Analysis of responses to NDA "preliminary view" paper on commissioning disability services

Introduction

The National Disability Authority is the independent state body providing information and advice on disability policy and practice to the Minister, and promoting Universal Design in Ireland.

The National Disability Authority review of contemporary disability service systems[1], completed in 2010 identified three basic funding systems in jurisdictions reviewed:

- Block funding
- Commissioning
- Direct Payments & Personal Budgets

In 2011 the National Disability Authority has undertaken work on commissioning and on personal budgets[2].

The National Disability Authority circulated a "preliminary view" paper on commissioning disability services to just over a hundred stakeholders in August 2011. A copy of the "preliminary view" paper on commissioning disability services is contained in Appendices. The National Disability Authority received 20 responses, including:

- 6 from individuals
- 7 service user or disability representative organisations
- 7 provider organisations (including two provider umbrella bodies and one private provider)

Some organisations have indicated that they will submit late responses.

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[1] National Disability Authority, 2010, Developing Services for People with Disabilities: A Synthesis Report; http://www.nda.ie/CntMgmtNew.nsf/DCC524B4546ADB3080256C700071B049/FF7105D82D4C7E6D80257877005A8745/$File/SynthesisReport.pdf 7 National Disability Authority, 2010, Advice paper to the Value for Money and Policy Review of Disability Services Programme; http://www.nda.ie/CntMgmtNew.nsf/DCC524B4546ADB3080256C700071B049/B6B630EA27AC94CC8025787F003D54F0/$File/Value_For_Money.pdf

[2] National Disability Authority, 2011, The Introduction of Individual Budgets as a Resource Allocation System for Disability Services in Ireland; http://www.nda.ie/CntMgmtNew.nsf/DCC524B4546ADB3080256C700071B049/DE4CF10DC964B4FA8025789A004B492E/$File/Resource_Allocation_Paper.pdf. In 2011 and 2012 the National Disability Authority is undertaking a feasibility study to guide the implementation of individual budgets as a resource allocation system for disability services in Ireland

The appendices to this synopsis paper contain all of the responses to the "preliminary view" paper from those individuals and organisations who have given their permission for their submissions to be published. To view an individual's or an organisation's submission please click on the relevant link below.

Organisation / Individuals who responded to the NDA's "preliminary view" paper on commissioning disability services

- Appendix 1: Acquired Brain Injury Ireland (a)
- Appendix 2: Acquired Brain Injury Ireland (b)
- Appendix 3: Autism Life Care Trust
- Appendix 4: Brainwave the Irish Epilepsy Association
- Appendix 5: Caremark Ireland
- Appendix 6: Damien O'Reilly
- Appendix 7: Dara Residential Services Ltd
- Appendix 8: David Egan
- Appendix 9: Declan O'Keeffe
- Appendix 10: Drumlin House Training Centre
- Appendix 11: Eugene Callan
- Appendix 12: Inclusion Ireland
- Appendix 13: Irish Society for Autism
- Appendix 14: Irish Wheelchair Association
- Appendix 15: Kerry Network of People with Disabilities
- Appendix 16: National Federation of Voluntary Bodies
- Appendix 17: National Parents and Siblings Alliance
- Appendix 18: Not For Profit Business Association
- Appendix 19: Peter Moore
- Appendix 20: Ita Kilgarriff
- Appendix 21: Val Horgan

Summary of responses to “preliminary view” paper

Main advantages of commissioning

Service user views

- Ensure service provision reflects the needs and views of service users
- Provide service users with more choice and control
- Focus on quality, person-centred services and personal outcomes
- Could be a driver personalisation of services and personal budgets

Service Provider Views

- More transparency and accountability
- Opportunity to for some organisations to expand or diversify into new service areas
- Greater focus on service quality and more choice for service users
- Local service provision would be more closely linked to local needs
- Shift resources from poor performers and inappropriate models of support to high quality service providers and appropriate models of service provision
- Force providers to examine their existing service provision and to “up their game” if it is not appropriate
- Closer relationship between service funders and service users
- Better control of public expenditure

Main disadvantages of commissioning

Service user views

- Create environment of uncertainty for service users, at least initially
- Divert resources to application writing and compliance work
- Possible rise in service provision costs
- Fragmentation of responsibility for service provision both between various providers and various agencies involved in the commissioning process

Service provider views

- Introduce time-consuming bureaucratic processes
- Create short-term and possibly ongoing anxiety and disruption for service users
- Could favour large, low-cost, for-profit providers – or even to more institutionalised / congregate provision

- Periodic renegotiation of contracts, even for very high-quality providers, which will threaten providers' ability to plan for future
- Lead to less skilled, less professionalised workforce
- Could reduce service user choice

Risks associated with commissioning

Service user views

- Focus on price, leading to diminished service quality
- Absence of commissioning skills within statutory sector
- Independence of commissioners, particularly if the agency commissioning is also delivering services
- Become a bureaucratic process that changes nothing
- "cherry picking" of certain services which leads to service gaps
- Commissioning contracts may not cover "soft" but vital supports

Service provider views

- Contract "cherry picking" leading to service gaps in rural areas
- Expertise and independence of commissioners
- Failure to align with other initiatives[3]
- Could reduce service user choice by favouring "big battalions"
- Commissioner may be too powerful vis-à-vis providers
- Absence of national quality assurance system
- Industrial Relations and implications of TUPE requirements

Critical issues to get right

Service user views

- System of assessment of service users' needs
- Role and function of commissioner – should they be in health sector or in a separate social care sector? Should commissioning & procurement be separated?
- Service user involvement in commissioning process

[3] such as, the Health Information and Quality Authority Standards for Residential Services for People with Disabilities, the New Horizons – the Adult Day Services Review, Settings Review, Time to Move On – the Congregated Settings Review, the introduction of personal budgets)

- Balance between specifying service requirements and allowing flexibility for services to innovate to meet service users' needs

Service provider views

- Transparency and evidence base of commissioning process
- Balance between price and quality / innovation / individualisation in the awarding of contracts
- Appropriate support / brokerage services for service users
- Recognition of holistic nature of support provision
- "True" contracting culture (sanctions for breaches by either party)
- Appropriate parameters of competition / negotiation processes
- Establishing a common understanding of what "quality" means
- Quality assurance systems

Appendices

Appendix 1: Acquired Brain Injury Ireland (a)

Comments on NDA questionnaire

Q1. Is Commissioning a good tool to deliver choice?

Yes, but this is only if the procurement criteria is based on full research into client need so that when tendering occurs providers are fully able to design services which meet all requirements. Also commissioning needs to ensure that service providers are selected based on quality as well as value for money. As my experience would be that price could become the main detriment of provider selection, and processes I have been involved in , in the UK would have score weighting based on anything from 50%-75% just on price. Also the commission process needs to ensure monitoring occurs once the service has been assigned, this should be quarterly and involve discussion between the commissioner and provider on a range of areas such as budgets, complaints, service development in line with the contract, client involvement and empowerment.

Q2. How best can service users/families inform the commissioning process or be involved in it?

Families and clients should be involved in the setting of the tendering criteria, either directly through consultation groups or questionnaires or through assessment of need by the commissioning body. Families and clients can also be involved in the selection of service providers where applicable, in activities such as visits to services or representation on interview panels.

Q3. What needs to be done to ensure an adequate supply and choice of service providers capable of delivering quality services?

This is a difficult Question as my experience would show that if a range of providers are not commissioned initially the unsuccessful ones tend to either merge with bigger organisations, or go out of business, therefore reducing choice in the long run. I believe that to ensure a range of providers and choice , cost although a major factor should not be the main determinate , and only hold 25-50% of any scoring process, this would ensure that providers are selected based on quality rather than being the 'cheapest' option , which in the long run may be counter productive.

Q4 What are the implications for service providers if Commissioning were introduced?

The main implication is providers will need to openly compete for services, which can have both a positive (improve quality, cost effectiveness) and negative (monopoly providers, low quality) side to it. The main issue for myself would be to ensure that commissioning fully complies with the EU directive on procurement, therefore ensuring a fully transparent process, where the quality services shine

through. The procurement process will highlight those providers who ensure good quality, VFM and effective services. However, my only concern would be the duration of any commissioned service, my own experience would be services being commissioned for 3-5 years, and after this point going through a new procurement process - even if the service provider was meet all the commissioner's requirements - the retendering process lead to services being moved to new providers, leading to inconsistencies, staff departures, and difficulties. Also due to TUPE regulations staff engaged on the contract would move with it, leading to providers losing members of their workforce (especially ones they had invested training resources into), this could ultimately lead to the provider no longer being able to enter into commissioning exercises, and reducing choice of providers.

Q5. What are the implications for service users if Commissioning were introduced?

Although commissioning would increase choice, and ideally the providers engaged would be able to meet the clients needs, the issue highlighted above is important as if contracts are time determined, after a period, if the present provider is not reengaged the client will need to start a fresh with a new provider which may cause issues, also due to points raised in Q4, the choice of providers over time may reduce.

Q6. What would need to be done to support the transition to a commissioning framework?

Q7. How can quality standards be best assured in commissioned services?

Quality standards would be instrumental in the initial stages of a commissioning process, and should be evidenced as part of the selection for any provider. Providers should be quizzed about their QA processes, policies and procedures, etc. As well as national standards compliance (HIQA), providers should be asked to evidence to other systems such as CAR, ISO, PQASSO, and these should be score weighted based on their effectiveness. Once the service has been commissioned through regular commissioning meetings, the organisations on going compliance with national, international and contract standards should be monitored.

Q8. What training and competencies do staff who are commissioning services require?

Commissioners need to be well versed in the EU directives on procurement. They need to be fully understanding of their client groups needs, as well as the range of service models to deliver support. They need to remain objective at all times, and ensure transparency of themselves and the commissioning process. They should have a good grounding in quality assurance in a social care setting,

and be able to manage contracts. They ultimately need to be client focussed and driven.

Q9. How could commissioning support personal budgets?

Commissioning would support personal budgets by ensuring that through 'framework arrangements', clients could access a range of providers who meet national requirements. The commissioning process could not direct clients to specific providers as this would go against choice, however by setting a requirement level for providers it would ensure that clients are not exploited or put at risk. Commissioners through the setting of this requirement level would also monitor all providers engaged in personal budgets.

Q10. Have you ever commissioned services [1], or been commissioned to provide services, and if so, what lessons have you did you learn from the process?

Yes, I have been involved in both the commissioning of services (support services) and also have been commissioned to provide services. The main lessons learnt are that contracts need to be monitored by the commissioner, to ensure outcomes are met, choice is promoted, and services remain value for money. The other issue is as stated before, that contracts in my experience have been time determined which leads to problems for both the client and provider, when the provider changes - especially if the initial provider is good at what they do, and the contract changes just due to the date.

Appendix 2: Acquired Brain Injury Ireland (b)

Q1: Is Commissioning a good tool to deliver choice?
Yes but like all processes it can be done well or done badly. How will the local aspirations be translated and how will the needs be assessed? Without a thorough assessment of need, how can services be commissioned with any certainty, services that people will use!

Q2: How best can service users/families inform the commissioning process or be involved in it?
All decisions must take account of the impact they will have on the end user. They are at the core of the commissioning process. The end users and their families should be engaged throughout the commissioning process which means:

- understanding their needs at the outset
- responding to their concerns about current services
- recognising how to use their feedback appropriately in future provision.

This can be done through a variety of means i.e. liaising with local representative groups, local fora etc

Q3: What needs to be done to ensure an adequate supply and choice of service providers capable of delivering quality services?
Firstly it involves finding out what is important to people with care needs and their families, and helping them to plan how to use the available money to achieve these aims. It is about keeping a focus on outcomes, and ensuring that people have choice and control over their support arrangements. Implementing self-directed support means ensuring certain elements must be in place such as

- self-directed assessment
- an up-front indicative allocation
- support planning, choice and control
- a review process to check that outcomes agreed in the support plan are being achieved.

Q4: What are the implications for service providers if Commissioning were introduced?
For all service providers, developing and delivering personalised services fundamentally means:

- the individual is the primary focus
- there is a vision and strategy for continuously improving services based on the experiences of people who use the service

- resources are used flexibly, including staff
- staff are supported to think about their roles in new ways
- a learning, person centred culture and listening mind-set is encouraged to flourish at every level
- ways of working, particularly policy and planning systems, and governance arrangements promote cultural change
- building co-productive, problem solving relationships with people who use the service, carers, care managers and commissioners, and the wider community.

This will require being prepared to think radically about what support is available to people who use the service currently, how it is delivered and what difference it makes to their lives. It also means harnessing the energies, goodwill and talents of everyone involved, particularly individuals who use the service, staff, families, friends and carers, volunteers, care managers and the wider community, in order to create vibrant networks of support and a shared approach to providing support and opportunities for social inclusion.

This may prove problematic with regard to flexibility, contracts of employment and industrial relations issues, where there would be changes to work practices etc. It may well prove easier in Ireland for the Section 39 organisations to respond to these issues than the Section 38 organisations.

Also there are implications if there was to be a similar initiative to the UK's Transfer of Undertakings Protection of Employee directive. In general terms organisations have different cultures and ethos's and is it a positive thing that employers have to take employees of another organisation without an interview process? How does this fit with organisational autonomy?

Q5: What are the implications for service users if Commissioning were introduced?

Looking at it positively, if done well, commissioning would allow for more direct contact with the person; support should be more tailored to the individual and in theory there would be greater choice. Having more choice and control over your life improves your quality of life, so commissioning should be a positive experience. However there are significant implications such as:

- Individuals may find it difficult to communicate their wishes and understand what other people are telling them. Even though they can be articulate and give the impression that they understand everything being said, they may not understand at all.
- They may have a wish to please others and to conform. This leaves many people vulnerable when dealing with others.

- They can trust too easily and may not have a full understanding of what is going on. This can lead to financial vulnerability if they are handling their own budget.
- Individuals can have difficulty with social understanding, meaning that relationship boundaries may be problematic. The boundary between ‘friend’ and ‘paid support’ becomes blurred.
- People who lack capacity in certain areas may need advocacy. The provision of advocacy is good practice, as it ensures someone independent is part of the person’s relationship network, which can reduce the risk of a person being mistreated.

In taking personal budgets they can be managed in different ways.

- Direct payment
- Direct payment to agent,
- Direct payment to Trust
- Broker
- Individual Service Fund (provider)
- Care managed

In looking how the budget is managed some of the amount of the agreed budget may go to third party i.e. broker, for no actual service.

Q6: What would need to be done to support the transition to a commissioning framework?
Commissioning, at both the strategic and the individual level, can be an important tool in helping to achieve improvements. Getting it right can transform people’s lives giving more flexibility, independence and choice as well as quality and value for money. Getting it wrong can lead to uncertainty, lack of continuity, undermining the potential for people to be part of the solution – sometimes being shoe-horned into provision, just because it is there.

Any significant move towards developing and delivering personalised services with an outcomes focus can be facilitated or constrained by the clarity of the commissioning strategy in respect of personalisation, and the approach used in the commissioning process.

Q7: How can quality standards be best assured in commissioned services?
There should be a systematic approach to measuring the quality of the services commissioned, and in turn, to provide assurance to the commissioners that there is a consistent approach to safety, personal experience of the service and cost effectiveness throughout all commissioned services.

Quality means delivering services to the best standard possible on an ongoing basis. Some may view accessibility as paramount, and others that the services operate efficiently and effectively and within financial resources. What is clear is that quality may mean one thing to a clinician, another to a manager, and something completely different to service users and their families.

External & independent oversight i.e. HIQA should also be utilised.

Q8: What training and competencies do staff who are commissioning services require?

Commissioning competencies are the knowledge, skills, behaviours and characteristics that underpin effective commissioning. When put into practice they become capabilities. World class commissioners will secure effective strategic capacity and capability to turn competence into excellence, transforming people's health and social outcomes at the local level, while reducing health inequalities and promoting inclusion. Competencies would include:

1. Are recognised as leaders within their area
2. Work collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
3. Proactively seek and build continuous and meaningful engagement with the public and service users, to shape services and improve health
4. Lead continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilisation
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
6. Prioritise investment according to local needs, service requirements and the values of the HSE or commissioning body
7. Effectively stimulate the market to meet demand and secure required clinical, and health and well-being outcomes
8. Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9. Secure procurement skills that ensure robust and viable contracts
10. Effectively manage systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes
11. Make sound financial investments to ensure sustainable development and value for money

With regard to training, there is a role for educational establishments, improvement agencies and established commissioners from other public, private and voluntary sector organisations in the teaching, training and developmental

process. Commissioning competencies should feature in the personal developmental goals of individuals, so that collectively individuals and the organisations in which they work cover the full required competence span.

Q9: How could commissioning support personal budgets?
In Ireland, using personal budgets will be a very different way of commissioning care. It will mean the introduction self-directed support principles to allow people as much flexibility, choice and control as possible in planning their own care. This could be through a notional budget, where the money still sits with the HSE, a third party arrangement, where the money is transferred to an independent organisation or a charity, or a direct payment for care, where the money is transferred to the individual. In all cases, the person knows about the costs of services offered and what can be afforded within the constraint of the personal budget. The money can be spent on addressing the health and wellbeing needs as set out in their care and support plan.

In the UK document, **Putting People First: Self-directed support**, it gives examples where commissioning could support personal budgets.

1. At the person's request, the HSE either directly provides services to the value of the personal budget,
2. Placement of the budget with a third party/provider under a contract. Under this latter kind of arrangement the contract is between the council and the third party/provider, whilst the day-today arrangements are between the individual and the third party/provider as provided for in the contract.

There is a third option where the person uses their budget for a non-contracted third party provider excluding the HSE. However this leads to a myriad of additional questions re quality of service and oversight.

However there may be far more choice in some areas given the rural/urban divide and where demographics can and do not support multiple service providers.

However individual may:

- choose services not currently provided by the HSE
- choose different providers to those with whom the HSE has service level arrangement with.

This could lead to an element of double running costs where the HSE has a service level arrangement with one service provider but the individual chooses another.

Also different standards can apply. For example if an individual chooses a private provider and not an organisation with a Service Level Arrangement they may not have the same rights to access information under FOI for example.

Q10: Have you ever commissioned services[4], or been commissioned to provide services, and if so, what lessons did you learn from the process?
No

Q11: What are the strengths/advantages that Commissioning might bring?
Strengths/Advantages

- Empowering people and putting the principles of independent living into practice
- Enabling people to be active citizens in their communities;
- Reducing or removing the physical, organisational or attitudinal barriers that people may experience in the world around them;
- Providing flexibility, choice and control and a decent quality of life;
- Promoting confidence and wellbeing for those with an assessed need.
- Working together with others outside a local area partnership can deliver economies of scale when commissioning certain types of services such as high cost, low volume specialist provision for children and young people with complex needs. This can help drive innovation across a region or nationally.
- Ability to manage markets that might be inefficient or controlling commissioning organisations
- Local needs analysis which can identify the needs of individual communities distinctly from one another can support the devolvement of resources to localities and the introduction of locality based commissioning.
- At an individual level, through opportunities such as direct payments, personal budgets and budget holding lead professionals, a relatively high level of flexibility can be achieved in resource allocation which can impact positively on the needs of individuals

Q12: What are the weaknesses/disadvantages that Commissioning might bring?
Weaknesses/Disadvantages

- Significant cultural change needed
- It's change at a time when many organisations and the Voluntary/Not-for-Profit sector are already feeling the squeeze.

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- It will take a while to get the process working and for organisations to get used to the new ways of working.
- Commissioners cannot be passive, when to do their work efficiently they must insist on quality and challenge the inefficiencies of providers, particularly unevidenced variations in practice.
- Commissioners not having enough knowledge when commissioning services, in particular with regard to specialist services
- Weaknesses in the process can be not having enough data, poor analysis of the available data
- HSE management issues in that different areas act differently and there is not a coherent stable local structure. The situation has been made worse by the constant re-organisations and high turnover of staff, particularly when there is a recruitment moratorium**.**
- Commissioners do not have adequate levers to enable them to motivate providers of hospital and other services i.e. Hospital Consultants being independent practitioners.
- There needs to a quantitative study of what levers should be introduced to enable Commissioners to motivate providers of services better and a review of contracts to ensure that rigid, enforceable quality and efficiency measures are written into all contracts with providers of health & social care.

Q13: Any other issues you would like to raise about Commissioning?
For Commissioning to work there has to be:

- a common set of values that respect and encompass the full diversity of individuals' differences
- an understanding of the needs and preferences of present and potential future service users and their carers
- a comprehensive mapping of existing services
- a vision of how local needs may be better met
- a strategic framework for procuring all services within politically determined guidelines
- a bringing together of all relevant data on finance & activity
- an ongoing dialogue with service users and carers and service providers in all sectors
- effective systems for implementing service changes, whether of in-house or of independent sector services
- an evidence-based approach which continuously evaluates services with a view to achieving measurably better outcomes for service users and their carers

- an improving alignment with the way that other health and social care services are commissioned

Given both the variation of HSE structures and accountability nationwide, lack of evidence based local data & the politicisation of health and social care services, how can services be commissioned with any certainty?

While the responsibility for commissioning decisions rests with budget holders how will they be held openly to account by other stakeholders?

Will the commissioning process be equitable and transparent, open to influence from all stakeholders including users, carers and their advocates, as well as service providers from all sectors?

It is accepted that commissioning bodies need to understand from the provider perspective, the incentives and deterrents to entering or leaving the health and social care market as it were, in order to refine their commissioning and contracting processes accordingly. How is this likely to happen?

Appendix 3: Autism Life Care Trust

The Autism Life Care Trusts view is that if and when commissioning takes place the process and its implementation must at all stages include the representation and views of the service users and their families. The service providers must change their mindsets and practices to those demonstrate their willingness and commitment to embrace the concept of individualisation and inclusion for all service users and their families. The service providers will need to demonstrate that they understand of their commitment and their competence to implement the changes that would be required to provide services that reflect the wishes of the service users and their families. A funding stream should be developed to adequately fund support plans of the service user and should not be restricted by economic circumstances that exist at the present

A commissioning system for Ireland must have very clear aims and objectives based on the hopes, wishes and desires the person and their families, who have a right to a good life, to be valued and treated as equal citizens in Irish society.

Q1. Is Commissioning a good tool to deliver choice?
Yes for the service users and their families are enabled to express their wishes and desires through an appropriate person centred planning process

Q2. How best can service users/families inform the commissioning process or be involved in it?
By being enabled to have equal representation on and in any consultation and implementation process

Q3. What needs to be done to ensure an adequate supply and choice of service providers capable of delivering quality services?
Through facilitating, enabling, supporting, monitoring and evaluating the process of Personalisation for the Service Users and Standards of the Service Providers

Q4. What are the implications for service providers if Commissioning were introduced?
If commissioning was introduced in the correct way it has the potential to improve the sustainability of funding the Service Provider and also the potential for proper monitoring and evaluation the standards and practices used by Service Providers in the area of Person Centred Practices and Service user/families inclusion in the type of services that they deliver.

Q5. What are the implications for service users if Commissioning were introduced?
Has the potential if developed following equal and inclusive consultation with service users and their families to ensure that the service user gets the type of services that they or their families really want.

Q6. What would need to be done to support the transition to a commissioning framework?
A better understanding of what person centred planning and Person Centred service deliver really is. Education & training for Service Providers in the Person Centred Planning Tools e.g. the ethical principles and values that underpin the Person Centred Planning Process. Education and Training for Service Users and for their families and Carers

Q7. How can quality standards be best assured in commissioned services?
The quality of standards can best be assured in commissioned services by the inclusion of service users and their families and their carers in the monitoring, evaluation, the development and evaluation of these standards

Q8. What training and competencies do staff who are commissioning services require?
On what personalisation, person centred planning, person centred facilitation and inclusion really means. How to use person centred planning tools and how to advocate and support the service user and their families in achieving their dreams and wishes for a good life.

Q9. How could commissioning support personal budgets?
By conducting an audit of what services already exist and who is delivering these services then making this information accessible and open to everyone.

The inclusion of services users, their families in a survey/audit on their needs and their families.

A mechanism to bring about changes in service delivery that address the needs of the service user and their families

A remit to support the service user and their families to access and deliver personal budgets

Q10. Have you ever commissioned services[5], or been commissioned to provide services, and if so, what lessons have you did you learn from the process?
No.

[5] In this Question you are specifically being asking if you have ever commissioned an element of your **core care and personal social services work** rather than commissioned for the provision of an ancillary service.

Q11. What are the strengths/advantages that Commissioning might bring?

Q12. What are the weaknesses/disadvantages that Commissioning might bring?

Q13. Any other issues you would like to raise about Commissioning?

Appendix 4: Brainwave the Irish Epilepsy Association

With respect to people with epilepsy and commissioning of services Brainwave would make the following responses.

Current service models in HSE areas often do not match the needs of our members. Many services within these models are not accessed by our members yet there is unmet need within HSE areas where people with epilepsy identify service needs. This has often led to in low levels of engagement of our members with HSE services at community level with the risk of needs being unidentified or unacknowledged. A concern for Brainwave would be that due to participation issues our members are not adequately reflected in service user populations in the current model.

Where services are to be commissioned there needs to be a more flexible approach to assessment of needs in a service user population to capture the range of needs our members express. In this regard we would emphasise the essential nature of the strategic planning process to establish and define needs and assess the appropriateness of current service provision. The proposed commissioning plan needs to reflect a broader range of supports than the traditional service model has outlined to date. This area would be seen as key to Brainwave as extending the parameters of service provision beyond those of current models and the constraints imposed. This would have the desired effect of facilitating choice for service users.

Q1. Is commissioning a good tool to deliver choice?

Brainwave is of the view that the delivery of choice will be optimized by emphasising the role of the strategic planning process in eliciting current unmet need. The means proposed to assess service user needs have the potential to elicit a greater breadth of information about unmet need. However the process will be dependent on levels of participation.

Q2. How best can service users/families inform the commissioning process or be involved in it?

Participation in the process can be enhanced by having a widely publicised extended consultation with a range of information gathering approaches. Meetings and focus groups are useful but not always accessible. Organisations can encourage members to participate. The likelihood of participation is enhanced if people feel they have a stake in the process and can readily access it. Brainwave has noted increased levels of participations by its members in online engagement and for this reason would suggest having an online forum component as integral to the process.

Q3. How could commissioning support personal budgets?
Personal budgets will mean service delivery moves to a more service user led model and existing services would adapt to take account of that.

Q4. What are the implications for service providers if commissioning were introduced?

Q5. What are the implications for service users?

Q6. What needs to be done to support the transition to a commissioning framework?
The introduction of commissioning will impact on service providers in terms of their programme content, programme delivery, strategic objectives in service delivery and delivery practice. This will require flexibility and commitment to changing service models and work practices to take account of a user led service. Services need to be well place to respond effectively to a change in demand profile in order to secure contracts to continue to provide services. It will be a very new experience for many to have to compete in this way with other services and will potentially change the service provision landscape opening it up. There may be concerns that those services which were previously offering services could be overlooked in favour of new service providers and that consequently a pool of expertise could be overlooked.

Service users will have wider choice in a commissioning model and can use personal budgets to seek the service of their choice. Concerns might arise in respect of inappropriate services. Is there any risk that service users could opt to choose services that are not optimal for their needs? How would such a situation be addressed? Is there an advisory to support service users in making their choices? Will the contracting process mean that service providers direct the person to more appropriate services or seek to keep them in their service? What happens in terms of re-contracting and at what stage can this be put in place?

To support the transition it would be helpful for service users to have access to advisors or advocates who can assist them in obtaining appropriate services. Given that some new services are likely to emerge; these will be less familiar to a person making a purchase decision.

Q7. How can quality standards be best assured in commissioned services?
There needs to be comprehensive monitoring and evaluation of commissioned services and avenues of redress for service users who are not satisfied with a particular service.

Q8. What training and competencies do staff who are commissioning services require?
Staff need comprehensive ongoing training in disability issues and in assessing services and service user needs.

Q9. What needs to be done to ensure an adequate supply and choice of service providers capable of delivering quality services?
The approaches outlined in the briefing document are in use in the UK to this end and can be a model for the commissioning process here. However there may local or regional constraints on service delivery given the history an evolution of services in this country.

Q10. Not applicable

Q11. What are the strengths and advantages commissioning might bring?
Multiplicity of choice in service provision is the main advantage. Potentially the competitive nature of contracting may improve quality of services. The model of purchasing services gives control back to service users.

Q12. What are the weaknesses and disadvantages commissioning might bring?
This is difficult to predict. Uncertainty about the changeover to a new model could undermine confidence in existing services unnecessarily. Contracting may change the service provider/service user dynamic. New services will be difficult to assess initially due to unfamiliarity though there may also be a perception that new is better whether this is borne out in fact or not. The current pool of expertise may be overlooked in some instances. Services may not necessarily be optimal for those who choose them.

Appendix 5: Caremark Ireland

This is based on some of our experience in the UK and makes no comment on current funding or procurement in Ireland. I make comment upon each numbered Qin turn.

Q1. Is commissioning a good tool to deliver choice?

It can be. Commissioning enables the Authority to keep control of public expenditure and whilst this might be seen to restrict complete choice, with the correct attitudes and framework within which to work, this can be managed with minimal impact. The key is to allow service users to have input into the commissioning process, giving maximum choice and influence, which in turn hopefully begins to create a 'true' market. Providers must be allowed to give value for money and stand on the quality of service they provide. Another facet to consider is the number of providers who are selected, this is where choice can be overly restricted for the service user.

Q2. How best can service users/families inform the commissioning process or be involved in it?

An independent survey of current service provision, added to a survey on aspired shape of services would give an opportunity to begin to influence at the outset. SU's the need to be given the opportunity to sit in panel, giving personal input into the nature of services and how they would like choice to look. They should then be given access to any evaluation process towards the end of any procurement.

Q3. How could commissioning support personal budgets?

This can depend upon the definition of personal budgets. In terms of a cash payment (direct payment) true choice and control can be offered to those with capacity. Potentially then permitted to choose form a whole range of approved providers, the service user can influence the market shape. The downside to this can be SU expenditure not being monitored / misappropriated and subsequent safeguarding /debt issues. What needs are more complex (and an individual budget being allocated), multi agency consultation and input can be used very effectively with commissioning involvement. In both scenarios (recognising the impact upon HSE internal costs) it is critical to monitor the progress made against desired outcomes for the individual. This can ensure that value for money is being achieved.

Q4. What are the implications for service providers if Commissioning were introduced?

No comment on current situation or process, as no knowledge. One would envisage a need for providers to be more flexible, adaptable and with a desire to provide person-centered services and the subsequent ability to work on a multi agency basis. It requires of any organization to have a highly skilled

communicators and communication process. It would also, if managed correctly, introduce a healthier competition to raise standards, on an ongoing basis.

Q5. What are the implications for SU's if Commissioning were introduced?
The Service User would (probably) find themselves in a new environment, finding themselves needing to understand the logic and process behind the new methods being introduced, creating potential anxiety. Good signposting to services, comprehensive information sharing, coupled with managing the Service user's expectations. They would also find themselves between parties, negotiating with a minimum of two entities to arrange the service. Dual assessment and revisiting of issues are one of the most common complaints of an individual.

Q6. What would need to be done to support the transition to a commissioning framework?
As some points in Q5, added to a realistic timeframe to commencement of services and the opportunity for the workforce to be assimilated into any new system. It may be a consideration to trial any new process in two or three distinct areas, where challenges will be different.

Q7. How can quality services be best assured in commissioned services.
An ethos of value for money need to be adopted and scrutinised at the outset of this considered change. Where control of a budget sits with an individual, lowest price will prevail and compromise services down the line. Where commissioning is directly involved on a multi agency basis, a fair price can be evaluated. There is a strong argument to have tiered provider lists in terms of a scoring system based upon quality and then price. Quality must then be maintained by a comprehensive process of review and involvement. QMR, service user input, and provider self assessment and unannounced inspection are efficient tool, but as a combination, not in isolation.

Q8. What training and competencies do staff who are commissioning services require?

I am not aware of any specific training course/s, so make no comment here.

Competencies need to revolve around person centred approaches and experience of others across perhaps UK and Europe. It is interesting to note that more private sector involvement should be utilised to prevent the scenario arising of the 'irresistible force meeting the immovable object' arising in the future. A mistake over the years made by UK commissioning and procurement over recent decades is the failure to see longer term impact on quality of services by designing a processed that suits one side of a negotiation. Power in terms of funding allocation cannot and must not be over leveraged.

Q9. What needs to be done to ensure adequate supply and choice of service providers capable of delivering quality services?
Primarily, the success of any transition, such as this, needs to be in the eyes of the service user, it is they who have the vote and who will benefit from service enhancement. To this end, their involvement from the outset will influence longer term susses, creating and attractive proposition for any future changes. This will then translate into greater willingness for more providers to engage and create the desired environment to move forward. It is likely that there will be more providers focusing upon population centres, to the detriment of more rural areas and this needs to be addressed at the outset. A realistic framework, considering the logistical challenge on all providers must be contemplated, delivering value for money for all parties and a consistent, equal offering for the service user. This should incorporate a supportive approach to recruitment of support workers in relevant areas, allowing a solution to a long standing problem in services.

Q10. Have you ever commissioned services, or been commissioned to provide services, if so, what lessons did you learn from the process?
We have been commissioned to provide services. Some comment above reflects lessons learned in terms of the relationship between commissioner and provider, the power balance needs to be considered early in the process to avoid a suppression of core values within a provide, giving sufficient room for broader, more creative thinking and imaginative solutions for the service user.

Q11. What are the strengths/advantages the Commissioning might bring?
Commissioning enables the purchasing authority to have a closer relationship with the service user and thus create an environment of upward and future strategy creation. It allows sufficient control to manage budgets and also puts into place a framework that should safeguard the service user more robustly.

Q12. What are the weaknesses/disadvantages the Commissioning might bring?
Too open a process (particularly in terms of direct or cash payments) can deliver safeguarding and debt issues. A large enough choice and approved list should be considered to offer real choice and control. A new process will also bring anxiety for more vulnerable members of any society and needs to have a long term structure offering the process time to embed and for short term problems to be overcome.

Q13. Any other issues you would like to raise about Commissioning?
A review of many commissioning practices within many authorities in the UK has resulted in a decline in commissioned hours, although the uptake of personal budgets and direct payments has increased markedly within the fields of disabilities, particularly in younger adults. There is no doubt that where capacity exists, there is a fundamental desire to take advantage of such a process and

any future framework needs to reflect this, with careful consideration to longer term impact and should also consider the ramifications of losing ultimate control of how public funds are finally ex[ended, particularly with direct payments.

Appendix 6: Damien O'Reilly

Have read through your Preliminary Discussion paper a few times and thought this is the way to go.

Even though it is focused more on service providers rather than service users, I feel my view is valuable.

As a young person with cerebral palsy needing high level of support I always think naturally enough, would this work better for people like me.

Commissioning would appear to give more choice to people with a disability.

I must clarify I am looking at this from the Independent Living and the Personal Assistant (P.A.) perspective.

I live in a rural area of Co. Cavan where there is no Service Provider to administer a P.A. service, and there are many other counties in the North East region that would be very similar. So how will commissioning work for the people in my situation and many more like me.

In my own case after much searching for a service that would meet my needs and more important give value for money, I felt the only solution was to use my "Private Package" of funding for P.A. service and administer it myself as a "Direct Payment".

I have total control over my service and it is tailored to meet my needs and it is definitely value for money as far as the H.S.E. is concerned. The only problem from my perspective is that it also comes with all the responsibilities that being an employer entails.

So, how can commissioning help me?

I sincerely hope that you will take my views on board, that there may be a way of including them in your preliminary discussion paper.

I look forward to your response,

Kindest Regards.

Damien O'Reilly

Appendix 7: Dara Residential Services Ltd

A couple of general comments on Commissioning Disability Services, and in particular **tendering for services**:

There is considerable experience of tendering for larger contracts in Ireland, but not in the disability field.

Tendering would put enormous power in the hands of the Commissioner, as the process is very amenable to manipulation. Key decisions such as: the size of the tender (large tenders effectively rule out smaller agencies from competing) and the relative weight given to price (would favour for-profit agencies who have already develop capacity (don't then have to take on the staff from the "losing" agency), or what are considered quality systems for the purposes of the tender (much easier to get accreditation with PQASSO that CQL) – these are all examples of how tendering can be managed to get a predetermined result.

This raises the Q of the expertise and independence of the Commissioner – the point that XX made at the Federation meeting.

If HSE staff or ex-HSE staff are appointed, then conflict of interest issues clearly arise, and no amount of Chinese Walls will change that! The experience of pseudo-tendering in east-Meath is worrying.

One of the problems with the current "Service Arrangement" is that it becomes a contract when it suits the HSE, but is not a contract when it doesn't. More clarity in the relationship between the HSE and the voluntary bodies would help. In my view, it should be a straightforward contractual relationship, with breaches of contract on either side having clear consequences.

Tendering suggests competition; yet the HSE and perhaps the government appears to favour reduction in the number of providers. How can the Commissioner or indeed families have any choice of provider if there is only one provider.

It is the larger providers that seem immune from any suggestion of amalgamation, yet they are often the providers with the large expensive congregate settings that, for years, have made no effort to replace them with community services.

A final general comment: There are currently a number of initiatives which will impact on the delivery of specialist services: the introduction of the HIQA National Disability Standards; the HSE Report on congregate Settings; the HSE Day Services Report; The Supports Intensity Scale or In Control model for determining individualised funding; etc. It is important that all initiatives are

congruent, that there is a consistent model implied in all of them; that there are clearly stated values undermining all these initiatives. The Q of model coherence is frequently overlooked.

Hope these comments are helpful.

Appendix 8: David Egan

Q1. Is Commissioning a good tool to deliver choice?
Commissioning can be a good tool to deliver choice to service users around personal budgets provided the commissioners understand the need for 'soft' services to run concurrently as part of the process. Soft services are those which inform and give capacity to the service user about how to make choices and how to control their service to ensure their expected outcomes are met. These soft services can be provided through peer support groups, user led organisations, families and friends (microboards, circles of friends etc) or by an advocate, and should be independent of the service provider. The Commissioners must appreciate from the outset that these soft services have a cost.

In 2005 the UK Government strategy document 'Improving the Life chances of Disabled People' recommended that by 2010 "each locality should have a user-led organisation. Disabled people are best placed to take the lead in identifying their own needs and in identifying the most appropriate ways of meeting such need. Techniques such as Person Centre Planning enable the views and preferences of individuals to drive assessment of need. Such forms are effective both in terms of enabling disabled people to play their full part in society and make effective use of public funds."

In its Preliminary Discussion Paper the NDA states that the HSE funds voluntary disability service providers and seem to assume that this will remain the case. This view is supported by the NDA paper **'The Introduction of Individual Budgets as a Resource Allocation System for Disability Services in Ireland'** which states "any introduction of individualised funding for people with disabilities based on support need is likely to sit within the framework of the current Assessment of Need legislation and practice."

The assessment of need as set out in existing legislation does not reflect the aspirations of People with Disabilities (PWD) to have a 'good life' outside of the areas of health and education currently specified in the Act. Before any service commissioning takes place the Commissioners must be aware of the needs of the individual which reflect the aspirations of that individual for a 'good life' as expressed by them.

Thus the most fundamental Q of 'who' should commission disability services is not addressed by the NDA in its 'Preliminary Discussion Paper.' There needs to be a clear distinction between 'health services' and 'social services' for PWD. The Commissioners of social care for PWD should reside outside of the health arena. The failure of the assessment of need process as set out in the Disability Act 2005 is a clear case in point. The assessment is focused on health issues and has become 'bogged down' in clinical inputs arising out of an over emphasis

on the medical model of disability. If the social or citizen model is to succeed then the Commissioners of such services might best be placed in a Government department with a social remit.

Commissioning should be undertaken by one central body with responsibility for setting national criteria to which successful applicants must adhere. This will avoid duplication, differing criteria in separate HSE (LHO) areas, and would be more cost effective.

The Commissioning Service can ensure the quality of assessment by establishing national criteria for assessment of individuals and by contracting suitable qualified and experienced persons who will be obliged to undergo mandatory training to carry out assessments. Training modules would include administrative law, human/disability rights, process for handling applications, appropriate communication skills, gaining knowledge on personal circumstances surrouding an individual, formulating decisions and documenting applications.

Q2. How best can service users/families inform the commissioning process or be involved in it?

Users and families should be involved at the earliest opportunity before the commissioning model is constructed. To ensure buy-in and ownership of the commissioning model service users need to be part the architectural team responsible for designing the model.

When consulting with PWD care needs to be taken that the independent views of families and service users are represented. Service providers will be consulted in great depth.

Having representation on any consultative panel from national representative bodies of disability organisations is not enough. Equally service providers do not necessarily represent the views of all of their members/service users. Independent advocates and small user-led service providers, as well as service users/families themselves, who do not represent any organisation should be sought out and considered as advisors on the design of any commissioning model.

Involving service users at design stage will ensure that the necessary weighting criteria, against which applications to provide services are evaluated will include ‘social value’, ‘peer support’ and ‘user-led’ as embedded practices in service provision. In this way small service provides who adhere to value sets such as ‘person centred’ and the philosophy of ‘independent living’ will not be disadvantaged against large organisations or for-profit companies who may score more highly in the area of competitive pricing but who place little value on realising the full potential of PWD.

Q3. How could commissioning support personal budgets?
Personal budgets have different manifestations and are not clearly defined in the NDA Preliminary Discussion Paper. Commissioning can support personal budgets in many different ways depending on what type of personal budget is envisaged.

Broadly speaking personal budgets are used to give effect to the policy of "funding following the service user." This concept is based on the notion of the service users assessed needs being met by the service provider within an agreed budget. The provider is accountable for demonstrating how the budget was used for that individual, how the individual was consulted, and how their needs were met. The budget is therefore notionally 'owned' by the service user. This will require providers to unbundle their annual budgets but it does not mean the budget is in the hands of the service user.

In such a scenario Commissioning assists the user to choose their provider who they feel will best meet their needs. Commissioning also allows the user to choose to have their needs met by a number of different providers and to switch to an alternative provider.

Personal budgets can mean the service user is given cash in lieu of services with a view to constructing their own personalised service package. Commissioning can facilitate this option by deciding who qualifies for such a direct payment, what the payment may be used for and to whom the individual or their supporters is accountable for the correct use of their budget. This aim may best be achieved through legislation, specifically a Personal Assistant Act (see supporting documentation)

Q4. What needs to be done to ensure an adequate supply and choice of service providers delivering quality services?
Choosing service providers may prove difficult as traditionally there may only be one service provider operating locally in the area of intellectual disability. Such a provider may supply an entire package of supports such as group homes, school, day care, transport and respite breaks. It may not be practical for an individual to move to another provider as this may mean moving away from their locality and any natural supports which may exist. Choice can be introduced gradually by breaking up the service users package among different service providers with expertise in different areas and by allocating part of the budget for personal (non-group) activities through the provision of a number of personal assistant hours.

Quality of service should be the responsibility of the provider with external monitoring and inspection.

In terms of PWD taking cash in lieu of services to purchase their own assistance Commissioners will play a pivotal role in assuring service quality, in the first instance, by setting out the purpose of a Personal Assistant inside and outside of the home, and secondly by ensuring the service users are adequately compensated for the cost of hiring Personal Assistance as per the description of that role, including the secondary costs associated with employment, and having regard to the ongoing supports required by some service users who choose this option (see supporting documentation).

The Commissioners must ensure we avoid a race to the bottom in terms of service quality which could arise if service users are left to contract with for-profit companies, or by self employing, on the basis of squeezing the maximum number of service hours out of their budgets by paying minimum wages.

Q5. What are the implications for service providers if Commissioning were introduced?

Service providers will be required to put an individual budget in place for each client and to demonstrate that the clients personally expressed needs are met.

Providers will need to become more flexible and innovative in how they deliver their services. Providers must become open to the idea of specialisation in the provision of certain services and to having some of the clients needs met outside of the providers core services.

The main challenge for providers may be to change the ethos of their organisation so that ‘person centered’ becomes an embedded lived experience for service users and not just another tick box exercise for staff.

This will present challenges for providers, for the staff of providers who may resist major changes in work practices and perhaps most importantly for the organisation to become less risk averse. Parents of PWD must also be open to change. Deciding on acceptable levels of risk for the service user in the life they choose to live and deciding who holds that risk - the Commissioners, the Providers, the Service User or the supporters of the service user, will challenge all of the stakeholders

One example of an existing service arrangement is John who has an intellectual disability and lives in a small midlands town. John went to mainstream primary and secondary school. He lives in his own rented apartment which is subsidised by his local Council. John’s primary service is personal support. He has a number of core hours of support during the day for personal care, cooking, cleaning and social activities. Personnel are recruited by his provider. His provider also gives John a monthly cash payment which allows him to employ people for ‘sleep overs.’ He does his recruitment with his mother and usually

employs college students around his own age. John also has the option of attending a local day care service (but not with his core provider) on three days a week. He is well supported by his family who live locally and he has an old school friend who acts as his advocate at meeting with his service providers.

The challenge for both service providers and Commissioners is to ensure this type of flexible arrangement can be put in place. In this example there are two service providers, some flexible arrangements around sleep overs, a personal advocate, the local Council and Johns family and friends, all of whom come together to give John choice and control over his life.

This example of one matrix of flexible supports, which will vary and change over the lifecycle of the individual, is the way of the future.

Appendix 9: Declan O'Keeffe

With reference to the 'Preliminary View' Paper on Commissioning Disability Services, I should like to make a few brief comments.

For the past nineteen years, I have had two people to work as my Personal Assistants - both of whom are employed by the Irish Wheelchair Association. I form part of the Self-Directed Package, which means that I am essentially a Line Manager and have responsibility for the following:

- Recruitment and interviewing of prospective PAs
- Furnishing all required documentation to the Assisted Living Services Office of the IWA
- Arranging the timetables and work of my PAs (their work includes assisting me at my workplace)
- Submitting completed time-sheets to the ALS once a fortnight
- Ensuring that work done by my PAs complies with Employment and Health & Safety Legislation

You will see from the above that this provides me with a very considerable amount of flexibility, choice and control, and allows me to live my life in the way that I want.

Therefore, in commissioning any type of service, it is vital that the user has the maximum amount of choice and control, etc., over what he/she requires.

I am aware, of course, that at the present time every effort has to be made at reducing costs. Nonetheless, at no stage must this lead to deterioration in the quality of service.

In connection with this, it is necessary to avoid a 'one size fits all' approach. For example, the role of a PA is quite different from that of a Care Attendant, and the two should not be confused with each other.

I realise that my comments are confined to quite a specific subject, but I hope that they may be of some use, nevertheless.

Yours sincerely,
Declan O'Keeffe.

P.S. Perhaps I should have explained above that I live on my own and that, therefore, any change or reduction in the service provided would have very serious consequences on my life.

Appendix 10: Drumlin House Training Centre

Feedback NDA paper on Commissioning due 9/9/2011

1. This paper was received on 15th August at a time when staff are on holidays or preparing for the new intake in September so it did not allow adequate time for a considered response.

2. The statement that the service has "evolved" seems somewhat loaded as if this was a bad thing when in fact voluntary services have jumped in to a fill a gap that was long neglected and to support parents, families & friends who were ill equipped to cope.

3. The paper "jumps in " without clarrification or background of "commissioning". The background is that many providers have only recently been given a "service agreement" and yet have been providing a service requested by HSE for many years. There have been no issues about "commissioning" raised in our parents meetings and no quanntitative data on why "commissioning" might be an issue.

4. There is no definition of "commissioning" and most readers will associate this process with major capital works, complicated electronics or defence contracts. This mechanism may be appropriate for larger organisations with dedicated departments such as government bodies but does not seem appropriate for the ID sector where back office service are minimal.

5. It is inferred that commissioning offers "gretaer choice" but the opposite could also be argued.

6. The requirement of a person-centred service is written into all service agreements and is not necessarily predicated on a "commissioning process".

7. The correlation of personal budgets and a commissioning mechanism is not stated and the suggestion of allowing market forces to shape services seems to be counter to person-centred principles

8. The recognition of the need for quality assurance would seem to argue that consistency and resourcing will be found where there is a critical mass of delivery rather than in piece-meal or specialized services. This seems to favour the "big battalions" . However there are many example of small providers delivering a flexible service to a high standard.

9. The paper reasons "commissioning implies poorly performing service providers" but no evidence is given. In the context of ID I find that defamatory and insulting. There are already mutiple providers in our area and adequate individual choice between services and within services. Longer intervals been

renewals may result in a reduction of administration costs but the argument for a wider “pick and mix” choice of providers will necessitate a lot more monitiong by the commissioner. Longer funding terms & more cooperation are indeed desireable but the paper fails to show how a funding mechanism might achieve this.

10. It is interesting that the paper has no comment to make on Q 4, 5 & 6 . There appears to be more text missing at the foot of page 5

11. The paper has little to say how parents/carers might manage a personal budget & procure services suited to service users.

Appendix 11: Eugene Callan

Q1. Is Commissioning a good tool to deliver choice?
Perhaps. If the Commissioner is also the Funder, then there is a conflict of interest. The Funder has a primary interest in achieving cheapest cost. Where is an independent commissioner has the interest in achieving best quality and most appropriate services. Also, commissioning services could be seen to yet again remove control from the individual in need of the service. In such a scenario the Commissioner would say to the individual, we have commissioned this service for you.

Q2. How best can service users/families inform the commissioning process or be involved in it?
Families/service users can only inform the commissioning process if they are familiar with service models that exist in other countries and other locations. For example, an individual who has been living in residential care for 20 years, cannot reasonably be expected to be able to inform the commissioning process about the most ideal service for themselves. Therefore they would need to be a certain amount of educational process, before even trying to inform the commissioning process.

Q3. What needs to be done to ensure an adequate supply and choice of service providers capable of delivering quality services?
The normal rules of supply and demand will ensure that this is achieved. If the funding is provided to the family/individual. They can buy the service that they need. Providers will over time tailor their products to attract the customer. This has been the experience in Sweden.

Q4. What are the implications for service providers if Commissioning were introduced?
It would make service providers pay much more attention to what is needed, rather than simply what they provide. In essence, it would help to make them fit for purpose.

Q5. What are the implications for service users if Commissioning were introduced?
It could be positive, but it could also be negative, in terms of so-called experts designing & commissioning services. This service may end up being over-designed, rather than being simply what the service user needs.

Q6. What would need to be done to support the transition to a commissioning framework?

Q7. How can quality standards be best assured in commissioned services? By ensuring the cheapest price is not the highest priority.
Again, if the service user is in control, they will ensure that they are receiving a service of a high standard, or else would choose another service. Supply and demand.

Q8. What training and competencies do staff who are commissioning services require?
The most important competency is a broad range of experience in best quality services that exist internationally, coupled with a genuine ability to work in tandem with the service user. To have a good listening ear. A Masters in social care provision will not necessarily provide the skills. The experience of service users is that when they are dealing with highly trained individuals, those individuals/experts feel that "they know best", which is a portent of failure.

Q9. How could commissioning support personal budgets?
It can perhaps help to inform what the hourly cost will be for services.

Q10. Have you ever commissioned services[6], or been commissioned to provide services, and if so, what lessons have you did you learn from the process?

Q11. What are the strengths/advantages that Commissioning might bring?

Q12. What are the weaknesses/disadvantages that Commissioning might bring?
If there is a large add administrative framework, this will eat into the funds available for the services, and also inevitably lead to delays in processing. One might have the best commissioning service in the world, but that can only deal with very small numbers of service users.

Q13. Any other issues you would like to raise about Commissioning?
That main one that I would raise is the excessive administrative burden for the service user who has a personal budget, in terms of compliance requirements by the Funder. This needs to be enormously streamlined and put on a much more practical footing.

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[6] In this Q you are specifically being asking if you have ever commissioned an element of your **core care and personal social services work** rather than commissioned for the provision of an ancillary service.

Appendix 12: Inclusion Ireland

Q1. Is Commissioning a good tool to deliver choice?
Yes but the model/method needs to be fleshed out and clearly stated i.e. parameters, max and min funding allocation, who can avail of it, who can provide it, what can and cannot be provided etc.

Q2. How best can service users/families inform the commissioning process or be involved in it?
Commissioning panels and end user focus groups made up of service users and family members, review panels or customer panels would also be helpful. The commissioning panels could vet and approve applications from providers wishing to become commissioned.

HiQA mandatory standards and inspections must be in place for all services as a prerequisite. Services should have service users and Family Members as part of consumer panels and be involved in internal inspection teams would be good.

A QA system similar to EFQM might be useful to support or inform standards.

Q3. What needs to be done to ensure an adequate supply and choice of service providers capable of delivering quality services?
There are lots of not-for-profit providers operating across the country but many will need to change their model of delivery, they may need some time/support with this, so pilot programmes and a time framed change process may need to be put in place and supported by government, ultimately providers will have to follow the money. In addition the number of for profit services who are being used by the HSE is growing. The market is distorted by this quasi system where the individual; is not contracting with a private provider as with private nursing homes. Furthermore there are no mandatory standards or inspection which is very worrying.

Quality services will need to be supported by a good QA model + mandatory standards and inspections, a reward system for services of exceptional excellence could also be developed.

Q4. What are the implications for service providers if Commissioning were introduced?
Possible closure for some providers and opportunities for others. Service providers that cannot change and adapt to the new environment will disappear if they are still offering a model of service delivery that is inappropriate and outdated.

Q5. What are the implications for service users if Commissioning were introduced?

- More control and choice in the quality and method of service delivery and eventual ownership of whatever type of service they ask to be commissioned
- Service users will be pushed to take a more active role in how their service operates (this may be a positive or negative depending on the individual)
- More positive outcomes at an individual level but the process may be challenging for some people.
- Quality will improve if there is a direct connection between choice by consumer and service. More competition is required
- Parents and families of people with disabilities may be concerned about lack of continuity of services. Their fears may be used by providers who do not wish to change their model

Q6. What would need to be done to support the transition to a commissioning framework?

- A phased series of pilots partnered between willing providers, willing participants (users and families) and the commissioning body/board/organisation- a reasonable budget in the first pilot phases. As services grow the model, economies of practice and scale should develop
- A lead in time for service providers and service users to begin to understand and test the model
- A lot of training for all stakeholders
- A communications strategy for families staff and service users
- The development/implementation of a universally accepted QA system and the implementation of HIQA mandatory standards
- The sourcing of early adopters and champions for the model both from service providers and service users
- A strong commitment from government that the model will be implemented across the spectrum of service provision irrespective of reluctance or opposition from providers.

Q7. How can quality standards be best assured in commissioned services?
QA systems and standards, mandatory, independently verified and spot checked with reward systems for the high performers and sanctions for the underperformers.

Q8. What training and competencies do staff who are commissioning services require?

- Advocacy and individual support skills including non-instructed advocacy
- Individual or personal planning skills

- Strategic planning skills
- Operational planning skills
- Mapping and strong knowledge of service provision by area
- Negotiation and conflict resolution skills
- Budget management and planning skills
- Assessment and evaluation skills
- Clear understanding of QA systems, standards, policies and procedures.
- Knowledge of all regulatory structures such as HIQA

Q9. How could commissioning support personal budgets?
They support each other. There is no point in having a personal budget if you cannot spend it the way you want to, no point in having commissioning if people don't have the money to buy the services they want.

It could eventually also lead to individual service brokerage.

Q10. Have you ever commissioned services[7], or been commissioned to provide services, and if so, what lessons have you did you learn from the process?
No.

Q11. What are the strengths/advantages that Commissioning might bring?

- A stronger focus on person centred provision
- The provision of a service more focused on individual outcomes
- More ownership of the service by the service user
- More completion ending of monopolies
- The possibility of further mainstreaming service provision
- A partnership based approach to service provision between service users/families/service providers and commissioning bodies
- A good opportunity to bring in professional QA systems
- The introduction of mandatory standards and inspection Commissioning should and cannot not occur without this.
- Possible better value for money results at an individual level
- Possible de-commissioning of larger, mass managed services.

[7] In this Question you are specifically being asking if you have ever commissioned an element of your **core care and personal social services work** rather than commissioned for the provision of an ancillary service.

Q12. What are the weaknesses/disadvantages that Commissioning might bring?

- Possible fragmenting of services to an unsustainable level
- Possible rise in service provision costs
- Danger of private providers cutting costs for commercial financial private gain – lowering of quality
- Quality of service commissioning may significantly depend on the quality of commissioning staff
- Potentially a significant level of staff training/re-training
- Services may not be able to provide all of or elements of an individual plan within the commissioning agreement
- Families and service users may not wish to engage with commissioning because of a fear of losing what they currently have
- There may be a tension between what the service user needs and what s/he wants
- Delivery costs may be unsustainable
- There may be significant gaps between what the service user/family wants and what the service provider can deliver.

Q13. Any other issues you would like to raise about Commissioning?
No.

Appendix 13: Irish Society for Autism

Q1. Is Commissioning a good tool to deliver choice?
Yes, providing that the need of each individual (service user) has been appropriately assessed and that a range of services are developed so that real and meaningful choices can be made and that a national strategy is agreed and priorities set. A strategy should also make recommendations as to the appropriateness of existing services and the range of services required. Families and service users should be consulted as to the type of services required.

Q2. How best can service users/families inform the commissioning process or be involved in it?
User/family forums, discussion papers, seminars etc.

If the commissioning process is to succeed its aim should be to enhance, quality of services available and giving full choice to each service user.

Q3. What needs to be done to ensure an adequate supply and choice of service providers capable of delivering quality services?
More information, improved relationships between statutory and not for profit sectors. Mutual respect, realistic timeframe for achieving change.

Q4. What are the implications for service providers if Commissioning were introduced?
An overall evaluation of the organisations from governance to frontline staff. Regarding education and training, new focus, new skills, more business like approach, become customer orientated and cost and quality conscious.

Q5. What are the implications for service users if Commissioning were introduced?
An improvement in the range of quality of services available. More choice for the service user and a realisation by service providers that the service user is a valued customer and will need to be treated as such.

Q6. What would need to be done to support the transition to a commissioning framework?
A total change in the way business will be conducted. This will require information, training and a solid working relationship between the Commissioning Agents and the service providers. There will also be a cost consideration.

Q7. How can quality standards be best assured in commissioned services?
The HIQA standards should apply with a robust inspection process. I consider this the easiest problem to solve

Q8. What training and competencies do staff who are commissioning services require?
They will require knowledge of the Disability Sector, the Not-For-Profit sector and an appreciation of the wishes and choices of service users and their families. There would also need to be an appeals procedure for service users and their families regarding the choices provided to them.

Q9. How could commissioning support personal budgets?
Commissioning once developed will most certainly encourage people with disabilities (service users), to have control of their disability budget. It will enhance their dignity and give them control of their lives.

Q10. Have you ever commissioned services[8], or been commissioned to provide services, and if so, what lessons have you did you learn from the process?
No

Q11. What are the strengths/advantages that Commissioning might bring?
An improvement in the range and choice of services, improved financial services, a more business like approach to service provision and an overall strategy for the development of services enabling organisation to forward plan.

Q12. What are the weaknesses/disadvantages that Commissioning might bring?
There is a danger that it will create more paperwork for already overstretched organisations.

1. That it will limit the range of services rather than increase them. Consideration will need to be given to rural vs. urban, community homes, integrated settings, farm settings, apartments – shared or individual, housing estates, support in ones own homes. Who will determine the appropriateness of a persons (user) choice?
2. The choice of the individual (user) and his family or guardian will it be respected. If not who will make the choice.

Below taken from the European Charter of Rights for People with Autism (full copy available from the Irish Society for Autism – www.autism.ie):

> "4. THE RIGHT of people with autism (and their representatives) to be involved in all decisions affecting their future; the wishes of the individual must be, as far as possible, ascertained and respected,

[8] In this Question you are specifically being asking if you have ever commissioned an element of your **core care and personal social services work** rather than commissioned for the provision of an ancillary service.

People with autism have a particular difficulty in making decisions. This is the result of a) not being able to envisage the consequences of decisions which are made and b) not being able to express their views or opinions.

Consequently, it is tempting for those having responsibility for the implementation of services to make the decisions on behalf of the person with autism and the person for whom the service is provided is left frustrated and disappointed at decisions made in his or her name. People with autism do not always make a fuss or react violently to suggestions made to them but acquiescence should not be taken as agreement with decisions taken in their name.

No effort should be spared in explaining the options available even though this may be time consuming and the explanation, perhaps, unintelligible to the subject. No attempt should be made, by the enquirer, to obtain particular responses by deception or by the omission of significant details. Exploiting the vulnerability of people with autism by allowing them to express an opinion based upon false, incomplete or inadequate information is worse than allowing no choice at all.

Even those people with the severest forms of handicap can usually make their preferences evident. Even when unable to verbalise, their behaviour, equanimity, pleasure or distaste are easily observed and their preferences determinable by those who know and understand them. When, and only when, it remains impossible to determine the wishes of individuals concerned, the person's relatives, carers, advocates and friends, (particularly those suffering from autism,) may need to be consulted.

Even when the person with autism is believed to be incapable of understanding proceedings where decisions may be taken which affect them directly, they should be present during that discussion. Their physical presence will help to focus the minds on the subject of discussion and will expose and minimise comment which undermines the dignity and humanity of the individual.

It is recognised that it may not be in the best interests of the person with autism that all his/her wishes be acceded to but where such wishes, expressed or not, are over-ruled explanations should be provided.

All records of agreements, statements and minutes from such meetings should be subject to the approval of the person with autism and/or their representatives."

Q13. Any other issues you would like to raise about Commissioning?
If commissioning is properly implemented and support by appropriate legislation it will enhance the lives of people with Disabilities and expand the range and quality of service provision.

Appendix 14: Irish Wheelchair Association

Q1. Is Commissioning a good tool to deliver choice?
If the purpose of commissioning is solely for the purpose of asking a number of providers to compete to achieve a contract then it is not a good tool to deliver real choice. The competitive nature of procurement through commissioning can result in a range of suppliers offering the same service focusing on competitive costing only. Unless the commissioning criteria clearly specifies that suppliers will be selected, not only on pricing, but also ensuring that the other aspects of what they can provide will receive equal or greater recognition within the commissioning process.

It could be a good tool if the "choice" is identified and taken on board with extensive service user input. Establishing the criteria within the model for commissioning should have significant input from potential service users. These service users should decide on the priorities within any commissioning process, ensuring that it is not only driven from a value for money perspective but that the whole spectrum of choice is taken into account, including all social and quality of life requirements. A broad holistic range of criteria is required to meet individual support needs.

Q2. How best can service users/families inform the commissioning process or be involved in it?
In terms of individual service users, public focus groups should influence the specification of services which are to be commissioned. This would need to be carried out in a sensitive and professional manner to encourage service users to provide meaningful feedback and opinions.

It is vital that individuals receive support in relation to identifying the aspects of commissioning which will ensure that it provides them with a quality person centred service.

Historically service development in Ireland has been led by the voluntary sector. Groups of concerned service users and/or families came together to develop a response to a service gap they were experiencing. These groupings became charities which in time developed and became professional. Service users' views and experiences are still strongly reflected in these organisations. These groups are not just service providers; they are frequently and often largely made up of service users. It is important that the body of knowledge contained in these organisations is facilitated to inform and shape the nature and type of commissioning process being developed.

Q3. What needs to be done to ensure an adequate supply and choice of service providers capable of delivering quality services?

The commissioning process must have a clear criterion which is designed to meet the requirements of the service user rather than from a value for money perspective only. If this process is driven by financial criteria then the choice of service will significantly be diminished as only a low cost model of service will be delivered. Experience has shown that a low cost model of service will only be able to offer service users a model of service which barely meets their basic requirements and does not allow for any personal control or support within the service.

By pursuing a low cost model of service it may exclude many of the current service providers from entering into the commissioning process as their model of service focuses on providing quality person centred services to individuals which may result in the service having additional costs. This could result in only for-profit businesses, low-cost model of service, entering into the commissioning process and precluding the not-for-profit sector whose main focus is to provide service users with holistic supports to improve the quality of their lives.

If this was to happen there would be large pockets of the country where there would be no services available for service users as the low-cost model of service can only operate in high density population areas.

Commission process should avoid allocation of supply to a single provider and must seek to identify minimum quality standards in service provision from a number of different providers who can offer the service as specified in the commissioning criteria.

Q4. What are the implications for service providers if Commissioning were introduced?

Not-for-profit service providers may find it difficult to compete on a financial basis with many of the for-profit businesses within the sector. The primary reason for this is that many of these not-for-profit agencies currently pay staff in line with HSE pay scales, whereas for-profit businesses generally pay significantly less to their staff for basic and antisocial hours worked.

Not-for-profit service providers have worked to improve the quality of service for service users over many years. There is a genuine fear that the standards achieved may be diminished as a result of the introduction of commissioning unless there are minimum standards of service clearly defined in the process. These minimum standards of service must meet the current quality of service being delivered.

Under the commissioning process there may not be an ability for service providers to be innovative in relation to developing services. The ability for organisations to develop and set standards within the sector has been a significant aspect in relation to the development of quality services in Ireland. It would be detrimental in the long-term if this aspect of service development was lost as a result of the introduction of commissioning.

In the commissioning process it can be extremely difficult for organisations to have the holistic aspect of the service they provide valued or acknowledged as a vital component of the service for the service user. Holistic aspects could include case management where the service user is supported with all aspects of life, such as an assistant living service coordinator supporting an individual with their housing requirements, education supports, etc. Holistic aspects can also include providing service users with supports outside of those funded through the commissioning process. These could include transport services, full access to an organisation's entire service portfolio e.g. access to social activities, sports, holiday breaks, driving tuition and inputs from volunteers to support individuals etc.

For both service users and service providers it is vital that the introduction of commissioning does not result in a diminishing of the quality of service for service users.

Q5. What are the implications for service users if Commissioning were introduced?

The introduction of commissioning will be a significant change for individuals currently receiving services. Individuals who choose to purchase their own services should be encouraged and supported as much as possible. A support process for individuals is essential at the point where they select a service provider and also on an ongoing basis to ensure they are supported to manage the service. If this support is not put in place service users could find that they are seriously disempowered by the introduction of commissioning. Service users will also need to be part of the ongoing monitoring, evaluation and feedback of the services they are provided with.

Unless service users are included in the development of criteria outlined for the service provider in a commissioning process they may find themselves in a position of purchasing a service from a successful service provider which does not meet their specific requirements.

Unless there are minimum levels of standard of service specified within the criteria for commissioning, the service individuals receive through commissioning may be significantly less than the standard and quality of service they currently receive.

It is vital, when establishing criteria for commissioning, that there is no diminishing of the range and choice of service which is currently available to service users as it could have detrimental effects for individuals. An example of this is if commissioning criteria stated that service providers could not offer assistance to individuals to support them with their medication requirements. This could result in individuals no longer being able to live independently in their community.

Q6. What would need to be done to support the transition to a commissioning framework?
The important piece of work which needs to be completed before any transition can happen is the involvement of all stakeholders, including current service providers, to establish the minimum criteria for the delivery of the service.

A genuine effort is required to develop a process where the input from the service users regarding their desired outcomes and the views of the service provider regarding the operational issues are taken into consideration. This input is crucial at the point of designing the service specification for commission.

A structured support system must be put in place to support individuals in relation to understanding and availing of a commissioning framework. It has been established that continuity of services is an important element of service for most service users, therefore, the introduction of commissioning should protect against causing service users unnecessary anxiety in relation to continuation of their current service.

Service providers should be given a clear understanding of what is expected in relation to changing to a commissioning process. Current service providers should also be given adequate notice in advance of the introduction of commissioning as there may be staffing and other implications to be addressed in relation to services currently being delivered.

Q7. How can quality standards be best assured in commissioned services?
Quality standards need to be set out at the outset and criteria provided on how to meet these standards with ongoing monitoring and evaluation once the services are set up. Minimum criteria should be provided for all parts of the service so that a certain standard will be obtained and maintained. Persons providing services should have standards, training, etc., and those obtaining services should understand what this is. It is essential that the demonstration of success in quality is not a statistical exercise i.e. Reporting of X number of monitoring visits a quarter will not guarantee quality service.

For those persons choosing a personal budget, information should be provided on this so that they are fully informed and can make a choice. All service users

should be involved in reviewing and monitoring of the service as these are the best people to confirm whether the service is meeting their requirements. Service users may require support in identifying poor service delivery as they may fear that if they voice their concerns it will impact on their service going forward. For this reason it is vital that service users are supported in relation to the ongoing review and monitoring of their services.

Q8. What training and competencies do staff who are commissioning services require?

The staff need to be trained in procurement processes and related areas. Staff also need in-depth training regarding the operation issues and delivery challenges of the service they are working with. It is essential for staff to design service specifications and marking systems and to evaluate submissions. Operational understanding brings a much sharper focus to the service specification and increases the potential for real time responsiveness to be built into the design.

Q9. How could commissioning support personal budgets?

Commissioning can provide service users with a selected panel of service providers from which they can choose to have their services provided. This panel will have met minimum criteria in relation to quality assurance which will guarantee the service user a service which they can be assured will meet their requirements.

Commissioning will only support personal budgets if the service user can be assured that the selected service providers meet their specific requirements. As already stated, it is vital that service users have an input into the development of the criteria for commissioning in relation to their services.

Commissioning will also need to have a support structure which supports the service users in relation to the administration, management, review and monitoring of service purchased through a personal budget. Without this support structure, international experience demonstrates that there is a greater likelihood that individuals purchasing their own services will face problems and possibly withdrawal from the process. It can also result in individuals purchasing services which do not meet their requirements.

The challenge for an individual who receives services under the current process to start to purchase their own services directly should not be underestimated.

Commissioning may not support personal budgets in relation to individuals employing non-selected service providers e.g. if an individual wishes to purchase a service from a next door neighbour. While we believe that individuals should have the right to purchase their services from wherever they choose, we strongly

advocate that there must be minimum criteria in relation to any service an individual purchases through their personal budgets. Our reason for this is to ensure that there is a minimum quality standard of service maintained to support the individual.

Q10. Have you ever commissioned services[9], or been commissioned to provide services, and if so, what lessons have you did you learn from the process?

We have experience in commissioning / tendering to provide services. While there were many positives in the process to confirm e.g. standard of training for staff, requirements to provide an array of policies and procedures, outline of management and support structures, etc., the process limited the potential for creativity and responsiveness to emerging service needs.

Because the process is so focused on the specifications within the service it did not allow us to demonstrate the additional supports and aspects of service which we could provide as standard elements of our service. e.g. if we were providing a service to an individual for five hours a day there was no opportunity for us to demonstrate how we support that individual beyond the five hours services which we were funded for. This support could take the form of advocating with the individual, supporting individuals while in hospital, supporting the individual in relation to social activities and outings, linking the individual with other services - both our own and mainstream, supporting the individual in relation to housing requirements, etc. The tendering process was only focused on core funded elements of service.

If the criteria used for the commissioning / tender that we tendered for was transferred to our current service, which is similar to what we tendered for, it would significantly challenge the ability for people with disabilities to remain living in their communities independently. The issue in question related to supporting individuals with their medication requirements. The tender process we entered into specifically stated that this was not part of the service. While the service we tendered for was for over 65s, it is a similar support to what we provide to our current group of service users and, as stated, if the same criteria was transferred to our current service users it would create insurmountable challenges for many individuals.

This is a clear demonstration why there has to be exhaustive consultation with all stakeholders in advance of the introduction of any commissioning for services.

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[9] In this Question you are specifically being asking if you have ever commissioned an element of your **core care and personal social services work** rather than commissioned for the provision of an ancillary service.

Q11. What are the strengths/advantages that Commissioning might bring?
It could support more cost effective service provision which ensures adherence to minimum quality standards. It also could have the opportunity to ensure that there is transparency and accountability in relation to the delivery of all services.

Commissioning could be a very useful tool in relation to ensuring that all service providers adhere to criteria that would promote quality person-centred services which would enhance the lives of people with disabilities.

If introduced correctly, with the proper supports, it also should provide service users with the opportunity to manage personal budgets in a way that would ensure they receive quality services that meet their requirements.

It would also give organisations the opportunity to tender for services which they are currently not delivering.

Q12. What are the weaknesses/disadvantages that Commissioning might bring?
If commissioning was not developed in a collaborative approach with all stakeholders it could seriously diminish services which service users currently receive. If the roll out of the process was not done with the required supports it could cause service users significant distress at the thought of losing their current services. It could also limit the responsiveness to emerging issues and restrict the ability for service providers to be able to meet the changing needs of service users on an ongoing basis.

There is a possibility that it could develop as a 'one size fits all' service specification which would reduce the quality of services to individuals and could also restrict their ability to continue to live independently in their community.

If commissioning is primarily focused on securing financial savings it may result in the closure of many of the not-for-profit organisations. This would be a significant loss to the disability sector, considering how it has been the not-for-profit organisations that have driven and led the development of quality services for people with disabilities in Ireland over the last 50 years.

Q13. Any other issues you would like to raise about Commissioning?
We have concerns about the effect of how the introduction of commissioning may restrict our ability to be innovative in developing services.

As alluded to above, in a number of questions the introduction of commissioning will challenge many of the not-for-profit organisations to be able to compete with for-profit organisations who pay their staff significantly less. While this may not be an issue for a government

considering introducing commissioning, it is an issue in relation to ensuring that the quality of service currently being provided to people with disabilities is continued. It is also an issue in relation to acknowledging the holistic service model which many of the not-for-profit organisations provide.

Appendix 15: Kerry Network of People with Disabilities

In response to your Commissioning Disability Services Preliminary Discussion Paper. We have the following points to make and question to respond to.

Page 7 of the attachment

Q2. How best can service users/families inform the commissioning process or be involved in it?
Is there a complaints procedure that Parents of or People with Disabilities can avail of, while I believe there well may be I also feel that when a complaint is made on a service or service provider the complaint is not acted on in the appropriate manner, the service provider been more listened to than the service user.

Q8. What training and competencies do staff who are commissioning services require?
We find that a percentage of service providers are not properly trained to do what they are required this leads to frustration on both the individual provider and the service user it is a no win situation for either side and can often lead to more problems than solutions, individuals working are slow to ask for help from a supervisor as it shows their incompetence to handle certain situations.

Q10. Have you ever commissioned services[10], or been commissioned to provide services, and if so, what lessons have you did you learn from the process?
We on a regular basis ask for help on behalf of our members, assuming this is not going to be national news within the next two days I will give you an example of two people providing the same service in Co Kerry.

There are a team of Occupational Therapists in Co Kerry in one part of the County the Therapist involved could not be more helpful and our success rate with her is second to none.

On the other hand we can get little or no satisfaction from a Therapist in another part of the County.

A recent case was a girl looking for an electric wheel chair she was given two wheel chairs for a period of three months each to find out which one was more

[10] In this Question you are specifically being asking if you have ever commissioned an element of your **core care and personal social services work** rather than commissioned for the provision of an ancillary service.

suitable, she picked one of them as been suitable but it was taken back from her and she was told that she was now on a waiting list.

We lobbied on her behalf and rang the Therapist one day to be told that her family were well off and could well afford to purchase a wheelchair for her.

The actual fact is the Mother was working for a contract cleaner and the father was a block layer, need I say that at this time they are both unemployed.

The girl in question lives about one mile outside a fairly large town here I Kerry but cannot use her manually propelled wheelchair to the town to meet with friends for a cup of coffee or tea, socialising is a no go area for her.

This is leading to bouts of depression and recently a spell of three weeks in hospital I have been told.

The question asks what lessons did we learn from the process, I could be rude but that will not get the girl the wheelchair but it does say that there are people who care and people who do not out there.

Q13. Any other issues you would like to raise about Commissioning?
I don't advocate people been given things that they do not really need, but common sense seem to go out the window on cases that are clearly deserving while those who appear to have pull are proffered over those more deserving.

Appendix 16: National Federation of Voluntary Bodies

It was noted that this topic is especially relevant to our members in the Dublin – North East region as many of the agencies had engaged with a local HSE initiative in 2010 (Day Placement Services East Meath) related to the commissioning of Day Services.

HSE Day Placement Services East Meath

There was an acknowledgment that this 'commissioning' initiative was innovative by the HSE in Co. Meath. It is a region that has also introduced and applies cost bands for Day Services. With this as a background, agencies put their names forward to be part of the tendering process. However, their experience was very poor in that they felt it was not a fair and transparent process from the outset. There was no consultation with service users, families or local service providers in advance of the commissioning initiative. Parents and families felt intimidated by the process as they had the experience of HSE social workers and community nurses visiting their homes outlining the need for their family member to transfer their Day Service or else face the possibility of losing their transport service. For those being transferred from their existing service provider to the new East Meath service in Duleek, there was no consideration invested on the personal impact of the individuals' concerned.

The experience was also targeted to certain clients as others who resided very near to Duleek were not given the opportunity to access the new service. This initiative could not be considered a new or enhanced service development, as individuals were taken from a service they were content and satisfied in and essentially pressurised to transfer. Significantly, in the context of commissioning, the initial tendering document that was circulated to agencies made no reference what so ever to principles i.e. individualised approach, person centred planning, rights, citizenship with no reference what so ever to **Quality.** Rather, it primarily concentrated on inputs i.e. staffing levels, clinical inputs, hours of service and numbers of clients.

This brief summary sets out a commissioning innovation by the HSE that contradicts documents such as New Directions and national policy emanating from the Department of Health. From our perspective, the learning from the experience with regard to the commissioning of services is very informative.

In examining the NDA paper, the potential of commissioning services has to be acknowledged as do the potential difficulties that could arise from same. The document asks many questions and makes some statements of concern. Most especially under Section 2 - Procurement of Services - it states "A tendering procurement involves inviting providers to compete on a number of specified criteria, which may include quality….." The Federation were deeply concerned at the word 'may' as it does not show a firm commitment to the most essential

criteria in awarding any service delivery contract. However, in Section 6 it says that quality standards are an intrinsic part of commissioning services. In this regard, the Federation expressed concerns that the document is not convincing on what it prioritises when commissioning. With this lack of conviction, money could become the driver of decision making.

The East Meath experience highlighted the need for the commissioners to be objective, informed, skilled and independent also became very apparent.

Concerns were also expressed by Federation members with regard to how the system had separate but interrelated initiatives in place at this time and would they be used to inform each other. Most especially the Department of Health Policy and Value for Money Review report (and costs findings), the NDA position on Commissioning and the reality of service purchasing on the ground where local HSE regions unilaterally dictate the rate of funding and the places given, which is informed by a simple division of the number of clients seeking a service into the budget available.

The following sets out the positives and negatives of commissioning as identified by the Federation Membership:

Positives - Commissioning has the potential to:-

- Develop and deliver choice within the delivery system;
- Formally introduce assessment of need and build the commissioning of services around that assessed need;
- Drive and determine service costs (built on a clear minimum standard);
- Shift resourcing from poor performers or inappropriate services to more efficient person-centred approaches;
- Move individuals (service user) to more responsive, appropriate and self directed services;
- Develop new models and approaches to service delivery across a range of providers;
- Create additional opportunities for co-operation between the different providers particularly in the area of shared services to the client. This opportunity goes beyond specialist service providers to include mainstream providers;
- Increase capacity within the sector and within local service provision;
- Bring forward a new way/s of purchasing services including the concept of brokerage;
- Create competition which demands agencies having to examine and “up their game” to compete;

- Break from the established ways of commissioning services.

Negatives - Commissioning has the potential to:-

- Fracture service provision to an individual and their carers, leaving the end user without surety, continuity and clarity of service;
- Allow the service user to fall between service providers if there is not appropriate and considered co-ordination;
- Damage relationships between service providers as they move from co-operation to competition;
- Lessen the service to the individual if the provision is shared across providers i.e. issues such as medication and medication management, specific care/support plans, behaviour supports and management, family support and management and future planning needs. Crossing service providers can dilute and confuse provision;
- Threaten the certainty and continuity as the awarding of contracts determines duration of provision;
- Put additional pressures and responsibilities on carers and families (especially as they are under constant stress due to their primary carer role);
- Shift services to less effective, lower cost provision including the re-engagement of institutional and congregated settings;
- Be more costly in the long term as agencies could lose the economies of scale;
- Lessen the quality of service provision if the criteria for the awarding of contracts is not set out clearly, applied objectively and reviewed consistently – especially assessment of need and capacity of service provider;
- Create additional bureaucracy and administration with associated costs;
- Create a 'cherry picking' approach within the system where more costly and complex services are not tendered for;
- Damage future planning as the commissioning system typically works on short term contracts;
- Reduce the skill base and skill mix within service providers as costs will be a significant criteria element in the awarding of contracts;
- Reduce the professionalism of services currently in the system (especially if cost becomes the primary driver);
- Reduce the scope of provision by an agency as contracts given will determine their offerings.

Appendix 17: National Parents and Siblings Alliance

Introduction

The essence of the NPSA view is that if and when commissioning takes place all services must demonstrate quality, efficiency and effectiveness to be selected. Those seeking contracts should demonstrate their willingness and commitment to embrace the concept of individualisation for all their clients. They should also show that they understand the significance of that commitment and be able to demonstrate their competence to implement the changes that would be required to provide such programmes. Cost is also very much an issue. However, it should not take precedence over the provision of quality services.

In broad terms any system of commissioning must take account of the above. In other words, the commissioning system must have very clear objectives based on the vision that people with disabilities have a right to a good life and be valued by society as equal citizens.

Q1. Is Commissioning a good tool to deliver choice?

Commissioning is a good tool if:

1. the assessment of needs has been extended to the entire population of people with disabilities
2. the assessment of needs is concerned with the person's full needs informed through a person centred approach to assessment.
3. the commissioning procedure is flexible, broad enough and allows for the breadth of people's needs – that it doesn't provide new formulas to replace old formulas.
4. Service providers are not permitted to cherry pick the type of service that they provide.
5. Service Providers restructure and become more client and family centred

Q2. How best can service users/families inform the commissioning process or be involved in it?

1. Service users/families can inform the commissioning process if the commissioners are obliged to actively engage with and listen to service users/families
2. The process of "listening" would be a slow process. Initially, it would involve "listening" to a lot of people until a rough pattern was established. The commissioners should also be aware that while a pattern might emerge people are still different.
3. Eventually, the commissioning process should be mainly informed by an appropriate 'assessment process'. Essentially, we are saying that the commissioning process should be informed by the person's real needs as

identified by one integrated assessment process. This assessment process should never end up being an additional requirement for people with disabilities or their families.

4. If the commissioners are engaging a particular service provider for a particular person they should be obliged to consult the person and his/her family before finalising the process.

Q3. What needs to be done to ensure an adequate supply and choice of service providers capable of delivering quality services?

1. New service providers (support providers) should be encouraged to enter the system. What would "encourage" new support providers is a totally open approach to commissioning. Support providers should be selected only on clear criteria (including quality). While it would be difficult for current providers, it should be clear that being a long time in the disability area is not a criterion.
2. This should be followed by stringent monitoring to ensure that all those commissioned were performing as they had promised.
3. The above means that the present system of going to existing service providers to provide a service (new or existing) must stop. A tender process should exist. Also parents, or parent groups should be encouraged to participate

Q4. What are the implications for service providers if Commissioning were introduced?

1. Service providers (support providers) must adopt a proper person centred approach. The alternative would be that they would not be given contracts. In other words, within reason, the emphasis of the agency would be on their clients rather than their organisation. This would mean, in cases, a total re-organisation of their systems.

Q5. What are the implications for service users if Commissioning were introduced?

1. Service users (clients) would expect to have their real needs met. The development of this expectation would be a gradual process as people got used to the new system and understood that the support provider was expected to meet their needs.
2. If clients were not aware of what was expected of their support provider and monitoring was inadequate things wouldn't change.
3. Commissioning should ensure the needs of end users are better met.
4. The commissioning process should ensure that people with disabilities and family preferences as to the service provider they feel comfortable and appropriate for them should be reflected in the commissioning of the service.
5. The overall needs and care of the client and support to the family may be lost by having a number of separate and discrete service providers. In other

words, with all its faults, in the present system, often the one service provider providing support for the person has a commitment to that person. If a person gets support from a number of service providers that commitment might not be there.

Q6. What would need to be done to support the transition to a commissioning framework?

1. There would need to be a consistent system for costing supports.
2. There would need to be detailed and clear descriptions as to what was expected of service/support providers.
3. State funding for disability services should be ring fenced within a separate budget heading and accountable separately to the accountable minister.
4. Publish research findings and outcomes where this approach and implementation of service has been employed elsewhere.

Q7. How can quality standards be best assured in commissioned services?

1. A combination of monitoring and listening to the users of supports.
2. It would be necessary to give very clear instructions to service providers as to what they were expected to do. This would be far from simple because the whole point of individualised supports is that supports be as flexible as possible. Therefore, there would have to be a very clear understanding that "flexible" doesn't mean "anything goes".
3. We would emphasise the need for monitoring, inspection and policing of standards.
4. The Commissioners should have similar powers of inspection and sanctions as HIQA. Otherwise task HIQA to carry out the inspections.

Q8. What training and competencies do staff who are commissioning services require?

1. Staff would need to think outside the box – be innovative, see their clients as fellow citizens with their own lives to live. Staff would have to be totally independent of service providers. Their only work criterion should be the good of the disabled person.
2. The personnel involved in the commissioning process would need to have a breath of experience in the field of disability support and social work with minimum training and competency requirements.

Q9. How could commissioning support personal budgets?

Commissioning would place the emphasis on individual programmes and would allow people with personal budgets, if they wished to pick elements of support from one or more service providers as part of their Plan.

Q10. Have you ever commissioned services[11], or been commissioned to provide services, and if so, what lessons have you did you learn from the process?

No.

Q11. What are the strengths/advantages that Commissioning might bring?

1. Commissioning would, hopefully, allow a more flexible system to develop in the provision of supports to people with disabilities.
2. It would end the virtual monopoly of current service providers.
3. It should bring more choice for clients and more relevance to the services offered.

Q12. What are the weaknesses/disadvantages that Commissioning might bring?

1. Inevitably, the commissioners' attitudes would be reflected in decisions. Therefore, if the commissioners had not minds open to improving the lives of people with disabilities or were not instructed in the right attitudes, commissioning would become "more of the same". The problem, in this case, is that the commissioners would have to have a degree of independence. The wrong person would have his prejudices supported by the system.
2. Because of the flexibility in the system, the State might be tempted to reduce costs at times of recession.
3. End users' voices need to be at the heart of ALL service provision. The weakness of commissioning revolves around whether the HSE/Government accept that end users should be the controlling instrument on service provision not protocols etc of HSE /Government/ service providers. Commissioning if done incorrectly will lead to no change and all existing players controlling everything and the voice of end users forgotten. The system needs to be transparent, open to all and accountable.
4. It's important for an enforcement process to be in place with real powers of sanction against parties who fail to live up to service agreements.
5. Parents and clients might get lost in the modularisation of services with services then being unwilling or unable to cooperate.
6. Service Providers could become overly focused on one narrow aspect of provision with little pressure to respond to changing needs.
7. The Commissioners could become just another QUANGO

[11] In this question you are specifically being asking if you have ever commissioned an element of your **core care and personal social services work** rather than commissioned for the provision of an ancillary service.

Q13. Any other issues you would like to raise about Commissioning?

1. There is a real danger that the ‘Commissioning System’ would evolve into nothing more than another layer of bureaucracy between those in need of support and the support services they need. That people might be lost in the spaces between the ‘funding’, ‘commissioning’ and ‘service delivery’. It would be imperative that this potentiality is guarded against from the outset and throughout the process. In this it would be essential for people with disabilities and their families to have an element of ‘real’ ownership of the commissioning process from the start. Further, transparency and accountability would have to be to the fore with built in mechanisms for people with disabilities and their families to feel confident that their needs will be secured through the timely, flexible and supportive commissioning of services and supports.
2. Once again we emphasise that the HSE should encourage new entrants to system. They must support new entrants so that a ‘level playing field’ is developed for all commissioning.
3. Change should not happen without a clear statement which identifies what is wrong and not working with the current model of service provision/funding. This needs to be itemised and then any new model should address specific point and problems. Otherwise the 'project' could become the project loosing sight of the original motivation and need. The implementation needs to have specific milestones and forums for feedback and evaluation. Evaluation criteria need to be published prior to the implementation of the change.

Appendix 18: Not For Profit Business Association

In responding to the questions contained in the NDA Preliminary Paper on Commissioning, the Not for Profit Business Association (NFPBA) acknowledge that a paper has already been sent in my NFPBA member, Irish Wheelchair Association. We would also like to add the points below, in addition to those raised by IWA, for consideration. While we are conscious of needing to send feedback in time for consideration by the speakers, we would also like to point out that, at the time of writing, Enable Ireland had not yet contributed.

We have included our additional points under the relevant questions below. Where no additional comments have been added, please refer to the IWA submission.

Q4. What are the implications for service providers if Commissioning were introduced?

- Registration, standards, regulation and inspection all form part of a commissioning framework. The PQQ is used to rule organizations in or out of the process based on meeting specific criteria. Service providers, when successful, often enter a framework agreement – as often, these agreement do not involve specific block contracts e.g. no set hours etc (every service model is different) and therefore service providers need to be secure financially. This is difficult for NFP organisations.
- Frameworks are set for a number of years. Then, depending on the next round of commissioning etc., Transfer of Undertakings (TUPE) can and does impact. In the UK, this is clearly factored in. In Ireland, full understanding of this is required.
- The impact of direct payments / personal budgets is dependent on what system is used. For example, if a client is directly receiving the funding, then the service provider needs to have robust credit control systems as there will be multiple invoicing.
- Clear service agreements are needed between client and service provider in terms of responsibilities etc.

Q5. What are the implications for service users if Commissioning were introduced?

- The impact of TUPE on a new round of commissioning can impact on service users, in that the service they are receiving may also change if their current provider does not continue to stay on the framework.
- Some of the needs of parents and children may be different than that of the adult service user and this needs to be clearly factored in.
- A number of adult service users would have mental capacity issues which could make it difficult for them to be involved in the process of choosing a

service. This needs to be considered when setting out on the road of commissioning.

Q9. How could commissioning support personal budgets?

- Difficulties can be experienced in terms of family members having control of finances, rather the individual.

Q12. What are the weaknesses/disadvantages that Commissioning might bring?

- Based on an NFPBA member's experience in the UK, some processes can be quite complex and indeed time consuming i.e. there can be 3 to 4 rounds between Expression of Interest, Pre-Qualification Questionnaire, Invitation to Tender etc.
- The need for health and technical supports for people with a physical disability increases the cost of service provision and this needs to be considered in commissioning services.

Question 13: Any other issues you would like to raise about Commissioning?

We look forward to engaging with the NDA on the issue of commissioning of disability services, and hope to see our views incorporated at the seminar on September 30th.

Appendix 19: Peter Moore

I would like to endorse the attached document written my David Egan. Especially the paragraph I quote here

'The assessment of need as set out in existing legislation does not reflect the aspirations of People with Disabilities (PWD) to have a ‘good life’ outside of the areas of health and education currently specified in the Act. Before any service commissioning takes place the Commissioners must be aware of the needs of the individual which reflect the aspirations of that individual for a ‘good life’ as expressed by them.'

I write all the time through dictation to my personal assistant. Therefore my pa needs to have good keyboard skills. Writing, and socialising in my local pub with people who have little interest in disability are my purpose for living. If my needs are seen purely through a medical model of disability these would be considered unimportant, whereas they are almost as important to me as eating.

I cannot put it in stronger terms than this.

Regards
Peter Moore.
Author of Rebel on Wheels.

Appendix 20: Ita Kilgarriff

As regards monitoring, evaluation and feedback it can be very good to have a TD or Counsellor sitting in on committee meetings. Very often a person with a disability can be associated with a few different disability organizations and the counsellor or TD can be very helpful in finding solutions to different complicated situations in a diplomatic way.

From

Ita Kilgarriff

Appendix 21: Val Horgan

At the moment the services given to assist a person with a physical disability, who are living an independent life in the community whether its someone living in their own home like myself who need assistance, or people living in group settings, are living in the fear that services or the PA's wages are to be cut, losing hours has an affect that stop some people from speaking up. The fact that the most vulnerable people in Irish society are the 1st to be cut by governments changes and budget is really horrific, do people who are in wheelchairs, sick living in tough situations have to be the first to protest is a bad reflection on society and the way the government think about people with disabilities.

Regards

Valerie Horgan BA(hons) psych, dip. suicide, dip counsellor,