NDA paper on commissioning framework for disability services

This background briefing paper is intended to inform the discussion on an outline commissioning framework, as referenced in the Value for Money and Policy Review and in Future Health: A Strategic Framework for Reform of the Health Service 2012 – 2015. Other jurisdictions are using commissioning as the way to manage social care.

Commissioning is a system to ensure that services secured address identified needs. The commissioning process involves a series of separate stages

* Assessing the needs of a population
* Setting service priorities and goals
* Securing services from providers to meet those needs
* Monitoring and evaluating outcomes for services users

Commissioning provides an opportunity to configure services around service user needs, rather than slotting service users into an existing service configuration. It provides an opportunity to involve service users and their carers in the different stages of the commissioning cycle identified above.

There is a lack of hard evidence that commissioning has had a major impact on costs or outcomes for service users, though given that commissioning is an overarching process this may not be surprising.

There are some key elements that would be required if Ireland were to move towards commissioning disability support services:

* A national needs assessment system generating adequate data to inform service planning and specification of service requirements
* A national eligibility framework for social support
* Standards to inform service specifications
* A system to monitor delivery of the agreed services to the required standards including measurement of outcomes

HSE at present both funds and delivers services. A move to a commissioning approach would involve a purchaser/provider split.

The following table sets out a summary of the differences from the current system. A more detailed version of this table is found in Appendix 2.

|  |  |  |
| --- | --- | --- |
|  | **Current system** | **Commissioning** |
| Needs assessment | Doesn’t underpin provision | Underpins provision |
| Eligibility | No clear rules – to a large extent provider-determined | Determined nationally |
| Priorities | HSE Service Plan sets high-level priorities. Otherwise set at local level by service providers | Explicitly set in commissioning strategy |
| Scope of services | Determined by service providers, subject to broad SLA | Determined by funder |
| Funding | Block funding based on historic allocations | Related to needs and contracted service |
| Contract length | Indefinite | Specific period |
| Monitoring | Limited | Built-in to process |

A number of points to consider are:

* What are the legal and industrial relations implications of moving from the current funding model to a commissioning model?
* What level of disruption would result from contract change in Ireland and how might this be managed?
* How can service providers be supported to change towards the new model?
* What skills would be required of those commissioning social care services, and how would these skills be developed and maintained?
* If service contracts are awarded subject to competition, how to ensure that quality is not compromised in favour of the cheapest solution?
* How to ensure that where contracts are subject to competition that they go to those who deliver the best services, not to those who write the best proposals?
* How might the self-directed / personal budgets issue fit together with a commissioning framework?

# Introduction

This background briefing paper is intended to inform the discussion on an outline commissioning framework, as set out in section 4 of this document. There are also further items for consideration detailed in Appendix 1 which would also be useful to consider in the context of developing a commissioning process for social care in Ireland.

Following discussion and agreement between NDA, HSE and the Department of Health on what should be contained in the Outline Framework commissioning document, a revised simplified version will be prepared and a supporting presentation to inform discussion on stage 2 of this work (workshops with three exiting disability programme working groups).

This paper is divided into three sections:

* **Context** **-** This sectionssets out how commissioning has been described in recent major Irish policy documents
* **What is commissioning? What impact can it have? -** This sectionsdescribes what commissioning is, how it has developedand whatevidence is available to support the introduction of commissioning
* **Outline Commissioning Framework –** This core section of this paper sets out what a commissioning framework might look like in an Irish context.

# Context

## Value for Money and Policy Review

### Definition of commissioning

The **Value for Money and Policy Review of Disability Services in Ireland** defines commissioning as follows:

Commissioning of social care has been defined by the UK Audit Commission as ‘the process of specifying, securing and monitoring services to meet people’s needs at a strategic level’. Commissioning as a concept applies to services regardless of source, whether they are directly provided by the public health sector or other public bodies, or by the voluntary or private sector. Procurement is one specific aspect of the commissioning cycle and focuses on the process of buying services[[1]](#footnote-1)

The **Value for Money and Policy Review of Disability Services in Ireland** goes on to note that the HSE already performs a form of commissioning:

Using the above definition, the HSE may be deemed to commission services by means of the SLA process. By and large, the HSE’s commissioning function is not proactive, but based on the continued provision of existing services by the established service providers. New services, too, are generally commissioned through a process of local negotiation with the established providers. New voluntary service providers have generally established a foot in the market through providing a service that was not available from an established source or through providing a service in a geographical region that had no existing service providers[[2]](#footnote-2)

### Commissioning and “directional re-shaping” of services

The **Value for Money and Policy Review of Disability Services in Ireland** suggests that commissioning may play a role in a process to reconfigure certain service areas:

The HSE should, in consultation with the disability sector, work towards the directional re-shaping of certain services and models of service delivery based on a new commissioning and procurement framework.

### Commissioning and congregated settings

More specifically the **Value for Money and Policy Review of Disability Services in Ireland** suggests that commissioning may be a means of driving the deinstitutionalisation process under way by the Congregated Settings Report Implementation Group

The Review makes reference to the implementation of recommendations in the HSE’s 2011 review of Congregated Settings and recommends that priority should be given to putting a new model of community based supports in place for persons moving from congregated settings, discontinuing admissions to existing settings and ending the commissioning of new settings.

### Commissioning as a competitive procurement process

The **Value for Money and Policy Review of Disability Services in Ireland** suggests in some cases competitive tendering should be used by the HSE.

The commissioning process, whereby the HSE arranges for the provision of services, should be formally documented. Opportunities for procurement by competitive tendering should be explored wherever this would maintain or improve service user outcomes at the same or lower cost. The HSE should move beyond a model of commissioning services from individual providers to one where, even on a pilot basis, services are sourced using a competitive procurement process[[3]](#footnote-3)

### Commissioning and widening service and support options

The **Value for Money and Policy Review of Disability Services in Ireland** appears to suggest that commissioning may be a way of bringing more choice to service users. However, how this might be done is not spelled out in much detail.

A comprehensive commissioning framework for disability services should be developed so that a range of service and support options will be available to people with disabilities. This should include, at least on a pilot basis, the sourcing of services through a procurement process[[4]](#footnote-4)

### Commissioning and market shaping

Furthermore, the Value for Money and Policy Review of Disability Services in Ireland identifies commissioning as a means of actively seeking to influence the market for disability service provision.

more ‘hands on’ commissioning, including management and direction of the market for provision of disability services[[5]](#footnote-5)

## Commissioning as set out in “Future Health”

In the area of health, rather than social care, **Future Health**, envisages “all payments” to providers being managed by a “Healthcare Commissioning Agency”

The directorate management teams involved in performance contracting and financing of services will be subsumed into a new commissioning body the Healthcare Commissioning Agency in 2014, where they will be charged with continuing to drive performance improvement through value-based purchasing

The Healthcare Commissioning Agency will encompass the funds previously managed by the HSE directorates. It will be subject to the instructions of the Department of Health and will transform national policy priorities and service targets set out by the Minister for Health into detailed performance contracts with healthcare providers. It will then manage all payments to providers. Performance contracts will explicitly link payment with the achievement of targets across the spectrum of quality, access and activity[[6]](#footnote-6).

### Strategic commissioning frameworks

Furthermore, **Future Health** envisages the new national directors taking their commissioning role beyond merely funding providers towards assuming a “performance management” role

[The new National Directors] will also be required to **work to develop the strategic commissioning frameworks for their areas in accordance with overall policy on financial reform**. Under the new management structure, the Regional Directors’ role will, over time, change from a direct operations management function to a control and performance management function for finance, access and quality[[7]](#footnote-7)

### Social and Continuing Care Fund

In social care, similar to healthcare, as outlined above, a funding agency, to be established in the short term, will in time take on a strategic commissioning function.

A new Social and Continuing Care Fund will allocate funds to public and non-public providers of social and continuing care. This will **eventually be done through a strategic commissioning model which will commission or procure packages of services specified by a care needs assessment**[[8]](#footnote-8)

### Commissioning and outcomes

**Future Health** states that an outcomes framework will be put in place and that providers performance will be measured in relation to these outcomes, once commissioning is introduced.

A rigorous performance management process will be put in place with defined national outcomes for all of the care groups. Providers will be measured regularly against the achievement of these outcomes and the results published. Performance against outcomes will be used, in turn, to inform the commissioning process[[9]](#footnote-9)

### Commissioning social care from public and non-public providers

**Future Health** suggests that core social care support for people with disabilities and older people will be commissioned on a similar basis from both public and non-public providers.

“The Social and Continuing Care Fund will use a standardised framework to commission services from both public and non-public providers. This will allow for an assessment to be made of the needs of all individuals requiring social and continuing care. People with the same needs should not be treated differently depending on whether they are classified as a ‘person with a disability’ or an ‘older person’[[10]](#footnote-10)

### A quality standards and regulatory structure

**Future Health** notes the necessity of a commissioning environment for having an appropriate quality assurance regime in place.

The introduction of central commissioning and individualised budgeting has to be accompanied by a regulatory structure which will underpin quality standards and allow flexibility in the commissioning of services from a wider sector. It will also ensure that services procured are up to a baseline of quality and safety[[11]](#footnote-11)

# What is commissioning? What impact can it have?

## What is commissioning?

Commissioning is a cyclical **process** involving the following steps:

* Assessing the needs of a population
* Setting service priorities and goals
* Securing services from providers to meet those needs
* Monitoring and evaluating outcomes for services users

While the commissioning process is led by the funder of social care, it will involve service users, carers and social care staff and providers.

In addition to defining commissioning, it is also important to say what it is not. Commissioning in the context of social care is not synonymous with:

* Outsourcing
* Tendering
* Competitive tendering

However, commissioning in certain circumstances **may** include elements of the above.

Commissioning is not a particular form of service delivery. Commissioning is not associated with any particular service provider type.

Commissioning tends to denote a **proactive**, strategic role in planning, designing service provision to an entire population sub-group, such as people with disabilities. While the **Value for Money and Policy Review of Disability Services in Ireland** notes, the Health Service Executive in developing its annual Service Plan and agreeing Service Level Agreements arguably does actually engage in a“form” of commissioning it also stresses that this “form” of commissioning is **not proactive**.

[the] commissioning function is not proactive, but based on the continued provision of existing services by the established service providers[[12]](#footnote-12)

This situation is not unusual. Most social care systems are largely based on decisions made in the past.[[13]](#footnote-13) They are based on:

* past views of best practice
* past profiles of needs
* past views of priorities
* historical investment decisions
* historical skills mix

However, social care systems face, and constantly will face, a changing context. Future investment in social care will be shaped by:

* the changing needs of service users
* changing views of wider society
* technological change
* demographic change
* economic change

Therefore, “the factors that determine what services are **provided** are not the same factors that determine what services are **needed.**”[[14]](#footnote-14)

This raises the question of **who** in a social care system, for example, Ireland’s disability services, has the **responsibility** to ensure that investment made this year will increase the likelihood that services will be well placed to meet the needs of all those who require social care in three, five or ten years time?

In a commissioning model the answer to the above question is that the **agency funding social care** has the responsibility to gather the evidence and develop a plan for how to meet current and future need, taking account of the profile of current provision.

In the absence of a commissioning framework, historical patterns of provision will largely determine the future shape of service provision in combination with:

* individual service providers (through developing innovative practices)

and

* central government (through periodic policy directions)

Understanding this model of proactive, future-orientated, evidence-based planning and decision-making is critical to understanding commissioning. Perhaps, the value of developing a commissioning framework may be that some **overarching process** to **plan** for current and future provision based on evidence of need, current service provision profile and evidence of outcomes, is more likely to produce a better effect than funding services in the absence of any such overarching planning process.

### Commission and the threat from reorientation funding towards current and future needs

As commissioning seeks to allocate funding to service areas which meet the current evidenced-based profile of need and invest in areas where increased future demand is anticipated, **funding services simply on the basis that they have received funding in the past is not tenable within a commissioning framework**. That is not to say that very many incumbent service providers would not receive funding if a commissioning framework was introduced. However, this re-orientating of the **basis of funding** away from past allocation towards current profile of needs and anticipated future needs is what makes commissioning a perceived and understandable threat to incumbent service providers.

Essentially, the threat posed by commissioning to providers is that implementing a commissioning process **only makes sense** if it is linked to a procurement strategy, which is focused on funding services **based on evidence of quality and value for money**. Furthermore, monies to invest in the types of services required to meet current and future needs of people with disabilities are raised, in part, from decommissioning service areas, where there is evidence that such services no longer meet needs.

As commissioning does challenge the status quo, it can also be perceived as a threat to service users. Those in well-funded services or well-developed service areas may, if the evidence supports it, see funding for their services diverted to other areas. Though there are measures for reducing the frequency and impact of service contract changes on service users[[15]](#footnote-15), those in poor quality services may see their services taken on by another provider.

Obviously, it is also true that, because commissioning focuses on the **needs of a whole population** rather than current service users, it may enhance access to services for those who currently **don’t have service or have limited access to services**. For those service users, who see the management of their service taken on by a new service provider, may after an initial inconvenience find that their new service is of a higher quality.

## Where did commissioning come from?

In Ireland, much of what we read and hear about commissioning relates to changes in how social care and, more recently, health care has been delivered in the United Kingdom.

Many Irish people, therefore, accurately associate commissioning with reforms designed to replace traditional public service delivery with outsourced providers selected by competitive tendering initiated in the United Kingdom in the 1980s[[16]](#footnote-16). It should be noted that while the design of these reforms in the United Kingdom, as detailed in the Griffiths Report 1988, did set out to ensure that more social care was delivered by outsourced (profit and not-for-profit) organisations. It also emphasises that social service users would benefit from choice, flexibility and innovation, which would flow from these reforms.

Moreover, in the United Kingdom, these reforms were a response to a service delivery system, which not only had spiralling costs but had incentivised people being cared for in residential settings, rather than in the community. In recognition of this, it was seen that the agency funding social services needed to have an “enabling” role, which would involve it having:

* A strategic overview of all sources of social care available
* An acceptance that not all services had to be directly delivered by public service providers
* A recognition that all the different sources of support available in the community should be utilised[[17]](#footnote-17)

Even in the original thinking which informed commissioning in the United Kingdom, the tension existed between commissioning as a service planning and reconfiguration framework and commissioning as means of outsourcing elements of direct service provision.

One commentator has stated that In the United Kingdom, “there is no common understanding of what commissioning means.”[[18]](#footnote-18) A group of authors recently observed that there “are many in government [in the United Kingdom] who confuse the distinction between commissioning, purchasing, procurement and contracting.”[[19]](#footnote-19) Furthermore, they note that this confusion continues to be unhelpful.

What is particularly damaging about such a confusion is that the belief that “commissioning” is the same as externalisation [or outsourcing] has soured the general attitude towards commissioning for many stakeholders[[20]](#footnote-20)

Furthermore, commissioning has been described differently over time in the United Kingdom, it has been described differently by different Government Departments and by the different devolved Governments within the UK.[[21]](#footnote-21)

In England, the assumption that outsourcing social care from directly provided (that is. local authority provided) to either profit or non-profit providers, would directly lead to savings, is now widely seen as flawed. Procurement strategies focused on competition have become, over time, subsumed with commissioning strategies which have a much broader planning function.[[22]](#footnote-22) However, in England the role that “choice and competition” contribute, within the commissioning framework, to increasing service user outcomes (by providing choice and driving innovation) is still often strongly emphasised.[[23]](#footnote-23)

In Wales, the value of commissioning **as means of service “planning” for a whole population group** (such as people with disabilities) is emphasised. That is not to say that the Welsh model does not seek to stimulate choice nor that the Welsh model of commissioning does not utilise competition. However, choice and competition are used as a **means** of delivering on the **objectives** of a **commissioning strategy** rather than as an end in themselves.[[24]](#footnote-24)

Looking beyond the United Kingdom, Governments across the political spectrum in a number of countries have introduced commissioning in recent decades.[[25]](#footnote-25) In both the United Kingdom and other countries, which operate commissioning, it is it is clear that the origins of commissioning are closely linked to the development of ideas of New Public Management,[[26]](#footnote-26) whereby the state uses the methods and concepts of the private sector to reform traditional public service delivery.[[27]](#footnote-27) These public sector reforms saw a greater emphasis on:

* Setting and measuring clear objectives and outcomes
* Disaggregating traditional bureaucracies and decentralising authority (but holding the frontline more to account for performance)
* Use of market mechanisms to drive down costs and improve quality
* Placing greater emphasis on customer responsiveness[[28]](#footnote-28)

In Section 3 below, a draft commissioning framework is set out. This draft framework draws heavily on the Welsh model of social care commissioning. This model strongly emphasises the role of commissioning as a service planning and service reconfiguration framework.

## What impact has commissioning had? What is the evidence base for the impact of commissioning?

While there are some reviews of commissioning practice which try to make the case for evidence of significant savings and service quality improvements accruing from funders implementing commissioning strategies,[[29]](#footnote-29) the evidence base is actually extremely thin.[[30]](#footnote-30) There is a wealth of good practice literature, much of it referring to other good practice literature and guidance, and few studies which can show what savings and / or service improvements actually flowed from the introduction of commissioning in social care.[[31]](#footnote-31)

Two points need to be made in relation to the above.

Firstly, because commissioning emerged over a number of years / decades and because it is a **process** covering all areas of social care (assessing, planning, funding, monitoring) it is probably not that surprising that neat ‘before and after’ evaluations of commissioning have not been done.

Secondly, the choice by policy makers in many countries of a commissioning approach appears to have been more informed by a consensus around the value of a certain model of public sector management and public services delivery, than by a strong evidence base.[[32]](#footnote-32) In particular, it is influenced by a view that it is no longer acceptable to fund public services without **proactively**:

* gathering evidence of current and future need for the service
* holding service providers to account for quality and value for money
* measuring what impact services (individually and collectively) actually have on the lives of those who use a particular public service
* providing choice of services for services which reflects the preferences of service users

## What is a commissioning strategy?

The **Welsh Practice Guidance on Developing a Commissioning Strategy for People with a Learning Disability** describes a commission strategy as follows:

A commissioning strategy is concerned primarily with effecting change in the **overall configuration of services** across a market to meet the needs **of a whole population …** It is specifically developed by **commissioning agencies rather than providers** and is a **statement of commitment** about the way in which they intend to purchase service **in the future**. An effective strategy helps to establish the credibility of the commissioner as an honest and effective broker in achieving the optimum range of services to meet the needs of a particular population[[33]](#footnote-33)

The purpose of a commissioning strategy is to:

* Provide better matching of needs and services
* Ensure that services are designed primarily to meet the needs of services users and carers, rather than, the interests of professionals or providers
* Have better balance between service tiers – improve the effectiveness of prevention and early intervention services, so that users will be better served, and demand for complex and expensive health and care services are reduced
* Ensure better engagement with the independent sector [non-statutory provider sector][[34]](#footnote-34)

## Rationale for a commissioning strategy

The fundamental point of commissioning is to systematically develop an evidence base and rationale for why funding is provided to different areas of support. That rationale can in turn be communicated to key stakeholders.

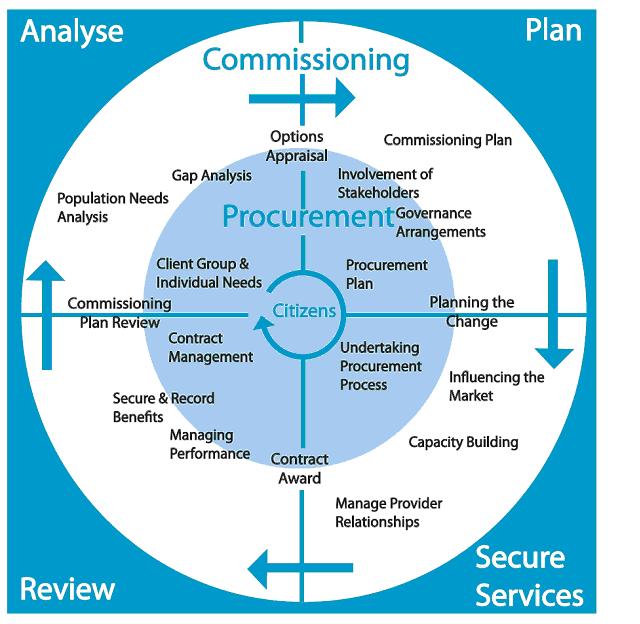
Commissioning is not a precise science in terms of applying precise formula to get the results required. It involves making judgements on the best information available .… [Commissioners] need to be able to explain the rationale for the current and future planned pattern of services to citizens and their families, to providers, staff, taxpayers, inspectors, etc. It is important to remember that commissioners are responsible for decisions about the services commissioned not providers. Providers remain responsible for the quality of services provided[[35]](#footnote-35)

# 4. Draft commissioning framework for disability services

Strategic commissioning is generally considered to involve a cycle involving four key activities.[[36]](#footnote-36) The activities are:

* Analyse
* Plan
* Source services
* Review

This diagram depicts the four stages of the commissioning cycle.



The **analysis stage** involves:

* Demographic analysis
* Findings from citizen and carers’ research and consultation
* Needs assessment
* Person centred planning [aggregated details from individuals’ person centred plans]
* Consultation with providers

The planning **stage** involves:

* Conducting a gap analysis
* Establishing the strategic commissioning intentions
* Producing the commissioning strategy

The **securing services** stage involves:

* Working with providers
* Purchasing and contracting services
* Market intervention, such as
* Commissioning new service
* Re-configuring exist service areas
* Investing further in existing services
* De-commissioning services
* Developing or negotiating Service Specifications

The **review stage** involves:

* Monitoring
* Contract Management
* Monitoring outcomes
* Evaluation and Review

## Analysis stage

Key activities in the analysis stage are:

* Clarifying the purpose and strategic aims of the commissioning strategy
* Undertaking a population needs analysis
* Undertaking a market analysis
* Analysing the resource base for the commissioning strategy

### Clarifying the purpose and strategic aims

This activity includes reviewing legislation on eligibility for services and legal parameters on what services can be funded. In addition, it involves, such things as, reviewing best practice guidance on services and relevant guidance. The resulting analysis should be able to answer the following questions:

* What are the key themes in the national guidance and legislation?
* What are the trends, technologies, treatments, service innovations which are likely to impact on the patterns of need, demand and cost?
* What does the national research say about effective services for the relevant client groups? What are examples of best practice sites and case studies?

### Needs analysis

The purpose of the needs analysis stage of the commissioning cycle is to ensure that the commissioning strategy is informed by an understanding of need in relation to the availability and quality of service provision.

A fully comprehensive needs analysis would cover:

* Demographic analysis
* Findings from citizen and carers’ research and consultation
* Person centred planning [aggregated details from individuals’ person centred plans]
* Consultation with providers

#### Demographic analysis

In terms of demographic analysis the aim would be that commissioners would know:

* What is the profile of service users by age, gender and location?
* How many people are supported across the service spectrum?
* What is the current demand for services and what is it anticipated to be in 3 and 5 years times?
* How many service users are approaching transitions such as:
* transition from childhood to adulthood
* transition from adulthood into to older age
* How many identifiable potential service users are:
* Living at home on their own and not receiving services
* Living at home with family carers and not receiving services
* How many service users are considered to be receiving support on the basis that they have “complex needs”?
* How many service users have expressed a desire to self-direct their own service?
* Where do referrals typically come from?
* What are the main areas of mainstream public services used by specialist disability service users?

It is likely that a project team will need to be appointed to conduct this phase of the analysis. This team might include a full time project manager with relevant analytic skills and project team comprising of relevant stakeholders / experts.

Countries that commission social care tend to have some form of assessment and review process which is separate from provision, such as a local authority social care assessment in the United Kingdom. Ireland currently lacks such a system, except for the assessment of need process under the **Disability Act 2005**. The **Value for Money and Policy Review of Disability Services in Ireland: National Implementation Framework** includes a commitment to developing a common assessment method. Presumably this method will provide information in a standardised way on some of the above themes.

Obviously, some of the above information is available from existing Irish data sources. Given the commitment in the **Value for Money and Policy Review of Disability Services in Ireland** to developing an information strategy framework it may be the case that much of the above information will be available to Irish social care commissioners in the future without recourse to separate data gathering exercises.

#### Citizen and carers’ research and consultation

This action is fairly self-explanatory. The purpose of citizen and carers’ research and consultation is to get the views of those who directly use services. Commissioners may use these consultation exercises to also get information for their market analysis (see below).

#### Findings for person-centred plans

The vast majority of specialist disability service users have a person-centred plan. However, this source of information is not aggregated up to local, regional or national level. Aggregated information, from person centred plans, is potentially very useful to commissioners, whose remit extends to planning for the future.

#### Consultation with service providers

This activity is pretty self-explanatory. The purpose of engaging with providers is to draw on their knowledge from day to day contact with service users and families and their practical knowledge of what works well. Methods for engaging with commissioners include:

* Meetings with individual service providers
* Service provider forums
* Focus groups
* Questionnaires

#### Market analysis

Market analysis involves mapping the service available to service users in an area or by areas. Market analysis can be done by:

* Mapping existing services
* Analysing the quality of services
* Consulting with service users and families

#### Mapping existing services

Mapping services is typically undertaken by way of questionnaires, reviews of annual reports, meetings with individual service managers. Mapping existing services would typically involve building up a picture of:

* Availability and location of current services across providers
* Accessibility of services (are there barriers to accessing services, such a inaccessible buildings, transport issues, opening times?,)
* Range of services provided by each provider
* Volume of activity and cost of there services
* How many people use each of these services?
* How do similar services for similar service user group compare in terms of demand, activity, cost and outcomes?
* Workforce – what is the skills mix of the service?

#### Analysing the quality of services

Commissioners need to analyse the quality and effectiveness of services to ensure that services are actually addressing the needs of service users. This can be done by:

* Reviewing previous inspections of local services (HIQA report on residential services when available plus other self-reporting by providers?)
* Undertaking an audit of a relevant sample of cases and care plans to compare service user experiences with good practice standards
* Reviewing the effectiveness of services provided in a selection of cases by interviewing service user, carers and professionals involved
* Analysing services delivered against policy requirements (**Value for Money and Policy Review of Disability Services in Ireland**, or **New Directions** or Congregated Settings)
* Reviewing compliments, complaints and serious incidents reports

#### Consultation with citizens, families and carers

This activity is pretty self-explanatory and as, mentioned above, a single consultation process covering service user needs and service users’ views on current market analysis (current providers) may be sufficient.

### Resource analysis

The purpose of resource analysis is to consider the existing and potential resource available to meet the needs of a particular group who require social care, in this case, people with disabilities. In order to do this, information is required on the following:

* Current and potential future budgets available for services for people with disabilities
* A breakdown of how budgets are allocated
* An analysis of how budgets are committed and where they may be flexible in the future
* A breakdown of capital and revenue spend
* Information about the distribution of resources between different sectors, client groups and across the tiers of service provision
* An analysis of the allocation of resources mapped against strategic priorities
* Information about existing resources available from related public service areas (such as, mainstream health, housing, mental health, mainstream employment.)
* Future areas which will require capital investment
* Areas where future savings or investment might be made

## Planning stage

Based on the information gathered in the **Analysis Stage** to allow commissioners to develop complete the following key activities in the **Planning Stage:**

* Gap analysis
* Strategic commissioning intentions
* Producing the commissioning strategy

#### Gap analysis

The purpose of gap analysis is to establish the gap between need – as evidenced by the needs analysis – and current provision – as evidenced from the market analysis.

The gap analysis should address the following questions:

* Are there any gaps in particular types of services?
* Is there an absence of services with a particular community?
* Are some services weak or of poor quality?
* Are some services in inappropriate locations or inaccessible?
* Is there an over-provision of particular services?
* Is there an over-provision of services within particular communities?
* Is the funding for particular services sustainable?

A second phase of the gap analysis requires assessing the risk that each service gap poses to the achievement of local or national objectives. It might be worth consulting with stakeholders regarding their views of the risks associated with each gap.

#### Prioritisation and strategic commissioning intentions

After carrying out the gap analysis commissioners should be in a position to identify how the current configuration of services needs to be changed. Commissioners should be able to set out their intentions for:

* Continuing to invest in existing service areas
* Disinvesting or de-commissioning in certain existing service areas
* Commissioning new service areas
* Re-configuring existing service areas

At this stage, the legal and contractual implications of ending or revising existing contractual arrangements. Clearly, the legal framework for any potential renegotiation to contracts between the Health Service Executive and the Section 38 and Section 39 providers would need to be given early consideration in the context of developing a Commissioning Framework in an Irish context.

As part of the planning phase, commissioners may wish to set out an Options Appraisal to be discussed with service users and carers in particular, but also with providers, with a view to exploring possible new models of delivery and partnerships. The Options Appraisal would take needs as it starting point and set out:

* the advantages disadvantages of each option
* risks of each option
* costs, including opportunity costs

#### Publish Commissioning Strategy

The published commissioning strategy should include:

* An analysis of relevant legislation, policy, guidance, research
* A population needs analysis
* An analysis of current and potential survives and resources and an analysis of the extent to which they are likely to meet future needs
* A statement about the strengths and weaknesses of current services and the changes needs and some details on the types of services (not providers) and services areas which will be funded in the future and those which won’t be commissioned in the future
* Some details on the plans to monitor and review the impact of the strategy upon the range and quality of services to be delivered

As mentioned previously a **procurement plan** with greater detail on resource allocation and which should specify budgets for service areas and details of what service areas will be funded, as well as details of immediate planned service improvements, dis-investment and decommissioning. A procurement plan is typically developed in tandem with a **market development plan** which sets out how the processes for how services will be funded and contracted. This would include setting out a rationale for what service areas will be subject to competition and which will not, and why.

## Securing services stage[[37]](#footnote-37)

In the securing services stage commissioners are engaged in actively trying to ensure that the services identified in the commissioning plan are delivered. The language used in Wales and other parts of the United Kingdom for the main activity, in this stage, is “market facilitation”. This reflects the fact that direct payment recipients and some self-funders seek will seek to access social care services. Therefore, commissioners have a responsibility to ensure an appropriate range of services are available, of which they may directly fund the majority but not all.

### Market facilitation

Market facilitation involves three linked activities:

* **Market intelligence** -involved developing a common and shared perspective of supply and demand in the market leading to a published market position statement. A **market position statement** details current supply of services in the market and a description of what the service market will look like in the future and why. The purpose of a market position statement is to provide incumbent and potential new providers what the supply of services will look like in the future.
* **Market structuring -** this activity involves engaging with the provider sector to:
* Brief providers on the market position statement
* Engage with providers on their business / strategic plans
* Engage with providers on the impacts of personal budgets / direct payments
* Develop open book accounting model with providers as a means costing the impact of new developments and innovations
* Identify and address with providers how barriers to market entry can be overcome
* Engage with providers on their potential to diversify into new areas of service delivery

### Market intervention – commissioners’ activities

In order to develop a stable market of services that is incentivised to offer better quality, wider choice and more flexibility, commissioners will need to directly intervene in a number of ways. Undoubtedly, this intervention will be difficult for some stakeholders but the purpose of commissioning is that these interventions will be evidenced based and be the outcome of a transparent process. The range of interventions include:

* **Commissioning new service areas** - commissioners will commission new services where there is evidence of unmet need locally or nationally for services which are not part of the existing service offering
* **Re-configuring exist service areas** **-** commissioners may need toengage with providers who are currentlyoffering a service which no longer meets the evidence based needand discuss with them capacity or desire to deliver services in line new service specifications
* **Investing further in existing services** - this may appear to be the most straight forward option but consideration needs to be given as to how additional benefit from additional investment will be assessed
* **De**-**commissioning services** – in other words, termination of existing service arrangements. Although de-commissioning is challenging and likely to be controversial, it is crucial that it is included among the range of intervention options available to commissioners. De-commissioning will be crucial if commissioners are to have resources to invest in new services. It is appropriate in commissioning framework to terminate contracts or service level agreements where services are not meeting the needs of service users and/ or quality standards. An advantage of commissioning is that it is transparent process, involving key stakeholders, and that it is based on evidence.

In addition to the above intervention activities, commissioners may wish to initiate other strategies to develop existing providers and encourage new providers, such as:

* Investing in provider training
* Investigating schemes for how providers may attract capital investment from other sources
* Stimulating the development of social enterprise organisations

### Working with providers

Commissioners need to develop constructive relationships with providers. To this Commissioners should:

* Provide training in contract management / tender management skills for all providers
* develop provider forums
* meet with providers regularly to discuss performance and not just when a problem arises
* work jointly with providers to develop agreed mechanisms for measuring contract outcomes
* get the right balance in terms of monitoring / date requirements for providers
* where appropriate, offer long term (up to 10 years) “contracts-for-change” to providers, who will need to significantly invest to develop a service area or re-orientate service provision.

### Purchasing and contracting

Commissioners will need to purchase services to influence the market for social care provision.

The commissioning plan and accompanying procurement plan may indicate that certain areas of service provision will not be subject to any competition in terms of funding. Evidenced based reasons for using competition in some areas and not others should be set out.

Commissioners will need to keep the commissioning strategy in mind at all times, during the commissioning process, as the design of the procurement will impact on the capacity to deliver commissioning strategy outcomes. For example, will grouping service areas together into fewer larger contracts deliver economies of scale or will it deliver less choice? Bundling contracts will not deliver choice between providers, which **may** be a desired goal.

Social care services are known as Part B services and are not subject to the full conditions of European Directives on public procurement. There is no requirement to tender or re-tender social care services.[[38]](#footnote-38) However, if commissioners initiate a competitive process they need to be open and transparent.

Clearly, contracting for social services is a vastly different undertaking from purchasing goods or even from contracting for more routine services. A range of competitive processes are set out below. In many circumstances what many of us think of as a “tendering process” - an open, single stage competition - will be entirely inappropriate for selecting social care service providers.

As noted previously, procurement activities should be driven by the commissioning process. Therefore the chosen selection procedure should enable commissioners to achieve their **commissioning outcomes** in a timely manner, and ensure a continuum of engagement with service users and carers.

#### Open selection procedure

This is a completely open, one stage selection process. The main benefit of using an open selection procedure is to attract and accommodate a high level of respondents, with ensuing competition, and increased opportunities for a wide range of innovative solutions. A disadvantage may the high volume of tenders to be evaluated.

It is most appropriate to use an open selection process where the required service can be specified in detail. Where the service to be delivered and / or its pricing is complex, such a procedure is likely to be inappropriate.

#### Restricted selection procedure

An open qualification stage where applicants submit their details using a Pre-qualification Questionnaire is used to develop a shortlist of quality applicants who are then invited to take part in a more detailed selection stage which would involve submitting detailed plans for proposed service delivery.

A restricted selection process would be appropriate where the services to be secured are complex but where a relatively high level of detail on the nature of the service to be delivered is known. The main advantage of the restricted selection procedure is to rule unsuitable, poor quality applicants out early in the selection process to facilitate a very indebt selection process between the commissioner and a small number of quality providers.

#### Competitive dialogue

A competitive dialogue procedure enables the commissioner to conduct a dialogue with selected providers in order to identify one or more solutions which meets its needs. When the commissioning organisation believes that the solutions being proposed are viable and affordable, they close the dialogue and invite tenders from those providers remaining in the dialogue. In other words, the service specification **emerges** from the dialogue but once it has **emerged a competition does take place.**

A competitive dialogue should be used when the complexity of a service to be procured is such that, although there is a clear view of what needs to be achieved, the commissioner is not able to specify in advance the service specification up front and cannot conduct an open or restricted selection process without first engaging with providers.

#### Negotiated procedure

The Negotiated Procedure is used in exceptional circumstances, for example, where the commissioners are unable to draw up a sufficiently precise service specification, and even more exceptionally, where the nature of the requirement means that it is not possible for the provider to price the requirement in advance.

A negotiated procedure is a two stage process. Like the restricted selection procedure an initial qualification stage is used to rule out poor quality providers. After the initial qualification phase negotiation takes place with remaining providers on all aspects of the service specification **including the price.** Contracts are awarded on the basis of the negotiated contracts. Therefore, there is no competition process after the initial qualification stage.

#### Interviewing applicants

In relation to the above procedures, it may be useful after the initial qualifying stage for commissioners to conduct interviews with short listed applicants to clarify certain aspects their proposals as well as allowing them to further elaborate on the relative merits of their proposed service delivery model. The interview process must be the same for all those tenderers who are invited to be interviewed, although questions that are specific to particular tenders are permitted.

Interviewing applicants provides an opportunity to **include service users, carers and other key stakeholders** in the evaluation process. Interview panel members should be identified as early as possible in the process to ensure that any training and support needs are clearly identified and addressed before the process begins.

Like any competitive process involving public monies whatever selection procedure is chosen it will have to be open, transparent and evidenced based.

### Service Specifications

Commissioners need to be able to potential providers with specifications for the nature and extent of services they wish to fund. As mentioned above in some cases the service specification emerges from the selection process but in many cases the commissioner should be in a position to draft specifications in advance of a selection process. Commissioners need service specifications for **all** of the service areas covered in the commissioning strategy.

The focus of service specifications should be on the outputs and outcomes that the service is to achieve.

In developing service specifications services need to ensure that:

* Specifications reflect identified needs
* Specifications define the people for whom the service should be provided
* Specifications describe the purpose and parameters of the service
* Specifications will meet commissioning strategy objectives
* Specifications will set out staffing levels, training, qualifications and experience
* Specifications will set out the standards to which the service should be delivered
* Specifications will comply with local or national standards or guidance
* Specifications will include a standardised range of output and outcome measures
* Specifications will describe the monitoring arrangements to determine whether or not all the requirements are being met
* Specification have a requirement in terms of registration and compliance with national minimum standards
* Specifications are sufficiently detailed to ensure that providers can prepare contract application that meet the commissioner’s requirements
* Specifications should list key performance indicators that will be used in the service contract
* Specifications will identify requirements such as criteria for eligibility and access to services and some key links the service will have to make with other services
* Specifications will set out the information requirements needed by commissioners

Specifications should focus on **what** is to be delivered **based on the commissioning strategy**. Specifications should **not focus** on the **how** services will be delivered. Providers, through the procurement process should be responsible for developing and communicating innovative approaches **for how** they deliver the required outputs and outcomes.

Commissioners need to make sure that service specifications are clear and agreed by stakeholders. Service users’ and carers’ inputs to specifications will be required.

The development of specification is likely to require significant input from the provider through open, transparent and documented engagement with a range of existing and potential providers. However, commissioners are ultimately responsible for service specifications.

#### Contract finalisation

Post-selection commissioners and providers will need to formally agree a contract. In the Welsh experience ,this can take between 3 and 6 months depending on the complexity. Contract clauses typically will need cover contract period / timescale, review arrangements, specific conditions for the providers, such as, health and safety, confidentiality, insurance, options for variations /extensions, dispute resolution, termination or suspension.

#### Quality assurance

In addition to the above, commissioners need to develop and specify quality assurance criteria. Quality assurance criteria would include:

* Expectations about how providers will minimise barriers to accessing services
* Expectations about how providers will ensure that citizens are not excluded from services on the basis of race, gender, disability
* Expectations about provider inputs into (single / joint) assessment processes, care planning and review, referral and integrated care pathways / coordinated support
* Expectations about the type of outputs and outcomes providers are expected to report to demonstrate the extent to which their service is achieving its objectives
* Expectations about how providers will demonstrate that their service is cost effective and represents best value
* Expectations about levels of training and qualifications of staff employed by providers
* Expectations about how providers will ensure that national and local standards are met constantly

As with other commissioning activities, the quality criteria should be developed in consultation with key stakeholders.

## Review stage

The purpose of the review stage is to determine whether or not the objectives of the Commissioning Strategy are being met, assess the effectiveness of the services which have been commissioned and crucially assess the impact of the commissioning strategy on the outcomes for people with disabilities.

In order to effectively review a Commissioning Strategy, commissioners will need to able to:

* Develop a set of measures or indicators which, if collected and analysed regularly, will allow the commissioners to monitor activity, performance, outcomes and impact of the services commissioned. It is important to set measurable outcomes for people with disabilities.
* Develop a framework which ensures that regular review meetings are held to analyse progress against commissioning objectives using the measures identified above, consider changes in the environment, and agree any changes to objectives or action plans or resources
* Develop a mechanism which allows commissioners, providers and other stakeholders, to contribute to the analysis of progress
* Ensure that contracts, Service Level Agreements and grants with providers, will collect the service activity and performance data necessary to enable effective monitoring to take place

### Monitoring

Monitoring activities should allow the commissioners to regularly assess the **services it is commissioning**. It should facilitate commissioners asking the following types of questions:

* How are services performing against the agreed specification?
* Are services meeting assessed need?
* Are services being provided, to the required standard?
* How much do they cost and are they providing value for money?
* Are appropriate services being commissioned?
* To what extent are services meeting commissioning objectives?
* What are the views of service providers, citizens, stakeholders and the wider public about the effectiveness of services?
* Are outcomes being achieved?

Monitoring should also allow commissioners to assess the effectiveness of the commissioning strategy itself by addressing the following questions:

* Are the gaps in service need being met?
* Do commissioning priorities need to be changed?
* Do services need to be commissioned differently?
* Is there a need to review and reconfigure existing services?

In developing its monitoring activities a Commissioner will need to consider:

* Whether a core data set, to be collected by all service providers, is needed
* What areas a core data set would cover, including for example, activity and performance, finance or user outcome information?
* What reporting arrangements commissioners will require from each service provider? For example, one might require a quarterly submission of data from each provider.
* What data quality audit arrangements commissioners will need, to be able to check that data is reliable?
* How will commissioners collate and analyse the data from the different providers?
* What other information, relevant to the strategy, will commissioners need to review?

#### Contract Management

Contract Management is the process that ensures both parties - commissioners and providers - meet their respective obligations as effectively and efficiently as possible. To assess a provider’s overall performance against the contract, a commissioner will need to consider:

* Whether the quality of service delivery is satisfactory
* Whether the quality of service delivery has improved as expected?
* Overall performance against performance indicators
* Relationships – whether the provider is co-operative and proactive
* Service user satisfaction
* Cost of service – whether the expected savings have been realised
* Whether the service still represents value for money, particularly in relation to more recently-procured services

On the basis of the above, commissioners may wish to extend a providers contract or initiate a new procurement process.

#### Monitoring outcomes

The Welsh model of outcomes measurement is still being developed. Two suggested means of outcome measurement are suggested.

One approach is to build outcome based commissioning on outcome based person centred planning or outcome based care management. Essentially, some means of aggregating person centred planning information should be developed.

Another means of measuring outcomes could be through user satisfaction surveys. These are a familiar means of assessing the quality of service from the point of the service user. More specific questioning around particular aspects of service delivery can be valuable to explore.

#### Evaluation and Review

The purpose of this action is to review the performance of the strategy as a whole. It is suggested that a review group comprising of key stakeholders (which includes service users and carers) be established with terms of reference which covers:

* periodically examining the information gathered thought the various commissioning activities
* making decisions on where commissioning priorities need to be amended and consequent amendments to resource allocation

# Appendix 1

In this appendix some of the issues which would need to be considered or further investigated are briefly outlined and their implications in an Irish context noted.

## Assessment of need

The models of commissioning described have evolved in systems where individuals’ eligibility for social care and level of need is determined by an assessment conducted by a person employed the same statutory body that has responsibility for commissioning.

In the Irish context, the absence of an assessment system (with the exception of the assessment of need under the Disability Act) which covers all disability service users presents a significant challenge in developing a commissioning framework.[[39]](#footnote-39)

## Decommissioning - terminating service arrangements

From the document above it should be clear a requirement of commissioning strategy is that it is clear on the service areas which will no longer be funded. Monies from service areas which are no longer supported by the evidence base (which includes the preferences of service users and families) are used to invest in services which will meet current and future need.

Decommissioning has been defined as “a process of planning and managing the elimination of services in line with commissioning objectives”.

While commissioners need to be very clear with providers that some service areas will simply no longer be funded, actually shutting down a service may be only one option for decommissioning. Through negotiation and contract change, providers providing a service area which is no longer required can be facilitated to deliver other services.

Commissioners should have a decommissioning plan which stakeholders are aware of. The decommissioning plan should be informed by the following principles:

* **Transparency and fairness** – as with other commissioning areas developing a evidence base which can be communicated to stakeholders in open way is key people accepting that a particular service needs to close or a service are discontinued
* **Service users’ interests and welfare** are paramount to the decommissioning process
* **Staff** are consulted and their welfare considered
* **Value for money & service quality** inform decisions
* **Risk management** – risks should be identified and managed
* **Partnership** – commissioners should seek to work with all stakeholders to manage the transition
* **Communication** – commissioners develop a communication strategy for the decommissioning plan[[40]](#footnote-40)

In the Irish legal context (Health Acts; Protection of Workers and Transfer of Undertakings legislation) and industrial relations context (Croke Park and Haddington Road agreements and the consolidated salary scales) whether all providers can be decommissioned and at what cost is unclear. Therefore, if a commissioning strategy is to be further developed it should be done in parallel with work which clarifies the legal and industrial relations uncertainties around decommissioning.

## Managing disruption from contract change

As mentioned above a negative consequence of adopting a commissioning framework is that it will increase the risks that services being provided to services will be disrupted in circumstances where a new provider is a awarded a contract or where a service area is decommissioned. There are ways, however, in which the risk of disruption to service users can be reduced.

In relation to the procurement of services within a commissioning framework is it generally seen as good practice to provide high quality, high performing providers with as much certainty as possible. This can be done by awarding them contracts for longer periods of time, which thus reduces the risk of disruption to service users.

The continued operation of a range of local providers who have a track record of delivering accordance with requirements is essential to market stability. Recognition of providers who have been prepared to ‘go the extra mile’ is also appropriate. Such considerations may outweigh potential but unproven financial gains from untried providers

Secondly, commissioners will need to have protocols in place and take an active role in negotiations with the old and new providers in circumstances where a contract is being transferred between providers to ensure that disruption to service users is minimised.

Thirdly, commissioners will need to make clear to providers who win a contract that they will have obligations to staff currently employed by the incumbent provider under Protection of Employees on Transfer of Undertakings (TUPE) Regulations[[41]](#footnote-41).

While commissioners in the United Kingdom often describe contract change situations where frontline staff and service users experience very little change, but senior management in the old organisation are replaced by new management, who over time change the service orientation, ethos, work practices, etc. It is unclear in an Irish context where providers tend to have significant capital holdings whether contract change could be without disruption as suggested above.

In relation to the TUPE regulations obviously existing employees terms and conditions are protected but the experience in the United Kingdom is that new employees can be put on new, more flexible contracts. Whether these is scope in all organisations to place new staff on more flexible contracts may need to be considered in an Irish context where staff are covered by an Employment Control Framework.

## Self-directed Commissioning

What was described above in Section 3 was the Welsh model of commissioner-led social care commissioning. Central to that model is commissioning for personalisation – in the sense of planning and funding services which are incentivised to flexibly meet the needs of individuals.

However, with the introduction of personal budget and direct payments commissioning also takes place within an environment where some of those eligible for services will opt not to receive services commissioned by a commissioner.

The proportion of people available of personal budget and direct payments is much greater in England than in Wales. The context of commissioning social care in England has changed significantly. The Department of Health (UK) and Care Service Improvement Partnership have produced a framework for commissioning for personalisation which recognises that the presence of personal budget holders and direct payment recipients does make the job of commissioners even more challenging. The framework notes that there are two options for commissioners in this circumstance:

* commission the infrastructure which makes that makes personal budgets possible / direct payments possible **for those who want them** (brokers, advocacy and information provision, develop framework commissioning strategies e.g. approving providers who receive funding if personal budget holder / direct payment recipients choose to purchase their services, etc.)

or

* use the commissioning framework to make sure that **all users** of social care services have the benefits of personalisation (i.e. choice, supports tailored to their needs, flexibility in how they receive supports, services focused on outcomes, etc.)[[42]](#footnote-42)

Or as Duffy and Needham put it:

Commissioners must ensue that that personalisation is a model for fuller citizenship rather than a tool for individualisation and atomisation[[43]](#footnote-43)

Therefore, in an Irish context what “personal budgeting”, as set out in the **Value for Money and Policy Review of Disability Services in Ireland**, means , needs to be clarified and if commissioning is introduced a decision will need to be made regarding whether the focus of “commissioning for personalisation” should be only for those who opt for the “personal budgeting” option.

## Joint commissioning

Much of the attention in the United Kingdom over the past decade has been joint commissioning between local authority funded social care and National Health Service funded health care. While there is a consensus that health and social care agencies need to work together to support health and well being of those who receive social care there is a lack of hard evidence that joint commissioning efforts have actually delivered any improved outcomes[[44]](#footnote-44).

Nonetheless in an Irish context, if disability support services were to be commissioned, this would raise questions about how the planning, organisation and delivery of such services would interact with other social care services (older persons services, child and family service, mental health services) and mainstream health services, and in particular, primary care services.

## Commissioning for outcomes

While the guidance and best practice literature from the United Kingdom routinely emphasises the importance of commissioning for outcomes the actual practice of funding and evaluating service on the basis of outcomes for individuals is still “relatively young and unproven”[[45]](#footnote-45) and therefore at present there is very little hard evidence that commissioning for outcomes improves service users’ outcomes. That said, there are examples of commissioners, providers and services users developing contracts focused on service users’ outcomes.[[46]](#footnote-46)

Also, successful outcomes for disability support service users will be determined by factors which are at least in part outside the control of disability services (they are also likely to be influenced by mainstream public services, community organisations, societal attitudes, etc., etc.).

In Ireland, where unlike the United Kingdom where local authorities have a role across education, social care, community and sporting activities, it may be even more complicated to commission for outcomes where HSE funded disability services may have even less influence on other bodies which will impact on positive outcomes being realised.

## Eligibility and social care need

An issue to bear in mind when considering the scope for commissioning in Ireland in comparison to the United Kingdom is that United Kingdom has a well established framework (however imperfect) for determining who is eligible for social care. In the United Kingdom eligibility is defined in relation to categories of need under the fair access to care rules. Developing a commissioning framework to address the profile of need for a population group does presuppose that the population group can be defined.

## Good quality commissioning

Commissioning requires commissioners to have a broad range of skills and the outcomes of the commissioning process will be dependent on the actions taken and decisions made by commissioners.

In relation to the breadth of skills required these seems to be two approaches to this.

* Developing commissioning teams who have the range of skills in house to deal with statistics, finance, quality, procurement, contract management etc. etc.

Or

* Developing a small team who work with colleagues from across health intelligence, finance, procurement units to deliver joined up approach to commissioning.

The other point to note is that standards have been developed for commissioners to ensure that they are clear as to what constitutes good quality commissioning. In developing the standards for commissioning, it should be possible to allay some of the concerns around the introduction of commissioning. For example, a set of commissioning standards might include a standard around only funding person-centred, continuously improving providers, or a standard which requires commissioning plans to be clear about the expected outcomes for service users.

# Appendix 2

|  | Commissioning | Current Irish Service Planning and Funding Model |
| --- | --- | --- |
| **Assessment of population needs** | * Assessment details, gathered from ongoing assessments of need / assessments of eligibility conducted by statutory body, are collated at local & national level * Consultants retained to perform analysis around future demographic issues to inform commissioning process * Details from person centred plans aggregated * Information and analysis conducted on current service provision (gathered from existing contracts) * Numerous rounds of consultation exercises with service users and carers conducted to inform commissioning cycle | * Assessment of need under Disability Act * Providers conduct assessments and typically person centred plans * Two national databases maintained by HRB for planning purposes |
| **Determination of eligibility for services** | * Eligibility for social care determined by commissioning body, within national framework | * Eligibility determined by providers in consultation with local HSE management |
| **Determination of service priorities** | * Commissioning strategy determines priorities after extensive formal consultation with stakeholders – service users and carers in particular - and is also determined by analysis as cited above | * HSE service plan approved by Minister * Individual service providers may determine priorities at local level, working with local HSE officials |
| **Determination of scope of services** | * Service specifications informed by commissioning strategy * Final shape of service specifications determined either prior to provider selection process or during selection process | * The nature and scope of Irish disability services reflect an evolution over time, and are as determined by service providers in accordance with own ethos and values |
| **Determination of price of services** | * Price determined either prior to provider selection process or during selection process (depending on the procurement process used) * Price negotiations are conducted with reference to data from similar contracts | * Block funding by incremental determination |
| **Allocation of resources** | * Procurement plan based on commissioning framework sets out what will be procured and by what means * Procurement plan covers the entirety of the available budget * Procurement plan identifies service areas to procured rather than providers to be funded | * Budget determined by HSE Vote and approval of HSE service plan * Existing providers funded with reference to historical allocation * Negotiation between regional HSE managers and providers on additional resources such as demographic / school leaver funding |
| **Length of contracts** | * Contracts of varying length but all contracts have real, defined termination dates | * SLAs / Service Arrangements agreed annually but in effect contracts of indefinite length |
| **Monitoring contract compliance** | * Active monitoring of contracts by commissioning team, including monitoring of outcomes * Minimum quality standards monitored by Care and Social Services Inspectorate | * HIQA residential care standards incorporated into SLAs / Service Arrangements * HIQA monitor quality standards in certain service areas * Standards for adult day services being developed |

1. Department of Health, 2012a, Value for Money and Policy Review of Disability Services in Ireland [↑](#footnote-ref-1)
2. Department of Health, 2012a [↑](#footnote-ref-2)
3. Department of Health, 2012a [↑](#footnote-ref-3)
4. Department of Health, 2012a, [↑](#footnote-ref-4)
5. Department of Health, 2012a, [↑](#footnote-ref-5)
6. Department of Health, 2012b, Future Health: A Strategic Framework for Reform of the Health Service 2012-2015 [↑](#footnote-ref-6)
7. Department of Health, 2012b [↑](#footnote-ref-7)
8. Department of Health, 2012b (emphasis added) [↑](#footnote-ref-8)
9. Department of Health, 2012b [↑](#footnote-ref-9)
10. Department of Health, 2012b [↑](#footnote-ref-10)
11. Department of Health, 2012b [↑](#footnote-ref-11)
12. Department of Health, 2012a [↑](#footnote-ref-12)
13. Marshall, T. and Hothersall, E., 2012, “Needs Assessment” in Glasby, J., 2012, Commissioning for Health and Well-being [↑](#footnote-ref-13)
14. Marshall, T. and Hothersall, E., ibid (emphasis added) [↑](#footnote-ref-14)
15. The issue of decommissioning and disruption related to service reconfiguration are discussed in a bit more detail in the appendix of this paper. [↑](#footnote-ref-15)
16. Bamford, T., 2001, Commissioning and Purchasing [↑](#footnote-ref-16)
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18. House of Commons, 2008, Public Administration Select Committee, Public Services and the Third Sector: rhetoric and reality [↑](#footnote-ref-18)
19. Bovaird, T., Dickinson, H. and Allen, K., 2012, “New models of strategic commissioning” in Glasby, J. 2012 Commissioning for Health and Well-being [↑](#footnote-ref-19)
20. Bovaird, T., Dickinson, H. and Allen, K., 2012 op cit [↑](#footnote-ref-20)
21. Dickinson, H. and Ham, C., 2008, The governance of health services in small countries. What are the lessons for Wales? [↑](#footnote-ref-21)
22. Bamford, T., 2001, Commissioning and Purchasing [↑](#footnote-ref-22)
23. Le Grand, J., 2007, The Invisible Hand: Delivering public services through choice and competition [↑](#footnote-ref-23)
24. Dickinson, H. and Ham, C., 2008, The governance of health services in small countries. What are the lessons for Wales? [↑](#footnote-ref-24)
25. Greve, C., 2008, Contracting for Public Services; Figueras, J., Robinson, R. and Jakubowski, E., 2005, Purchasing to Improve Health Systems Performance [↑](#footnote-ref-25)
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27. McLaughlin, K., Osbourne, S., and Ferlie, E., 2002, New Public Management: current trends and future prospects [↑](#footnote-ref-27)
28. Glasby, J., 2012, Commissioning for Health and Well-being [↑](#footnote-ref-28)
29. Audit Commission, 2007, Healthy Competition [↑](#footnote-ref-29)
30. Knapp, M., Hardy, B. and Forder, J., 2001, Commissioning for Quality: Ten Years of Social Care Markets in England. Journal of Social Policy, 30, pp 283-306. [↑](#footnote-ref-30)
31. Huxley, P., Maegusuku-Hewett, T., Evans, S., Cornes, M., Manthorpe, J. and Stevens, M., 2010, Better evidence for better commissioning: a study of the evidence base of generic social care commissioning guides in the UK Evidence & Policy: A Journal of Research, Debate and Practice 6 (3) [↑](#footnote-ref-31)
32. Glasby, J. 2012 Commissioning for Health and Well-being [↑](#footnote-ref-32)
33. Welsh Assembly Government, 2010, Welsh Practice Guidance on Developing a Commissioning Strategy for People with a Learning Disability [↑](#footnote-ref-33)
34. Welsh Assembly Government, 2010 [↑](#footnote-ref-34)
35. Welsh Assembly Government, 2010 [↑](#footnote-ref-35)
36. This whole section is largely based on two sources: the Guidance on Developing a Commissioning Strategy for People with a Learning Disability and the “Social Care” section of the Welsh Procurement Route Planner, http://prp.wales.gov.uk/planners/social/ [↑](#footnote-ref-36)
37. The National Disability Authority has produced a guide to **Procurement and Accessibility** in 2012.This guide advises public bodies on how they can build accessibility into their procurement policies, procedures and practice [↑](#footnote-ref-37)
38. European Directives on public procurement are currently in the process of being revised [↑](#footnote-ref-38)
39. The National Disability Authority Resource Allocation Feasibility study will consider among other things whether any of the tools under consideration could meet the needs of a commissioning framework. [↑](#footnote-ref-39)
40. Institute of Public Care (on behalf of Yorkshire and Humber Joint Improvement Partnership), 2010, Decommissioning and reconfiguring services: a good practice guide for commissioners of adult social care [↑](#footnote-ref-40)
41. The relevant legislation in a transfer of undertakings situation such as this is the European Council Directive 2001/23/EC, introduced into Ireland as the European Communities (Protection of Employees on Transfer of Undertakings) Regulations SI 131/2003 (TUPE). [↑](#footnote-ref-41)
42. Department of Health (UK) & Care Services Improvement Partnership, 2008, Commissioning for Personalisation: A Framework for Local Authority Commissioners, [↑](#footnote-ref-42)
43. Duffy, S & Needham, C., 2012, Commissioning in an era of personalisation in Glasby, J. 2012 Commissioning for Health and Well-being [↑](#footnote-ref-43)
44. Dickinson, H. & Nicholds, A., 2012, The impact of joint commissioning in Glasby, J. 2012 Commissioning for Health and Well-being [↑](#footnote-ref-44)
45. Walis, M., and Bovaird, T., 2012, in Glasby, J. 2012 Commissioning for Health and Well-being [↑](#footnote-ref-45)
46. Local Government Improvement Unit, 2012, Outcomes Matter: Effective Commissioning in Domiciliary Care [↑](#footnote-ref-46)