Please find feedback (attached) on behalf of National Services Purchasing, National Health Board, Ministry of Health, on your Issues Paper 'More Effective Social Services'.

The broader Ministry of Health intends to submit on a later draft of the Commission's paper.

National Services Purchasing's feedback includes responses to 16 of the 56 questions from the Commission's Issues Paper.

Summary of Questions:

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Q9	**How successful have recent government initiatives been in improving commissioning and purchasing of social services? What have been the drivers of success, or the barriers to success, of these initiatives?**	• Health Alliances are a requirement of PHOs and DHBs. • Health Alliances are a successful example that have increased the focus on the outcomes for people, provided incentives for public sector and publicly funded agencies to work together and pool resources. • The policy settings are the drivers. • Time and a need for culture change are barriers. • The change in approach by purchasers is only 50% of what is required. Service providers have to share the vision and be prepared to work in partnership. • The move to individualised funding (IF) for about 2,000 people with disabilities who access Home and Community Support Services has worked well for this group of people, creating more flexibility, choice and control for the consumer. Enhanced IF is being trialled to include a wider range of disability support services that the disabled person can purchase directly. • What we can say is that IF and EIF have been successful for the person - there is some evidence of improved outcomes but it is early days. • Significant drivers of the move to IF have been demands from the disability sector allied with the Ministry's drive to provide people with more choice and control, as recommended by the Select Committee on disability in 2008. Introduction of IF host providers has been essential to the success of IF. These providers allow disabled people to opt out of directly employing service providers if they wish. The host provider organisation will do this on their behalf.

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		• The advantages of IF and EIF to date include better relationships, knowing each other's business, and finding the barriers. It also enables people to make choices about what is most important to them when there is limited funding and as a result, the funding is used more efficiently and effectively. • The Enabling Good Lives programme is taking this a step further by pooling funding between three government agencies (Ministries of Health, Social Development and Education) to allocate to the individual disabled person so they can decide how best to purchase the supports they need. Again this has been driven by disabled people themselves. Recent legislative changes allow pooling of different Vote funding allocations. Barriers to success include changing the processes and mechanisms for payment to providers to allow it to come from the disabled person rather than the government and providing more flexible contracts so that providers can meet these new, more individualised demands for services. Providers also need to change the way they invoice for services delivered e.g. instead of bulk funding, they now need to put a price on services provided to individuals. There is significant complexity in moving from the current model to the new model. This translates into significant additional work within each government agency, within current resource. • Sometimes the success of initiatives is not seen for a long time (e.g. Enabling Good Lives (EGL) and the Children's Action Plan). • 'Wrap Around Services' for children with disabilities has been very successful in terms of outcomes for clients. Involves close collaboration between MOH and MSD to integrate services to clients and their families. • Drivers of improving commissioning and purchasing of social services include, importantly and perhaps centrally, leadership. • The funding allocation tool of EGL, IF and EIF is also a driver in that it separates funding allocation from service utilisation and supports the choice of disabled people. • Barriers include: o A focus on short-term results vs long term outcomes o Models of care and the accountability model (also a big opportunity) o Inconsistencies in government resources for initiatives o A lack of transparency in DHB accountability mechanisms

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		o Risk aversion resulting from accountability mechanisms.
Q10	**Are there other innovations in commissioning and contracting in New Zealand that the Commission should explore? What lessons could the Commission draw from these innovations?**	• Table 3 (page 33) outlines selected NZ initiatives, including in Health. Suggest including Enhanced Individualised Funding as well as Individualised Funding. • Also, suggest that the Children's Action Plan (run out of MSD, and including Ministry of Health/DHBs) is included as an innovative approach to reducing assaults on children that would benefit from an assessment of drivers/barriers for success. • There are some good examples of joint MOH/ACC working. For example the National Ambulance Sector Office. • Lessons include it being hard to get traction for shared working with DHBs. NGOs complain that there is shared vision and willingness at governance and CEO/exec levels, but this does not filter down to those who control funding and contracts at operational manager level. • There is also need for clinical involvement and engagement at governance and senior/executive levels. • Lessons include: o Commitment needed across agencies o Resourcing o Focus on the low level long-term outcomes not only the high level acute outcomes o More self-assessment (by customers) is needed about needs and what is not needed o Communication strategies re the public o Long-term approaches o Equity is important – injury vs care o Funding needs freed from the short-term annual funding cycle.
Q13	**Where and when have attempts to integrate services been successful or unsuccessful? Why?**	Examples of services where integration has been successful include: • Autistic Spectrum Disorder – both in terms of the National Intellectual Disability Care Coordination Agency and Behavioural Services • Rheumatic Fever – Health and Housing

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		• Telehealth – portals • Open Home Foundation – MSD and Health (joint service specs, heavy upstream workload with benefits to be reaped in the future) In general, integration has been successful for these initiatives as people from the agencies have worked together regularly. It is early days for streamlining contracts of central agencies (Health, MSD, Justice, Corrections, TPK and Education) with NGOs. However, what we can say is that progress needs to consider the complexities of streamlining the audit process across multiple agencies; and (for National Services Purchasing, Ministry of Health) the staff and management time commitment needed to review all DSS (57) service specifications to include new streamlined, RBA and Outcome Measures reporting requirements. Ambulance clinical hub (Auckland) is another example of an integration initiative. This was successful because: a) wide engagement and joint 'ownership' was required by MOH b) potential benefits for all participants c) shared vision and goals d) shared governance set up e) shared development of performance measures and evaluation methodology. Capital and Coast and Hutt Valley DHBs Ambulance/primary care acute demand project less successful because: f) Lacked shared vision and priorities g) DHBs and PHOs inwardly focused. It is early days yet, but integrating service delivery and assessment for (non-complex) older people in the community in Auckland, Capital and Coast and Canterbury DHBs are early examples of service integration for older people.
Q14	**What needs to happen for further attempts at service integration to be credible with providers?**	• From an agency perspective, for further attempts at service integration to be credible with providers all government departments involved need to commit the necessary staff and management time and expertise to the attempt at service integration.

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		• Each department needs to specify the key contact person that other departments can go to with questions and issues with the expectation that these will be responded to in a timely manner. • Integration at a funder level will also assist. • To be credible, further attempts at service integration: o Need to Include people (providers and consumers) into service design • Having the right people involved, each agency needs to be willing to be flexible • A systems approach - including end-to-end processes, a clear understanding of 'how' to integrate services, who is doing what and how to measure. o Good change management focussing on outcomes for people: Need a road map and clear outcomes; and to look and be seamless.
Q15	**Which social services are best suited to client-directed budgets? What would be the benefit of client-directed budgets over existing models of service delivery? What steps would move the service in this direction?**	• DSS Home and Community Support Services, Respite (including Carer Support), Day Programmes, supported living, residential disability support services are all examples of social services best suited to client-directed budgets. • Specialist Disability Support services such as Behaviour Support and Child Development should be excluded; as well as high level Health of Older People services (e.g. rest home). Client-directed budgets are well-suited to: • services where the client's views and decisions are an important part of achieving the desired outcomes e.g. in disability where leading a good life requires having some control over what happens every day • situations where a client is receiving funding from different government agencies – and where by combining that funding there is an opportunity to get better outcomes for the client and better value for money for the government, and • situations where a client is receiving funding from one government agency – and where combining the total allocation for the year allows the client to improve their outcomes in ways that are not possible when the allocation is dispensed on a weekly basis. • Enhanced Individualised Funding moves away from 'services' to budgets. The benefits to disabled people include far more flexibility about what services and/or supports are

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		provided when, choice about who provides the support and control over how the support is provided. • Overseas (and now local) evidence shows there are likely to be cost savings if disabled people are able to manage their budgets and purchase relevant disability supports. These savings in overall spend have been offset to some extent by an increasing utilisation of the existing allocation, therefore cost savings are difficult to identify. • There may need to be a trade-off between more choice and control, and a slightly reduced allocation. • This is reasonable as the costs for a person to manage their own budget should be less than the overheads incurred by providers.
Q16	**Which social services do not lend themselves to client-directed budgets? What risks do client-directed budgets create? How could these risks be managed?**	Social services that do not lend themselves to client-directed budgets: • Population based programmes and programmes that rely on highly skilled and scarce workforce. • Where the person receiving social service is high acuity and/or where the person's condition and position (e.g. as dependent on others) make then vulnerable to abuse by their carers client directed budgets create risk. • Specialised services that require high levels of consumer expertise or technical knowledge to select a competent provider .e.g Behaviour Support Services because of the potential to exacerbate behaviours through under trained or partially trained providers • Child Development should also be excluded. • In general, where there is a health literacy issue; or where the client's input isn't needed for the intervention (e.g. an operation). Risks associated with client-directed budgets include: • The risk that the individual will spend the funding on things that do not meet the original intent of that funding e.g. the person is pressured by the family to pay for travel unrelated to meeting the disabled person's needs • There is a perception of risk related to fraud, however overseas evidence shows that this risk is not significant and can be mitigated • A degree of transparency may enable central agencies to assess the contribution that services and supports make to outcomes for people.

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		Individuals who adopt to hold and direct budgets take responsibility and therefore shoulder the risk themselves. Risks associated with client-directed budgets can be managed by: • putting guidelines in place to provide the person with guidance about what the funding can be spent on. • Where the person wants to spend funding on something outside the guidelines, a review panel needs to exist that can assess the request and approve it or not. • In some ways, the future might indicate that for disability supports we are recognising the myriad additional costs that people and families incur through having a disability, so that monitoring and accountability for this type of funding could be relaxed. • There is, however, also need to acknowledge that that this risk also exists with contracted providers.
Q18	**How could the views of clients and their families be better included in the design and delivery of social services?**	• Clients and their families are included in all aspects of procurement, for example, in identifying need, service design, the procurement of services, service delivery, and review of service. • Simply, views of clients and their families are best included by a) talking to the consumer/person, and b) putting it in the plan. • We do, however, need to be very aware of the rules of the game and their effect on the voice of the consumer. • The Putting People First (2013) report makes a number of recommendations with the objective of better including the views of clients and their families into the design and delivery of services and supports to people with disabilities. • It is early days as the report's recommendations are to be implemented by the end of 2015. • However, the suggestions from this report are based on good evidence and endorsed by government and include disabled people in the Steering Group to implement the recommendations of the report. • In terms of ongoing delivery, the views of clients – in this case disabled people – need to

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		be meaningfully taken on board and reflected in the design. • St John ongoing surveys of clinical hub clients are a good example of bringing clients and their families into the design and delivery of services. The question that is asked is "did the service deliver the outcome expected?" and "What has made a difference?" • Responses are reviewed and discussed monthly to identify which groups need slightly changed approach etc. and service responses are adjusted accordingly. • There could be a range of satisfaction survey or more feedback mechanisms in place in disability support services to ensure that the Ministry has an independent view of the satisfaction of service users with the services funded by the Ministry. • Different mechanisms are needed for different disability groups e.g. one-to-one for people unable to speak for themselves but who may use body language to communicate; braille or spoken surveys for people who cannot see; interviews with other disabled people where there is low trust in strangers. • Information from such feedback mechanisms would be used to inform annual and strategic planning. • Satisfaction surveys can only be part of the answer as people do not always know what they should expect to receive from a service. • Actively including advocacy groups and Disabled Persons' Organisations in planning and evaluation, standing positions on committees and working groups and for consumer reps where possible will partially assist. • Direct feedback from complaints is also very helpful. The literature states that only 4% of people dissatisfied with a disability support service will actually make a complaint about it – so complaints provide vital information that the other 96% are unwilling or unable to provide for a host of very good reasons. • For the past ten years DSS has used the input from its stakeholder groups to inform its business and annual planning. • Draft plans have been presented to the DSS Consumer Consortium for its advice and

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		input. • DSS hosts a number of client and provider forums and groups and has excellent connections with the disability sector. • Incorporating considered design principles that reflect real and consulted consumer needs (e.g. age friendly urban design principles) into the mainstream service is a standard setting example of incorporating the consumer's view.
Q19	**Are there examples of service delivery decisions that are best made locally? Or centrally? What are the consequences of not making decisions at the appropriate level?**	• National programmes design/set policy and standards. How they will operate/work in the local environment is set locally. The Youth Unemployment Programme is one such example. • DSS is a national funding agency so all decisions are made centrally. However, decisions affecting local areas involve consultation with local providers, NASC and service users. • DSS has trialled changes in service delivery in particular regions and has established local working groups including consumers and local iwi to inform development of new services e.g. Local Area Coordination in the Bay of Plenty, Enhanced Individualised Funding in the Eastern Bay of Plenty. Choices in Community Living in Auckland and Waikato. Regional trials are a good way of identifying barriers to change which can then be addressed locally. • There are some DSS service delivery decisions, however, that are best made centrally e.g. Regional Intellectual Disability Care Coordination Agencies (RIDCA) have been replaced by one National IDCA in order to gain national consistency and equity of access to services. • Regional decisions can lead to inconsistencies of services in terms quality and access. However, regions know their communities best, and the issues and resources better. Regions are also able to respond more quickly.
Q22	**What is the experience of providers and purchasing agencies with hightrust contracts? Under what circumstances are more relational contracts most likely to be successful or unsuccessful? Why?**	• Relational contracts are best when there are close, trusting, and highly communicative relationships between funder and provider at governance and operational levels, with stable personnel and organisational cultures. • Most DSS contracts are relational because they involve provision of services to individual disabled people and become part of their life e.g. residential services become the person's home; Personal Care staff visiting someone in their home to help them get up,

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		showered and dressed every day become intimately acquainted with an individual's particular needs. It's therefore not appropriate to retender such services as that would result in changing people's homes and staff more often than is desirable for living 'an ordinary' life. • Relational contracts are more likely to be successful when there is no effective market. With relational contracts, there becomes a dependency of government and NGOs to achieve the outcomes. • Relational contracts are, by definition, dependent on an organisation's relationships, which leave them open to cognitive biases which are based on perception of the individuals and their organisation (which may have little bases in fact, i.e. be prejudicial) • Relational contracts: o need to be a win/win o require trust that a provider has good systems.
Q24	**Are there examples of where government agencies are too dependent on particular providers? Are there examples of providers being too dependent on government funding? Does this dependency cause problems? What measures could reduce dependency?**	• St John Ambulances is an example of a service provider that we are highly dependent on. No one else could take over quickly if St John folded. • Ambulance providers are highly dependent on government funding. • Sleepovers, In-Between Travel and Terranova court cases all demonstrate over-dependence – of government on particular providers and on the same providers on government funding. These court cases were all taken against individual providers but the government has had to step in to resolve the situation because they were reliant on government funding. • For long-term care providers (e.g. Disability Support Services), the focus is on efficiency and productivity rather than innovation. • The solution, is to separate capacity and capability (where possible) – by separating the purchase of capital from the purchase of services – e.g. in Residential Disability Services a person would be able to contract with one (of many) provider(s) for the residence (or house) and one (of many) for the services. • Another measure to reduce provider dependency is supporting the capability of the wider (presently un-contracted) providers. • Within DSS there are a number of big providers and a number of providers reliant on Ministry funding. We manage these relationships by working closely with these

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		providers, providing opportunities for providers to understand what we are doing and why and for some big providers we have regular meetings. The reliance on Ministry funding also means that for providers who are struggling, the Ministry is put under pressure to increase funding, potentially outside of traditional guidelines. The KPMG pricing review has helped DSS to manage these funding implications and we are currently moving to more consistent funding practice.
Q27	**Which social services have improved as a result of contestability?**	• Home and Community Support Services for disabled people as a result of Individualised Funding (where the person has choice) has improved because of contestability, in terms of choice and flexibility. • For example, people are able to get a bath at the time the person desires as opposed to having to conform to what the provider has planned. • The driver for agency improvement is, for example, reviews by NZIER, PIFs (Performance Improvement Framework reviews) by the State Services Commission, and the Integrated Performance and Incentive Framework (the IPIF – for DHBs). • The tender for national DSS Behaviour Support resulted in a shift from multiple regional service providers to a single national service provider in order to improve national consistency of access and quality of service delivery. • Tendering for a new Physical Disability service in Tauranga resulted in significant improvement in the lives of people under 65 years who had previously had to live in aged care facilities. • Tendering for Individual Funding Hosts also contributed to improved services. • Contestability for new services always results in improved outcomes for clients, as the new service specifications are developed which incorporate up to date best practice.
Q28	**What are the characteristics of social services where contestability is most beneficial or detrimental to service provision?**	• Contestability is most suited to when you are trying to encourage change or new behaviours. The risk is the re-arrangement if the same (i.e. old wine, new bottles). • Drivers include a common or new market; and a need for a translational change.
Q33	**What changes to commissioning and**	• Changes to encourage improving services include:

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	contracting could encourage improved services and outcomes where contestability is not currently delivering such improvements?	o shared/joint outcome objectives o involving people who are service users o co-design of service improvements o partnering o relational approaches o interactions at governance and executive levels o ongoing dialogue o shared performance targets o monitoring and feedback o benchmarking with overseas services o inclusion of results measures and outcome measures in the revised service specs o provision of training / learning opportunities for staff and managers in the sector o involvement of consumers in the delivery of this training o raising provider awareness of the need to improve quality of service delivery and allow providers to learn from each other – this may be done through more robust quality monitoring and reporting on meaningful quality metrics o encouraging providers to work more collaboratively – mentoring and learning from each other.
Q42	**Are there examples of outcome-based contracts? How successful have these been?**	• We are moving towards outcome based contracts for the National Ambulance Service. However, it is hard to say how successful these outcome based contracts are yet. • Disability Behaviour Support Services in an outcome based contract. Initial indications are that information from the provider is more useful to monitor volumes and quality and can be provided at an individual service user level. • DSS has implemented an outcome-based contract with TePou and Lifelinks NASC, however, it is too early to tell if these have been successful. • The first outcome based contract that Disability Support Services established was with Te Pou and the Ministry is getting less relevant information now than it did before. • Youth Unemployment Contracts are another example of an outcomes-based contract.

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		• In general, what gets measured gets done. While it is difficult to contract purely for outcomes, getting providers to focus on outcomes is an improvement. • MSD led integrated contracts include Enabling Good Lives and Healthy Families. It is early days yet but there is some evidence to support these initiatives.
Q45	**What have been the benefits of government initiatives to streamline purchasing processes across agencies? Where could government make further improvements?**	• The benefits of government initiatives to streamline purchasing processes across agencies include reducing the number of contracts with providers: o reducing compliance costs for providers, and o reducing administration costs for funders allowing increased capacity to assist providers to achieve outcomes. • Government initiatives to streamline purchasing processes are raising the profile of procurement and the understanding of good procurement practice including learning opportunities. However, so far we do not see any evidence of less work for funders. • Additionally, benefits include: o shared (internal) learnings – in terms of procurement (as above), monitoring, relationships and putting faces to names o the operational involvement of mid-level managers and front line staff o awareness that there is no going back o less duplication and a more joined up approach o sharing of information between agencies o joint service development; joint audits and evaluation, monitoring etc. Further improvements: • Further improvements could be made (at least theoretically), by having an honest broker to assess and mediate any road blocks promptly (e.g. IT issues, payment systems). • The MBIE processes are models of good practice but when we have contract managers responsible for hundreds of providers/contracts and sinking FTEs it is not practical to implement for all in the short term.
Q48	**Would an investment approach to social services spending lead to a better allocation of resources and better social outcomes? What are**	An investment approach to social services: • An investment approach should lead to better long-term outcomes and efficiencies across the system in the longer-term.

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	the current data gaps in taking such an approach? How might these be addressed?	• The actuarial response is not appropriate for all health services. • Investment that is based on best practice evidence, so interventions are made at the intensity required and at the right time to make a difference e.g. the evidence is clear that early intervention works for a number of issues. • Benefits should then be calculated based on the whole of life cost/benefit when taking an investment approach so we can demonstrate saving later e.g. early intervention for Communication, Behaviour Support Services and Respite will pay significant benefits later in the life of the consumer such as better quality of life indicators and lower demand for residential placements. • Value for money can also be improved by ensuring that – where appropriate - disability service users have a say in how the funding is used - where they know the solutions to their own issues better than the government does. Current data gaps: • The problem with an investment approach is payback is usually very long-term and uncertain. • There is often a limited evidence base to support investment decisions and governments need to see savings within 3-5 years. • There ease with which to establish baseline and comparator data. • It also needs to be noted that cost-benefit analysis doesn't always apply, e.g. palliative care. Addressing gaps: • Data systems need to be invested in. • Often the Privacy Act doesn't allow the monitoring of outcomes across government, (eg, Youth Unemployment).
Q56	**Are you willing to meet with the Commission? Can you suggest others with whom the Commission should consult?**	Contact: Jill Lane Director National Services Purchasing Ministry of Health, National Health Board, National Services Purchasing HAS an EA/PA of Angela Radich 04 816 3635

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