that core costs for a service are often excluded. For example, a carer support service excluded travel costs. This had a very real impact on the level of service that could be delivered.

4.6.5   Birmingham Drugline stated that they had previously been offered training opportunities by Heart of Birmingham PCT, which had proved useful in terms of staff and organisational development.

4.7   The Birmingham Compact

4.7.1   The impact of the Birmingham Compact was of particular interest to the Committee. However none of the organisations which provided evidence to the Committee had had input into the content of the Compact but the aspirations of the document generally met with approval.

4.7.2   The Committee did not find any organisations which had any practical experience of the implementation of the Compact. Each of the organisations stated that the voluntary nature of the Compact meant that the commitments contained within it were not enforceable. That was of particular resonance with regard to the commitment to move away from short term funding cycles.

4.8   Birmingham Voluntary Services Council (BVSC)

4.8.1   The perception of the role of BVSC by each of the Voluntary Organisations which provided evidence was of particular note. Each organisation stated that due to the size and the disparate nature of the Voluntary Sector in Birmingham it would be unlikely that BVSC would be able to reflect the views of all organisations.

4.8.2   The Committee noted that each of the organisations that provided evidence had little involvement with BVSC. Evidence provided by Servol Community Trust indicated that whilst BVSC did operate as an umbrella organisation, it is mainly small Voluntary Organisations that tend to fall through the gap.

4.8.3   None of the organisations which provided evidence to the Committee had received any help with capacity development from a PCT. Organisations stated that they were aware of BVSC's contract with the PCTs to develop capacity but as yet had not looked into the implications for themselves.

5 Conclusion and Recommendations

5.1 Conclusions

5.1.1 The Commissioning processes across the city appear to be inconsistent. The move towards tendering has provided a more equitable environment for accessing funding but it is difficult for agencies to find out about tendering opportunities. Some of these problems could be alleviated by a systematic move towards joint commissioning across the city.

5.1.2 Many organisations found that after taking part in a tendering process they were not aware of why they had not been successful. This meant that they were not able to better tailor their services for future tenders. Such feedback would be a very useful tool to develop services to reflect need.

	Recommendation	Responsibility	Completion Date
R1	That the tendering process for each PCT explicitly states that tendering organisations have a right to receive feedback if their tender is unsuccessful.	Chief Executives of PCTs	October 2007

5.1.3 One of the most consistent concerns from the Voluntary and Community Sector is that they did not have sufficient time to develop services when contracts were only set for one year. They reported to the Committee that in many cases the latter part of the year was often spent attempting to secure future funding rather than delivering services. This also had a detrimental affect on staff retention. A move to a 3 or 5 year contracting cycle would alleviate this to some extent. There is a commitment across the city to develop such a cycle but at present it does not appear to be the norm.

	Recommendation	Responsibility	Completion Date
R2	That the PCTs provide a report to the Health O&S Committee setting out plans for moving towards three- or five-year contracting cycles with voluntary and community organisations.	Chief Executives of PCTs	October 2007

5.1.4 There is a need to improve communication between agencies which provide services and commissioning bodies. A common complaint from organisations which have been commissioned to

provide services is that they often do not know who inside the PCT is responsible for managing their service level agreement. Organisations rarely have face to face meetings with the PCTs and in the event that funding is not continued from one year to the next, no exit strategy is developed. Such meetings would provide a point of contact within the commissioning structure but also an opportunity to assess the implementation of contracts.

	Recommendation	Responsibility	Completion Date
R3	That service level agreements stipulate a six-monthly face to face meeting between the commissioner and service provider and explicitly recognise the need for professional development of staff.	Chief Executives of PCTs	December 2007

5.1.5   Monitoring of service level agreements is often quantitative in nature which, does not provide organisations with an opportunity to demonstrate that the services they provide are addressing health inequalities. This creates the additional problem that the PCTs are unable to demonstrate that the services that are commissioned meet the objectives set out in their Local Delivery Plans.

5.1.6   With the exception of the Drug Action Team, there is little evidence that Voluntary and Community Organisations are involved in strategic planning. This misses the opportunity of capitalising on valuable local knowledge which could be used to develop locally responsive services.

5.1.7   There is also a concern that there does not appear to be a common process to inform organisation of tendering opportunities. The chances of an organisation knowing a tender process is beginning appears to be largely based on reading national publications, a past contractual relationship or knowing someone within the commissioning body. A register of organisations, across the city, that would be interesting in tendering would provide better access to opportunity for small organisations and a more open and transparent commissioning process.

	Recommendation	Responsibility	Completion Date
R4	That each PCT create a preferred supplier list of Voluntary Organisations that are notified when tenders are available.	Chief Executives of PCTs	December 2007

5.1.8   The notion of full cost recovery does not appear to be reflected in the commissioning of local services. Of particular concern is the lack of support for developing suitable environments to

provide services. Each commissioning body should also recognise the need to support the training needs and professional development of organisations in order to enhance service delivery.

5.2   Recommendations

	Recommendation	Responsibility	Completion Date
R1	That the tendering process for each PCT explicitly states that tendering organisations have a right to receive feedback if their tender is unsuccessful.	Chief Executives of PCTs	Oct 2007
R2	That the PCTs provide a report to the Health OSC setting out plans for moving towards three- or five-year contracting cycles with voluntary and community organisations.	Chief Executives of PCTs	Oct 2007
R3	That service level agreements stipulate a six-monthly face to face meeting between the commissioner and service provider and explicitly recognise the need for professional development of staff.	Chief Executives of PCTs	December 2007
R4	That each PCT create a preferred supplier list of Voluntary Organisations that are notified when tenders are available.	Chief Executives of PCTs	December 2007
R5	Progress towards achievement of these recommendations should be reported to the Health Overview and Scrutiny Committee on a yearly basis. The first report should be made April 2008.	Chief Executives of PCTs	April 2008

6 Appendix 1

Proposed Scrutiny Review:

Engaging the Voluntary Sector to Address Health Inequalities

Review Outline

Subject of review	How do NHS bodies engage with the Voluntary Sector in order to address Health Inequalities. With reference to the commissioning process used by PCTs and Acute Trusts, monitoring of contracts and how such projects are mainstreamed.
Overview and Scrutiny Committee	Health Overview and Scrutiny Committee

Reasons for Conducting the Review

Reasons for conducting this review	The Government's White paper "Choosing Health" places the Voluntary Sector at the heart of the NHS' plans to address Health Inequalities. The Committee wishes to establish if there is a systematic approach to engaging, commissioning and evaluating the Voluntary Sector's role in addressing Health Inequalities.
Key question that the review is seeking to answer	What Commissioning structures are in place to commission services from the Voluntary Sector and to what extent is the commissioning plan informed by PCTs' Public Health Plans and Equity Audits? How are Voluntary Sector organisations monitored in order to ensure that their services are addressing specific Health Inequalities? What processes are in place to ensure that

	successful projects are mainstreamed into PCT budgets?
Objectives of review / Areas for investigation	To examine the current status of the Birmingham Voluntary Sector Compact.
	To identify good practice in commissioning.
	To identify areas where monitoring processes address health inequalities.
	To identify how projects are evaluated and mainstreamed.
	To look at particular health inequalities within BME communities such as healthy lifestyles and smoking cessation to ascertain the extent of engagement with the Voluntary Sector.
Outcomes expected from conducting this work	Encourage a consistent policy on commissioning and monitoring.
	Clarify the status of the Birmingham Voluntary Sector Compact as a framework for effective engagement.
	Clarify PCTs commitment to the Voluntary Sector through Local Deliver Plans(LDPs).
	Disseminate good practice to all bodies involved.

Project Plan and Resourcing

Overarching review question/s or aim of investigation

What is the basis for commissioning services off of the voluntary sector?
What account is taken of how commissioned services address health inequalities?
How are services commissioned from the voluntary sector monitored?
Do voluntary sector organisations have sufficient capacity to meet monitoring requirements?
How are services delivered by the voluntary sector mainstreamed once proven to be effective?

Detailed areas for Inquiry/Investigation

Meeting date/ timescale	Area	Methodology	Responsibility/ witnesses
End of September	PCT and acute Sector Commissioning strategies.	Write to each Trust and request :- copy of their commissioning strategy for the Voluntary Sector structure of commissioning department and lines of responsibility details on services commissioned over the previous 12 months (i.e. number of services and monetary value) copies of equity audits for each PCT details of standard service level agreements details on how services are monitored details on projects that have mainstreamed in the last 12 months	Darren Wright

Meeting date/ timescale	Area	Methodology	Responsibility/ witnesses
End of September	PCT and acute Sector Commissioning strategies.	Invite representatives of commissioning and monitoring from PCTs to present details on existing policies to the Committee	Darren Wright
End of September	Voluntary Sector experience	Survey Voluntary organisations on experience of commissioning and monitoring	Darren Wright
October	Voluntary Sector	Invite selected voluntary sector organisations to attend Committee and present their experiences of being commissioned and monitored	Darren Wright

Officer and External Involvement

Link Officer	Dr Jacky Chambers
Lead Review Officer	Darren Wright

Council Departments Expected to Contribute

Contact / Department	Objective	Contribution Expected
Social Care and Health	To compare and contrast commissioning and evaluation systems with those of Health Bodies	Written and attendance at Committee

External Organisations Expected to Contribute

Contact /Organisation	Objective	Contribution Expected
PCTs and Acute Trusts	To highlight good practice in Health Bodies.	Written and attendance at Committee
Voluntary Sector Organisations	To demonstrate experience of being commissioned and evaluated	Written and attendance at Committee

7 Appendix 2

Meeting Date	Organisation	Representative
22/07/05	Birmingham & Black Country Strategic Health Authority	Yvonne Thomas
05/10/05	BVSC	Brian Carr
05/10/05	Eastern Birmingham PCT	Tony Ruffell
05/10/05	Eastern Birmingham PCT	John Grayland
07/11/05	Heart of Birmingham PCT	Anna Frankel
07/11/05	South Birmingham PCT	Dr Chris Spencer- Jones
07/11/05	Eastern Birmingham PCT	Tony Ruffell
07/11/05	Eastern Birmingham PCT	John Grayland
28/11/05	Birmingham & Black Country Strategic Health Authority	Rita Symons
28/11/05	Birmingham City Council Corporate Third sector project	Pauline Roche
19/12/05	MIND Birmingham	Helen Wadley
19/12/05	NimHE	Paul Dodd
19/12/05	BITA Pathways	Erica Barnett
19/12/05	Servol Community Trust	Sharon Annakie
05/07/06	The Stroke Association	Chris Bennett
14/07/06	Birmingham Mencap	Dave Rogers
10/07/06	The Alzheimer's Society	Robin Felton
14/07/06	Age Concern	Elaine Jones
10/08/06	Birmingham Drug Line	Sophie Painter