Service Arrangement (SA) and Grant Aid Agreement (GAA) Review

Contents

GLOSSARY

ADL	Activities of Daily Living
CMSU	Contract Management Support Units
DF	Dialogue Forum
GAA	Grant Aid Agreement
HSE	Health Service Executive
IADL	Instrumental Activities of Daily Living
IRG	Independent Review Group
MOU	Memorandum of Understanding
NESC	National Economic & Social Council
PID	Project Initiation Document
PPs	Partnership Principles
SA	Service Arrangement
SPG	Service Provider Governance

1. Executive Summary

Purpose

This report is intended to inform the HSE Executive Management Team of progress in respect of the Service Arrangement and Grant Aid Agreement Review and to submit recommendations for approval.

Background

The Service Arrangement and Grant Aid Agreement (SAGAA) Review commenced in July 2023. Previous attempts to carry out a limited review in 2020 were deferred as a result of the Covid-19 pandemic. There have been significant developments in the area of the State and the Voluntary sector during the intervening period including: the work of the Dialogue Forum; the publication of the *Partnership Principles*; the completion of the Case Study Programme. The review is being conducted in the context of these important developments.

Scope

The scope comprises a review of the legal documentation (a 'Technical Review') and the engagement lifecycle (a 'Process Review') that supports the SAGAA process. Consideration of policy or legislative changes, or decisions in respect of funding at national or organisational level, are not within the scope of the project.

Governance

The project has a two-tier governance structure comprising an Oversight Group and a Working Group. The National Operations Senior Team, Dialogue Forum and Department of Health are kept informed through regular updates and engagement. Implementation of the recommendations requires the approval of the HSE Executive Management Team (EMT). Full membership of the relevant groups is provided at Section 5.

Objectives

The overarching objective of the project is to review the Service Arrangement and Grant Aid Agreement documentation and processes in the context of the *Partnership Principles*. In recognition of the limited opportunity to make changes ahead of the 2024 contractual cycle specific areas of focus were agreed.

Technical	*Process*
Financial threshold applicable to GAA	Timing of signing of SA documentation
Simplification of content of SA Part II	Consultation and engagement process
Examine specific Clauses in SA Part I:	Duplication of administrative processes
12 (Access); 14 (PN Process); 33 (Dispute)	Communication and engagement

Assumptions, Risks and Dependencies

The most significant assumptions, risks and dependencies identified by the working group include:

Assumptions

- The ways of working outlined in the *Partnership Principles* will be adopted and will inform and support the implementation of the recommendations proposed by the SA GAA Review
- Existing accountabilities and responsibilities will be upheld within the structures established as part of the reorganisation of the HSE into Health Regions
- Clear communications and supports will be put in place around any changes for 2024, in particular for the operational systems within the HSE and Voluntary Organisations.

Risks

- Initially there may be additional challenges for all staff in HSE and voluntary organisations in learning and dealing with service arrangement changes and new processes. This risk will be mitigated by clear communication and provision of an implementation support programme for key implementers.
- There may be a risk in terms of capacity to support the level of engagement required to implement these changes – in particular to agree activity and funding within a condensed quarter 1 timeframe. This risk would be mitigated, at least partially, by reviewing the allocation of responsibilities across existing resources, with a view to supporting increased demands during peak periods.
- There is a 'systemic' risk in that HSE/Agencies may have little latitude to influence external stakeholders and may be expected to absorb costs associated with new legislation and/or policies. This risk could be mitigated by requiring comprehensive impact assessments ahead of such changes.

Dependencies

- As with all changes to practice and procedure, implementation will require the support of service managers across both the public and voluntary systems
- Decisions will require clear and detailed communication with the relevant operational teams within the HSE and voluntary organisations

Summary of Recommendations

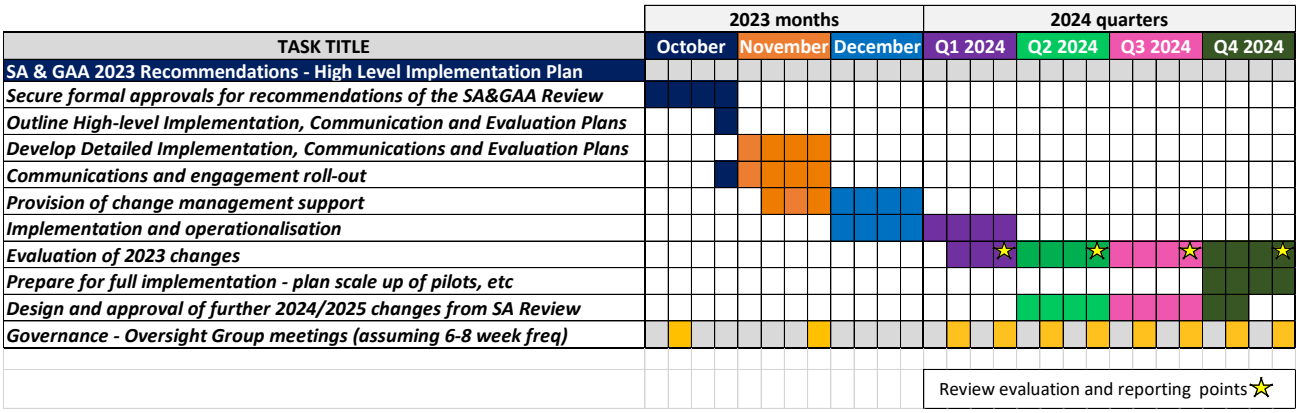
The review team developed seven recommendations which can be implemented to support the 2024 contractual cycle. These are outlined below.

No.	Area of Focus	Recommendation
1	GAA Threshold	Increase the threshold for the use of the GAA for all client facing and non-client facing organisations from €250,000 up to €1million.
2	Simplification of SA Part II	Simplify SA Part II by moving aspects of the current Schedules to an Annex to Part I with lead CHO/Region responsible for signing Part I. Explore use of IT-based systems to streamline the process.
3	Examine Clauses 12, 14 and 33 of SA Part I	Review clauses 12, 14 and 33 on access, the performance notice process and dispute resolution to ensure clarity, fairness and balance in respect of processes and obligations associated with these three clauses in the SA Part I.
4	Timing of signing documentation	Agree deadlines for both acute and non-acute services to be completed within Q1 of each year. (NB: reliant on allocations being notified to providers by the agreed dates and a process of engagement within which there is commitment to the principles.)
5	Consultation and Engagement	Establish consultative structures and processes to support both integrated stakeholder consultation and care group specific engagement. (NB: These should be developed as part of the design of Health Region integrated structures).
6	Duplication of processes	The largest funded CHO / Region (where multiple CHOs / Regions are involved) will review corporate documentation so that duplication across CHOs/Regions is reduced.
7	Communication and Engagement	Extensive communication and engagement process to be put in place that will support buy-in across the system to the ways of working identified in the *Partnership Principles* and to the proposed changes recommended by this review.

Further detail is provided on the recommendations, the benefits, risks and mitigations at Section 9.

Implementation

A high-level plan outlining the intended approach to implementation is summarised below for information.



The timeline to implement changes ahead of the 2024 contractual cycle is limited and represents a significant challenge to both the HSE and voluntary agencies. Successful implementation will require the prioritisation and allocation of responsibilities across the full range of existing operational resources to support the process.

Next Steps / 2024 and Beyond

The overall objective for 2024 and beyond will be to support the adoption and integration of the Partnership Principles as a way of working, by continuing to refine the documentation and management framework that support the SA and GAA lifecycle. The proposed recommendations contained in this report represent foundational steps in this process. Specific objectives for 2024 include:

- Continue to work to embed the ways of working outlined by the *Partnership Principles* at all levels in the relationship between the Statutory and Voluntary sectors
- Monitor and evaluate the impact of changes introduced as part of the SA and GAA Review (including the operation of the pilot projects)
- Continue to simplify documentation where possible, extending the 2024 pilot programmes across Disabilities and Acute services as appropriate
- Continue to review clauses within the SA (Part I and Part II) and GAA in the context of the *Partnership Principles*
- Review of the Business Cases process (to include documentation, procedure and data collection)
- Embrace digitalisation within the SA process with a view to enhancing efficiency and accessibility
- Consider the broader perspective on the timing of signing SAs with a view to seeking greater consistency and efficiency in the process
- Maintain consistent and regular communication and engagement with all stakeholders
- Continue to support behavioural change by ensuring that the SAAGAA Review is progressed as an exemplar project in accordance with the *Partnership Principles*.

Appendices

A series of Appendices are included in the report which provide additional information on, among other areas, the *Partnership Principles*, the Dialogue Forum, the SA Lifecycle, Examples of Good Practice from NESC Report.

2. Purpose

The purpose of this report is to inform the HSE Executive Management Team of progress in respect of the Service Arrangement and Grant Aid Agreement Review and to submit recommendations for consideration ahead of the 2024 contractual cycle.

3. Background and Context

The Service Arrangement and Grant Aid Agreement[1] Review (SAGAA) commenced with the first meeting of the Project Oversight Group, on 3rd July 2023. Previous attempts to carry out a limited review in 2020 had been deferred as a result of the impact of the Covid-19 pandemic. In the intervening period, there have been significant developments in the relationship between the State and the Voluntary sector. These include the ongoing work of the Dialogue Forum, the publication of the *Partnership Principles*, the completion of the Case Study Programme and most recently, the commencement of the Health Regions implementation plan. The current review is being progressed in the context of these important developments.

The Dialogue Forum

The Dialogue Forum was established in 2019 following the publication of an Independent Review Group report (the 'Catherine Day' report) which examined the role of voluntary organisations in the delivery of publicly funded health and social care services. The aim of the Dialogue Forum is to build a stronger working relationship between the State and the voluntary sector with a view to improving the quality of services for service users. Membership of the Dialogue Forum is listed at Appendix 1.

The Partnership Principles

The Dialogue Forum developed a set of guiding principles which provided a blueprint for how the statutory and voluntary sectors could work together in the future. They sought to build on the collaborative, integrated ways of working that were evident during the Covid-19 pandemic. The *Partnership Principles* were launched in April 2023 by the Minister of Health, who noted that the voluntary sector is "an integral and essential component of our public health service". An extract from the published document illustrating the partnership principles is provided at Appendix 2.

The Case Study Programme

The Dialogue Forum also commissioned a series of Case Studies which sought to identify practical ways to improve the relationship between the HSE and voluntary providers. The findings assigned a pivotal role to the SAGAA Review, which was designated by the Dialogue Forum as an exemplar project in the implementation of the *Partnership Principles*. The Case Study recommendations are shown in full at Appendix 3.

Health Regions Reform

Health Regions reform involves the reorganisation of the HSE into six operational regions with devolved responsibility for the delivery of health and social care in their geographic areas. While implementation is at an early stage any recommendations should be supportive of the future direction of the organisation.

[1] In many instances the HSE delivers health and personal services directly, however, in other circumstances it relies upon non-statutory Agencies to deliver services on its behalf. Sections 38 and 39 of the Health Act, 2004 provide for the HSE to set down the terms and conditions that attach to funding released in accordance with this legislation. For all voluntary Agencies that receive in excess of €250K these terms and conditions are set down in a Service Arrangement; for all voluntary Agencies that receive less than €250K they are set down in a Grant Aid Agreement. These documents are contracts and operate on the principles of contract law. There is a requirement on all Agencies funded in this manner to annually execute one of these documents, depending on the funding it receives, with the HSE.

4. Scope

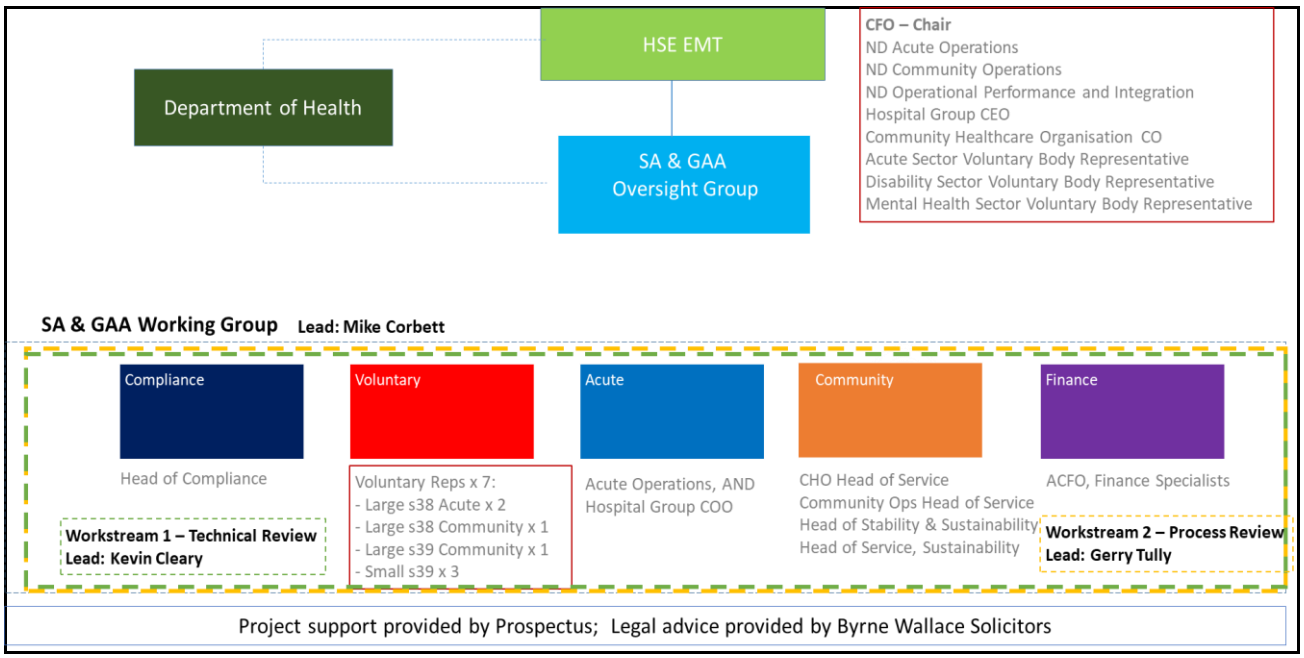
The influence of the Dialogue Forum, the Partnership Principles and the Case Study programme is evident in both the scope and governance of the SAGAA Review. Earlier terms of reference sought to focus more on the engagement process around SAs and GAAs. However, as a result of dialogue with voluntary representatives the scope was extended.

The scope now comprises a review of both the legal documentation (a 'Technical Review') and the engagement lifecycle (a 'Process Review') that supports the SAGAA process. It is important to note that the consideration of policy or legislative changes, or decisions in respect of funding allocations at national or organisational level, are not included within the scope of this project.

5. Governance

A two-tier governance structure has been adopted to manage the project comprising of an Oversight Group and a Working Group. The outputs and recommendations of the review are submitted to the HSE Executive Management Team for consideration and decision. The Dialogue Forum and Department of Health are kept informed through regular updates and engagement. An overview of the governance and reporting structure for the SAGAA Review is shown at Figure 1.

Figure 1: Overview of SAGAA Review Governance Structure



The Oversight Group

The Oversight Group is chaired by the CFO of the HSE at the request of the Chief Operating Officer. It comprises National Director and Executive Management representatives from the HSE and Chief Executives of voluntary sector representative bodies. The high level responsibilities of the Oversight Group include:

- Provide advice and support throughout the process to the Working Group
- Consider the outputs, recommendations and issues raised by the Working Group
- Update HSE EMT on progress and submit final recommendations for consideration

The membership of the Oversight Group is listed for information at Figure 2.

Figure 2: Oversight Group Membership

Fiona Coyle	CEO, Mental Health Reform
Mary Day	ND, Acute Operations, HSE
Mo Flynn	CEO, Voluntary Healthcare Forum
Alison Harnett	CEO, National Federation Voluntary Service Providers
Declan Lyons	CEO, Ireland East Hospital Group, HSE
Stephen Mulvany	CFO, HSE *(Chair of the Oversight Group)*
Tess O'Donovan	CO, Cork Kerry Community Healthcare, HSE
Joe Ryan	ND, Operational Performance and Integration, HSE
David Walsh	ND, Community Operations, HSE

The Working Group

The Working Group is led by the Assistant National Director, Acute Operations, HSE. It includes representation at Assistant National Director and Operational Management level within the HSE, as well as Executive Management representatives from a broad range of organisations across the voluntary sector. The high level responsibilities of the Working Group include the following:

- Review SA and GAA technical issues and supporting engagement processes in detail
- Escalate findings to the Oversight Group for consideration at key points in the process
- Submit recommendations to the Oversight Group for consideration in final report to HSE

The membership of the Working Group is listed for information at Figure 3.

Figure 3: Working Group Membership

Fran Brennan	CEO, Polio Survivors Ireland
Kevin Cleary	Head of Compliance, HSE
Mike Corbett	AND, Acute Operations, HSE *(Project Lead)*
Brid Cosgrove	DoF, Mater Misericordiae University Hospital
Clare Dempsey	CEO, St John of God Community Services
Mairead Dolan	Assistant CFO, National Finance Division, HSE
Ken Fitzgibbon	COO, Ireland East Hospital Group, HSE
Olive Hanley	Head of Service for Disability, DNCC CHO, HSE
Chris Hoey	Acting CEO, Irish Wheelchair Association
John Kelly	Deputy CEO, Tallaght University Hospital
Suzanne Moloney	Head of Service, Stability & Sustainability, HSE
Noel O'Meara	CEO, CareGivers Ireland clg
Bernard O'Regan	Head of Operations, Disability Services, HSE
John O'Sullivan	CEO, Enable Ireland
Gerry Tully	Head of Stability & Sustainability, HSE

Workstreams

Two distinct Workstreams have been established within the Working Group. Workstream 1 focusses on a review of the contractual documentation (the 'Technical Review'). It is chaired by the Head of Compliance within the HSE. Workstream 2 focusses on a review of the engagement processes around the implementation of the SAs and GAAs (the 'Process Review'). It is chaired by the Head of Stability and Sustainability within the HSE. The membership of each Workstream is listed below:

Figure 4: Membership of Workstream 1 – Technical Review

Fran Brennan	CEO, Polio Survivors Ireland
Kevin Cleary	Head of Compliance, HSE *(Workstream 1 Lead)*
Mike Corbett	AND, Acute Operations, HSE
Brid Cosgrove	DoF, Mater Misericordiae University Hospital
Clare Dempsey	CEO, St John of God Community Services
Ken Fitzgibbon	COO, Ireland East Hospital Group, HSE
Olive Hanley	Head of Service for Disability, DNCC CHO, HSE
Suzanne Moloney	Head of Service, Stability & Sustainability, HSE
Noel O'Meara	CEO, CareGivers Ireland clg
Bernard O'Regan	Head of Operations, Disability Services, HSE
John O'Sullivan	CEO, Enable Ireland
Gerry Tully	Head of Stability & Sustainability, HSE

Figure 5: Membership of Workstream 2 – Process Review

Kevin Cleary	Head of Compliance, HSE
Mike Corbett	Project Lead. AND, Acute Operations, HSE
Clare Dempsey	CEO, St John of God Community Services
Mairead Dolan	Assistant CFO, National Finance Division, HSE
Ken Fitzgibbon	COO, Ireland East Hospital Group, HSE
Olive Hanley	Head of Service for Disability, DNCC CHO, HSE
Chris Hoey	Acting CEO, Irish Wheelchair Association
John Kelly	Deputy CEO, Tallaght University Hospital
Suzanne Moloney	Head of Service, Stability & Sustainability, HSE
Gerry Tully	Head of Stability & Sustainability, HSE *(Workstream 2 Lead)*

Workshops

In addition to the above, a series of focussed Workshops took place involving all members of the Oversight Group and Working Group. Three Workshops have been held to date. These were facilitated by Prospectus.

6. Objectives

The overarching objective of the project is to review the Service Arrangement and Grant Aid Agreement documentation and processes in the context of the *Partnership Principles*. A listing of the detailed objectives included in the Project Initiation Document (PID) is provided below:

Figure 6: Objectives of Project

1. To undertake a detailed review of the content of the Service Arrangement (SA) (Part 1 & Part 2) and Grant Aid Agreement (GAA) to establish the necessity and appropriateness of all clauses within the documents.
2. To identify all necessary legal requirements within the SA and GAA that cannot be amended without specific legislative change.
3. To establish what currently works and what doesn't in the current engagement process between the HSE and voluntary providers.
4. To outline what needs to be done to fully implement the Partnership Principles throughout the SA and GAA lifecycles.
5. To detail any proposed amendments to text and processes that might be required.
6. To ensure that any proposed changes to the SA and GAA are consistent with all relevant legislation and contract law requirements.
7. To explore options to help reduce the administrative burden for all parties whilst meeting the minimum legal and operational requirements, including the use of IT solutions.

It became clear that there was a limited opportunity to introduce changes ahead of the 2024 cycle. This reflected the requirement to ensure that amendments to documentation and processes had to be agreed, approved and incorporated into the contractual and governance framework in time for issue in November 2023. It was accepted that a pragmatic and realistic approach was required to deliver a credible product within that timeframe. The areas of focus for 2023 were identified at the initial workshop on 19th July on the basis that any changes would need to:

- Be **meaningful** in terms of change
- Be **achievable** within the timeframe
- Provide **sufficient protection** to both parties
- Support the **longer-term** strategic objectives

Figure 7: Areas of Focus 2023

Technical	Process
Financial threshold applicable to GAA	Timing of signing of SA documentation
Simplification of content of SA Part II	Consultation and engagement process
Examine specific Clauses in SA Part I:	Duplication of administrative processes
12 (Access); 14 (PN Process); 33 (Dispute)	Communication and engagement

Workstream 1 was tasked with developing recommendations for consideration in relation to the Technical areas of focus. Workstream 2 was tasked with developing recommendations for consideration in relation to the Process areas of focus.

7. Assumptions, Risks and Dependencies

The key assumptions, risks and dependencies identified by the respective workstreams are listed below.

Assumptions

- The ways of working outlined in the Partnership Principles will be adopted and will inform and support the implementation of the recommendations proposed by the SA GAA Review.
- Existing accountabilities and responsibilities will be upheld within the structures established as part of the reorganisation of the HSE into Health Regions.
- Contract Management Support Units (CMSUs) will continue to exist under the Health Regions
- SPG and / or an enhanced ICT system will exist under the Health Regions.
- The work on SA Part II is the commencement of a process whereby the current paper-based system can in due course be transferred to an IT platform.
- HSE Service Managers and Voluntary Organisation CEOs will be involved in the decision on which organisations to include in the pilot programmes.
- Clear communications will be put in place around any changes for 2024, in particular for the operational systems within the HSE and Voluntary Organisations.

Risks

- HSE and Voluntary Organisation Service Managers will be involved in identifying participants in the pilot programme – there may be an inconsistent approach to risk-assessment and decision-making. This risk will be mitigated by providing clear inclusion criteria and ongoing support to the pilot process
- There is a 'systemic' risk in that HSE/Agencies may have little latitude to influence external stakeholders and may be expected to absorb costs associated with new legislation and policies (e.g. Regulation, Health and Safety, GDPR, ADM). This risk could be mitigated by requiring comprehensive impact assessments from the relevant external stakeholders ahead of introducing such changes.
- There is a risk in terms of capacity to support the level of engagement required to implement these changes – in particular to agree activity and funding within a condensed Q1 timeframe. This risk would be mitigated, at least partially, by reviewing the allocation of responsibilities across existing resources, with a view to supporting increased demands during peak periods.
- Initially there may be additional challenges for all staff in HSE and voluntary organisations in learning and dealing with service arrangement changes and new processes. This risk will be mitigated by clear communication and provision of an implementation support programme for key implementers.

Dependencies

- As with all changes to practice and procedure, any change in this regard will require the support of service managers across both the public and voluntary systems.
- Any decisions will require clear and detailed communication with the relevant HSE and voluntary organisations' operational teams.
- There is a specific requirement to agree the proposed model with HSE Service Managers and Voluntary Organsations in relation to those participating in the pilot programmes for 2024.
- Essential that relevant Service Managers have robust systems in place, if required, to deal with the matters covered in Clauses 12, 14 and 33.
- Requirement for Impact Assessments in advance of introducing new requirements to be raised at Dialogue Forum. A broad communications process is required around this, focussing specifically on the barriers that additional cost measures place on access of greater numbers to services.

8. Recommendations Summary

The review highlighted seven sets of recommendations in total - three from a technical point of view (Workstream 1) and four from a process standpoint (Workstream 2). These are summarised below.

No.	Area of Focus	Recommendation	Workstream
1	Thresholds/GAA	Increase the threshold for the use of the GAA for all client facing and non-client facing organisations from €250,000 up to €1million.	1
2	Simplification of SA Part II	Simplify SA Part II by moving aspects of the current Schedules to an Annex to Part I with lead CHO/Region responsible for signing Part I. Explore use of IT-based systems to streamline the process	1
3	Review Clauses 12, 14 and 33 of SA Part I	Review clauses 12, 14 and 33 in SA Part I on access, the performance notice process and dispute resolution to ensure clarity, fairness and balance in these clauses.	1
4	Timing of signing documentation	Agree deadlines for both acute and non-acute services to be completed within Q1 of each year. (NB: reliant on majority of allocations being notified to providers by the agreed dates and a process of engagement within which there is commitment to the *Partnership Principles*).	2
5	Consultation and Engagement	Establish consultative structures and processes to support both integrated stakeholder consultation and care group specific engagement. (NB: These should be developed as part of the design of Health Region integrated structures).	2
6	Duplication of processes	The largest funded CHO / Region (where multiple CHOs / Regions are involved) will review corporate documentation so that duplication across CHOs / Regions is reduced.	2
7	Communication and Engagement	Extensive communication and engagement process to be put in place that will support buy-in across the system to the ways of working identified in the *Partnership Principles* and to the proposed changes recommended by this review.	2

Each recommendation was worked through in detail as part of the review process. The risks and benefits associated with each proposal were assessed and appropriate risk mitigation strategies were identified.

The initial output of the Working Group was reviewed by the full project membership at Workshop 2, held on 31st August 2023. The clarifications and suggestions arising from the workshop were incorporated into the final recommendations set out above. These were reviewed and approved by the Oversight Group at its second meeting, held on 2nd October 2023. The recommendations are set out in detail, together with associated benefits, risks and mitigations in Section 9 of this report.

9. Recommendations, Benefits and Risks

The proposed recommendations of the SAGAA Review are set out in detail together with an outline of the associated benefits, risks and mitigations.

9.1 Technical Review Recommendations

Recommendation 1 – GAA Threshold

Recommendation:

Increase the threshold for the use of the GAA with client facing and non-client facing voluntary Agencies from €250,000 up to €1million.

- This will be introduced as a pilot in the first instance in three CHOs.
- All Agencies within this category in the three CHOs to be considered for the pilot and clear rationale will be required for an Agency to be excluded from the pilot.
- Where a voluntary Agency has multiple SAs/GAAs the applicable financial threshold will be the consolidated value of that Agency's SAs/GAAs
- Pilots to be progressed through the lens of the Partnership Principles.

Benefits

- ✓ Reduction of administrative burden: Increasing the threshold is intended to simplify the process and improve efficiency.
- ✓ Reduction in the number of Service Arrangements being used in these CHOs.

Risks & Mitigations

- There is a risk that moving Agencies from SA to GAA may result in:
  - a reduction in the level of contractual measures available to HSE service managers;
  - a reduction in the level of contractual protections available to the Agencies;
  - a perceived diminution in status for those Agencies who previously had SAs.
- This risk will be mitigated by:
  - an appropriate assessment process preceding the selection of Agencies for the pilot;
  - a clear communication process with key personnel from the organisations involved;
  - a wider communication across the system as to the nature and intention of the pilots.
- The risk will also be mitigated by careful monitoring of those Agencies that have been selected for the pilots and regular monitoring and evaluation of the pilot process.

Recommendation 2 – Simplification of SA Part II

Recommendation:

Simplify the SA Part II by moving aspects of the Schedules to an Annex to the SA Part I with lead CHO/Region responsible for signing Part I; Explore use of IT-based systems to streamline the process

- The current Part I and Part II are to be remodelled into two new documents.
- The first document will be the current Part I plus appropriate elements of the current Part II added as appendices.
- The second document will be titled the Health Provider Service Requirements (HPSR) and will set down the key variables, in particular, the Funding and Services that are agreed between the Agency and the HSE for the year in question.
- The remodelled Part 1 to be signed with an Agency by the highest-funding CHO /Region
- The HPSR to be signed locally in each funding CHO / Health Region on an annual basis.
- This change is to be piloted in 2024 for voluntary Palliative Care Agencies, voluntary Mental Health Agencies, 1 large S39 Disability Agency (Enable Ireland) and 1 large s38 Acute Hospital (Tallaght University Hospital).
- Following evaluation and learnings gleaned from these pilots during 2024, decisions can be made regarding extending this model to all other care groups for 2025. *

*The evaluation process must be agreed, with a focus on assessing the potential for reducing administrative tasks, evaluating the impact on services, and identifying any risks and issues.

Benefits

- ✓ The HPSR focusses on the annual variables and all other contractual requirements are included in the updated Part I.
- ✓ The HPSR is a more manageable and straight forward document, with all standard requirements set out in the Part I.
- ✓ Through this updated process Agencies and service managers will be readily able to identify the relevant Care Group requirements for that Agency.
- ✓ The current SA Part II contains repetition of elements already included in the SA Part I, these repetitions are removed in the updated documentation.

Risks & Mitigations

- ➲ There is a risk with updating contractual documentation, however, this is mitigated as follows :
  - Legal review and approval of the documentation to be used in the pilots.
  - The pilots cover a comparatively manageable number of Agencies and associated funding.
- ➲ There is a risk in changing any established contractual process, however, the key to managing this risk will be ensuring focussed communications through briefings, consultation and ongoing engagement with relevant HSE service managers and CEOs of Agencies.

Recommendation 3 – Review of Clauses

Recommendation:

Review clauses 12, 14 and 33 in the SA Part I on access, the performance notice process and dispute resolution to ensure clarity, fairness and balance in these clauses.

- Once legal advice finalised changes to each Clause will be included in the SA, Part I for 2024
- Commitment to provide clarification on performance notice processes set out in Clause 14
- Commitment to remove discretionary nature of HSE obligations regarding dispute resolution in Clause 33

Benefits

- ✓ These Clauses will be updated so as to remove any unnecessary HSE discretionary elements thereby ensuring that, as far as possible, the Clauses are clearer, more equitable and more reflective of fair procedure for both the HSE and Agencies.
- ✓ There will be greater certainty for service managers and Agencies as to how these Clauses will operate in circumstances where there is a requirement to invoke them.

Risks & Mitigations

- ➲ The proposed changes may result in a risk that contractual measures available to the HSE are potentially less robust than the current Clauses. This risk can be mitigated by seeking legal advice to ensure that adequate safeguards are in place.
- ➲ There is a risk that these changes to the Clauses are not understood by service managers and voluntary Agencies. This risk can be mitigated by appropriate briefings in this regard.
- ➲ Removing the optional condition to enter stage 4 of the dispute resolution process in favour of a mandatory requirement to enter arbitration, if referred, may result in increased use of the function and significant resultant legal costs for both parties. The risk can be mitigated by:
  - the adoption of ways of working outlined in the Partnership Principles;
  - the revised engagement processes envisaged ahead of signing of SAs;
  - maximising operational management and Stages 1-3 to resolve issues;
- ➲ Competing legislative requirements could place difficult burdens on both parties to an arbitration process and indeed on the arbitrator to reach a conclusive position. This risk can be mitigated by:
  - factoring any additional resource requirement as a remedy from arbitration into the annual estimates process (recognising that the outcome of this remedy may also be uncertain)
  - ensuring that the arbitration process complies with relevant legislative obligations and recognises the requirement to maximise benefits within resources available
- ➲ (Note: The impact of these changes will be monitored as part of implementation and evaluation. The HSE's legal advisors will continue to work on these Clauses, in particular Clause 33, to ensure that any emerging issues are resolved to the satisfaction of the HSE and the Agencies).

9.2 Process Review Recommendations

Recommendation 4: Timing of Signing

Recommendation:

Agree deadlines for both acute and non-acute service documentation to be signed off by both parties within Q1 of each year.

- SA target signing date for Section 38 Hospitals set at 31st March;
- SA target signing date for Other/Social Care set at 28th February;
- Section 10 allows for increase or decrease of activity or funding throughout the year.

Enabled by:

- HSE issues SA documentation in November (for both Acute and Community organisations)
- HSE to notify the allocation of majority of funding by end of January (commitment for significant proportion of allocation)
- Letter of allocation to include: current level of funding, less any once-offs, plus full year effect of prior year service developments
- Process of engagement to take place between HSE and providers, within which there is a commitment to the *Partnership Principles*, on activity levels and funding

Benefits

- ✓ The primary advantage is reaching agreement through engagement and building the relationship between the entities.
- ✓ Ensuring Timely Allocation of Public Funds. The timing of signing is crucial for ensuring that significant public funds allocated through SAs are disbursed in a timely and secure manner
- ✓ Increasing On-Time Signings: There is an advantage around the potential to increase the number of SAs that are signed within designated timeframes. Currently, some SAs remain unsigned, leading to uncertainties, operational challenges and gaps in the level of cover afforded to both parties.

Risks & Mitigations

- ➲ Gaps in senior representation/input into workshops could result in lack of buy-in. This risk is mitigated by oversight governance in approval and sign-off process.
- ➲ Uncertainty on fluctuating levels of activity (particularly in Acute services) to underpin agreed service levels for the following year. This risk is mitigated by an engagement process highlighting areas of agreement and disagreement and fostering open communication and collaboration between parties.
- ➲ There is a risk regarding prior year developments where full year effects are not secured and also where previous funding commitments might be rolled back on. This risk is mitigated by contingency planning, the engagement process for SA / GAA and open communication between both parties.
- ➲ Emerging challenges arising from changes to the process can be mitigated by effective communications and engagement.
- ➲ There may be a risk in terms of capacity to support the level of engagement required to implement these changes and to agree activity and funding within the condensed timeframe (particularly in context of staff vacancies, recruitment constraints and ongoing service challenges). This risk could be mitigated, at least partially, by reviewing the allocation of responsibilities across existing resources, with a view to supporting increased demands during peak periods.

Recommendation 5 – Consultation and Engagement

Recommendation:

Establish consultative structures and processes to support both integrated stakeholder consultation and care group specific engagement. (NB: These should be developed as part of the design of Health Region structures).

- There is a requirement to establish a pattern of engagement through these processes, starting with an integrated approach at health area level across acute and community for best outcomes for all.
- There will be specific sectoral issues to be addressed at times and also individualised engagement will be required.
- The principles of transparency, collective leadership and agreed and shared approaches underpin the intent. (Reference NESC Report for examples of good practice at Appendix 6).

Benefits

- ✓ Planning for New Developments, Amendments, and Current Operations: establishing consultation and engagement forums for section 38s provides a dedicated space to collectively plan for new developments, discuss necessary amendments to existing SAs, and ensure the effective management of current operations and forward planning.
- ✓ This proactive approach to consultation and engagement allows for the early identification of emerging needs and challenges
- ✓ Consultative structures and process such as those described above provide a basis for the development of more integrated for a in the future
- ✓ Multi-year SAs: The benefit of multi-year SAs lies in their ability to provide greater stability and long-term planning for service providers, improving efficiency and reducing administrative burdens.

Risks & Mitigations

- ➲ It may be difficult to capture a representative voice from diverse sectors / issues to be explored with Mental Health / Social Inclusion

  This risk can be mitigated by designing fora to accommodate different communication preferences and needs, such as virtual meetings, in-person meetings, or written submissions. This risk could also be mitigated by appointing liaison officers from diverse sectors, to facilitate meaningful engagement and ensure that all voices are heard. The commitment to engagement and collaboration is the key factor
- ➲ There is a risk that consultative fora could become time-consuming "talk shops" that could potentially hinder their effectiveness in terms of achieving their intended goals

  This risk can be mitigated by defining clear objectives, having structured meeting formats and agendas and periodically evaluating the effectiveness of the consultative fora with feedback mechanisms

Recommendation 6 – Duplication of Processes

Recommendation:

The largest funded CHO /Region (where there are multiple CHOs / Regions involved) will receive and review corporate documentation so that duplication across CHOs /Regions is reduced.

- Provision may be made for review by secondary CHO where appropriate for multi-area providers by the second largest CMSU/Contract Management Support Unit

Benefits

- ✓ Streamlined Administration: Reducing duplication significantly streamlines administrative processes, reducing time and effort required for documentation / coordination
- ✓ Efficient Resource Allocation: By eliminating duplication for both the HSE and providers, resources such as personnel and budget can be allocated more efficiently and effectively
- ✓ Improved Collaboration: Streamlined processes foster better collaboration between the HSE and providers and support a more efficient and effective service arrangement process

Risks & Mitigations

- ➲ While the risk is low, it is important to acknowledge the need to mitigate potential risks in the context of future reviews, especially considering the potential changes in Health Region dynamics and other structural shifts within the HSE

Recommendation 7 – Communications and Engagement

Recommendation:

Extensive communication and engagement process to be put in place to support buy-in across the system to the ways of working identified in the *Partnership Principles* and to the proposed changes recommended by this review.

- A defined communication strategy outlining the agreed recommendations will be implemented following final approval
- This strategy will encompass joint communication from both voluntary providers and the HSE in a co-ordinated approach with a shared commitment and responsibility to follow through.

Benefits

- ✓ Implementing a robust communication strategy ensures clear messaging of and understanding of the proposed changes which, in turn, promotes successful adoption

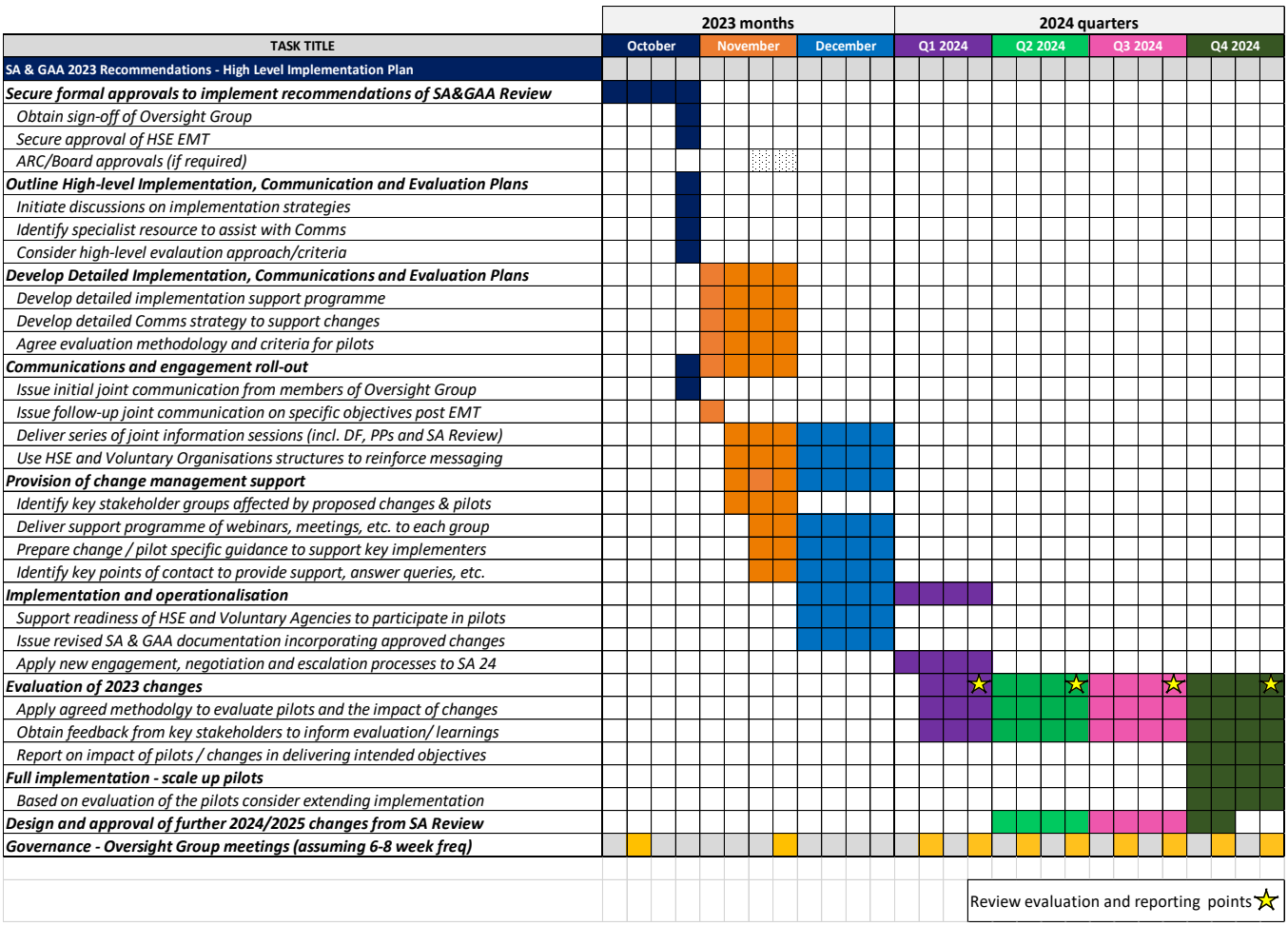
Risks & Mitigations

- Rollout requires planning and implementation to achieve buy-in - in the absence of engagement at an early stage there is likely to be a negative reaction to the project
  This risk will be mitigated by prioritising comprehensive stakeholder engagement as a fundamental part of the planning and implementation of this project.

10. High Level Implementation Plan

The proposed recommendations contained in this report represent foundational steps in the review of the SA and GAA documentation and process. The challenge remains to ensure that the recommended changes are accepted and adopted across the system in line with the Partnership Principles. A high-level plan outlining the intended approach to support implementation is provided at Figure 8.

Figure 8: High-Level Implementation Plan



This working group will further develop and refine this outline implementation plan following the decision of the EMT. Specific responsibilities will be assigned as part of the process.

11. Next Steps / 2024 and Beyond

The overarching objective for 2024 and beyond will be to support the adoption and integration of the Partnership Principles as a way of working, by continuing to refine the documentation and management framework that support the SA and GAA lifecycle. Specific objectives include:

- Continue to work to embed the ways of working outlined by the *Partnership Principles* at all levels in the relationship between the Statutory and Voluntary sectors
- Monitor and evaluate the impact of changes introduced as part of the SA and GAA Review (including the operation of the pilot projects)
- Conduct a more in-depth review of thresholds, further refining them where appropriate for greater effectiveness
- Continue to simplify documentation where possible, extending the 2024 pilot across Disabilities and Acute services
- Continue to review clauses in SA (Part I and Part II) and GAA in the context of the *Partnership Principles*
- Agree and incorporate improvements to Schedule 3 and examine additional clauses for clarity and precision
- Review of the Business Cases process (to include documentation, procedure and data collection)
- Embrace digitalisation within the SA process with a view to enhancing efficiency and accessibility
- Consider the broader perspective on the timing of signing SAs with a view to seeking greater consistency and efficiency in the process
- Maintain consistent and regular communication and engagement with all stakeholders
- Continue to support behavioural change by ensuring that the SAAGAA Review is progressed as an exemplar project in accordance with the *Partnership Principles*.

The implementation of the recommended changes requires several key factors to be addressed. Firstly, ongoing communications and careful planning will be essential to ensure a smooth and effective rollout of these changes. Support must be provided to assist the implementation process, including the development and roll-out of an effective communication and engagement strategy. Additionally, monitoring and evaluation mechanisms will need to be established to track progress, gather feedback and make necessary adjustments on recommendations where a pilot programme has been initiated.

In conclusion, the review conducted in 2023 has yielded valuable insights and led to the formulation of seven strategic recommendations that can be implemented in 2023/2024. These recommendations represent a significant step forward in the ongoing refinement and enhancement of the SA and GAA process but they are merely the starting point. The Working Group and Oversight Group are committed to the ongoing effort required to see the full extent of the proposed recommendations taken through to completion. It is important to note that these recommendations are not just isolated actions but integral components of our commitment to delivering effective and responsive services. We understand that these changes are a journey and that their successful implementation will require commitment, trust, collaboration and adaptability from all stakeholders involved.

12. APPENDICES

APPENDIX 1

Membership of the Dialogue Forum

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APPENDIX 7

Project Milestones and Dates 2023

APPENDIX 1

Membership of the Dialogue Forum

Organisation	Name	Position
Department of Health	Muiris O'Connor	Assistant Secretary, Research and Development and Health Analytics
	Siobhán McArdle	Assistant Secretary, Social Care, Mental Health, Drugs Policy and Unscheduled Care
	Niamh Bernard	Principal Officer, Acute Hospitals Oversight and Performance Division
Department of Children, Equality, Disability, Integration and Youth	Colm Ó Conaill	Assistant Secretary, Disability and Youth Division
	James Gibbs	Principal Officer, Disability and Youth Division
HSE	David Walsh	National Director, Community Operations
	Mary Day	National Director, Acute Operations
	Gerard Tully	Community Operations
	Robert Kidd	Acute Operations
	Niamh Doody	Executive Business Manager, CEO's Office
	Brendan Whelan	HSE Board member
	Fergus Finlay	HSE Board member
HIQA	Susan Cliffe	Deputy Chief Inspector of Social Services – Older Persons
	Finbarr Colfer	Deputy Chief Inspector of Social Services – Disability
Mental Health Commission	Alison Connolly	Head of Regulatory Practice and Standards
	Shane Faherty	Research and Regulatory Manager
The Wheel	Ivan Cooper	CEO, The Wheel
	Michael Smyth	CEO, Cope Galway and Board Member of The Wheel
Mental Health Reform	Fiona Coyle	CEO, Mental Health Reform
	Vacancy	*TBC*
Disability Federation of Ireland	Allen Dunne	Deputy CEO, DFI
	Fran Brennan	Chair, DFI and CEO, Polio Survivors Ireland
National Disability Services Association	Barry McGinn	Chair, NDSA
	John O'Sullivan	CEO, Enable Ireland and Board member of NDSA
National Federation of Voluntary Service Providers	Alison Harnett	CEO, National Federation of Voluntary Service Providers
	Clare Dempsey	Chair of the National Federation and CEO, St John of God Community Services
Voluntary Healthcare Forum	Liam Dowdall	Chair, VHF and Chair, Tallaght University Hospital
	Mo Flynn	Director, VHF
Voluntary Hospices Group	Mary O'Brien	CEO, Milford Care Centre
	Mary Nash	CEO, Galway Hospice
National Community Care Network	Noel O'Meara	Chair, NCCN and CEO, Crumlin Home Care Service
	Susan Kelly	CEO, NCCN

APPENDIX 2

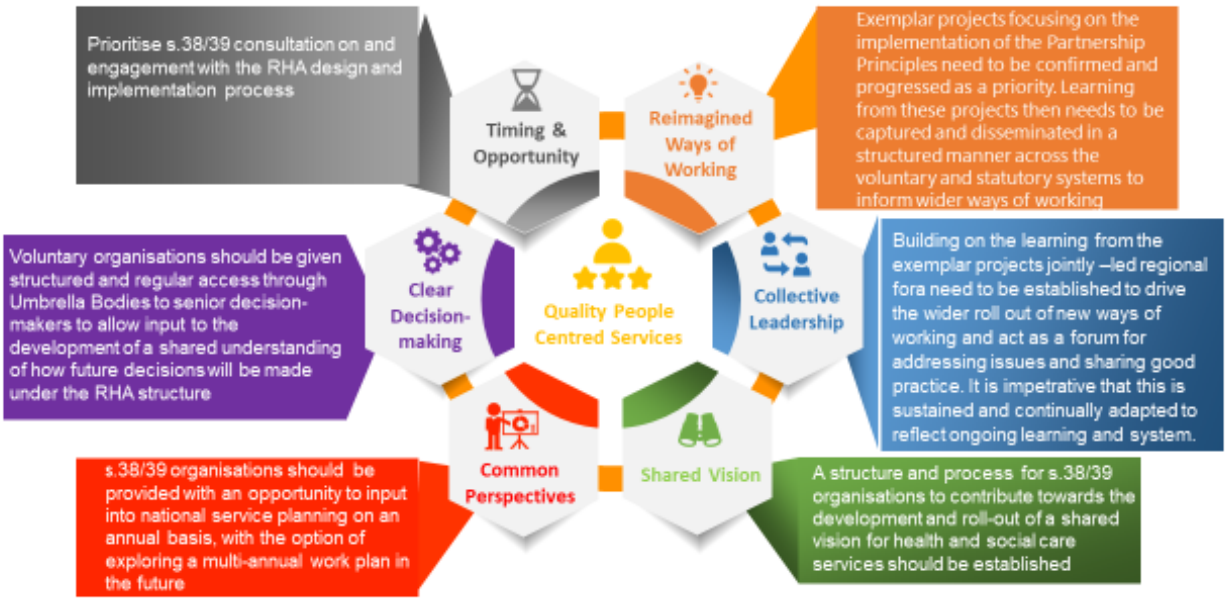
Extract from the *Partnership Principles*

The Dialogue Forum developed a set of core principles to guide how the statutory and voluntary sectors should work together in the future. These core principles are set out below in the extract from the report.

APPENDIX 3

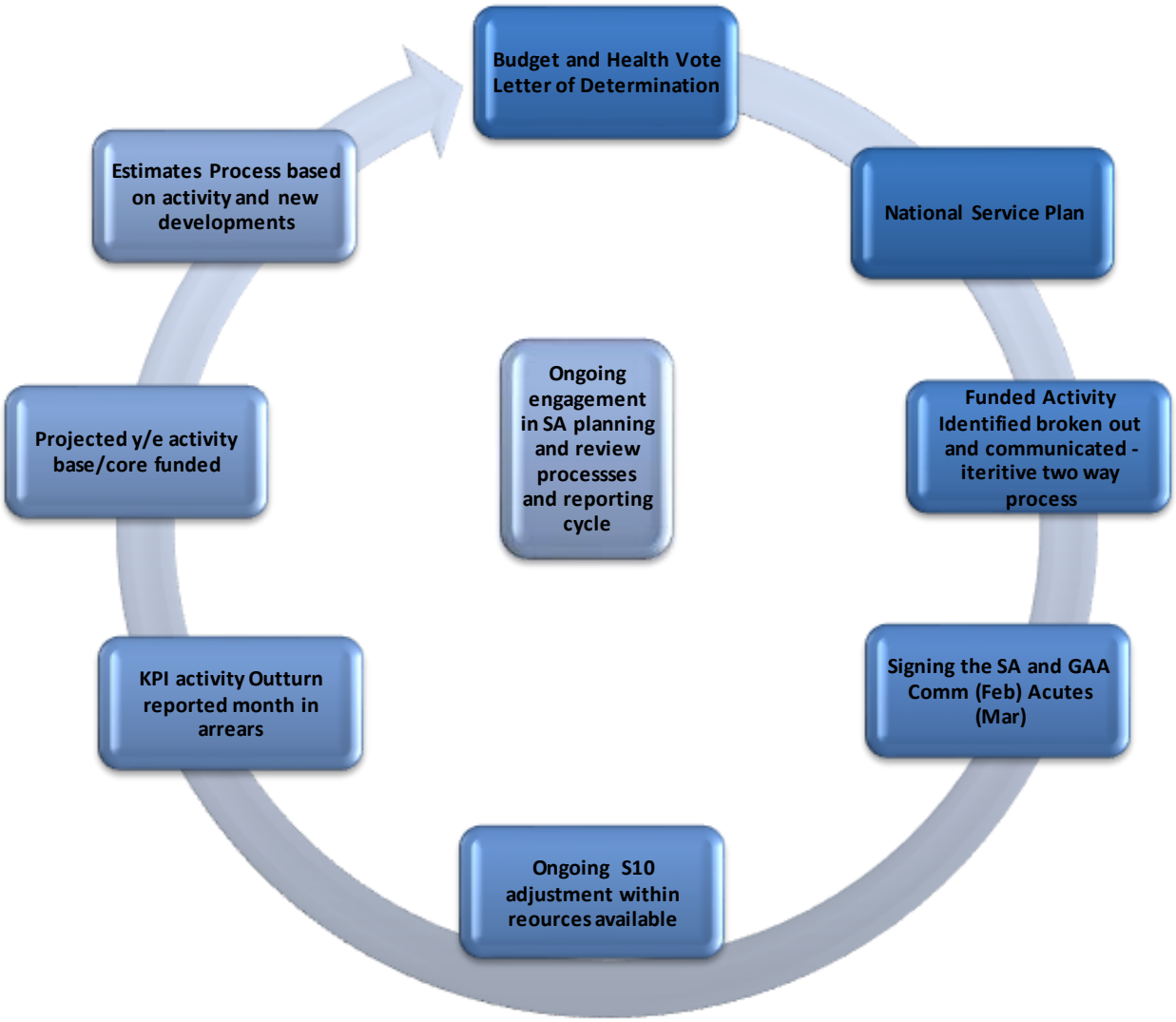
Recommendations of the Case Study Programme

The recommendations contained in the final report on the Case Study Programme are shown below:



APPENDIX 4

The Annual Life Cycle of Engagement around the Service Arrangement

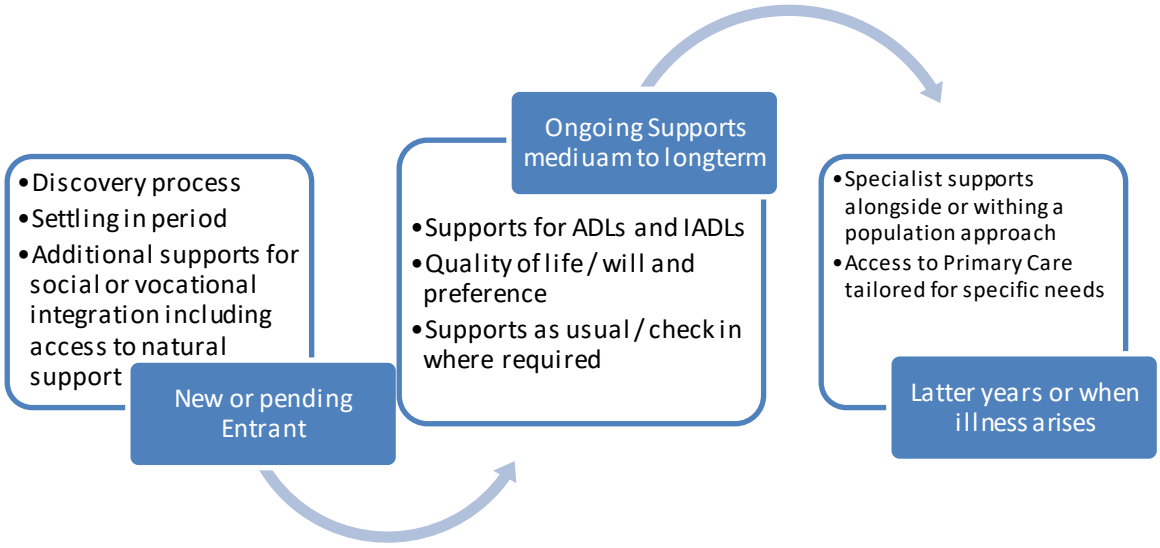


Commitments and acknowledgements;

There are sectoral and sub-sectoral differences in relation to activity and funding.

- There will always be some challenges to breakout the Health budget according to activity but the sooner this is done the better through the allocation process to the delivery system. The principle of identifying and agreeing the majority of activity and funding applies usually built on a baseline year on year.
- Acute activity can fluctuate significantly throughout the year and from one year to the next. The out-turn of activity in any one year does not determine the type and level of activity to be agreed and funded for the following albeit an amount of activity should be determinable. Available funding as a finite resource will determine what can be agreed in advance and adjustments otherwise made throughout the year through a functioning schedule 10 process aligned vertically to the performance and accountability framework.

- Opportunities for certain types of activity will arise during the year with targeted funding, some of which is associated with developments emerging from Clinical Programmes or pilots elsewhere. These are targeted and identifiable to specific hospitals and services, Public and Voluntary. Some are agreed under an MOU, other more general based on invoiced activity. Issues have been identified in relation to commitments earlier in the year and lifecycle that now seem to be rolled back on albeit there may be a back story with scope to balance elsewhere yet to be clarified.
- Activity for the most part in community services is largely determinable at the year-end or can be projected based on combined earlier quarters. This can underpin early engagement so each care and support area can plan to engagement at an early stage without being overly prescriptive on exact dates.
- Consultation and impact assessment is required around the development and rollout of new policy, legislation and agreements. Notwithstanding the commitment to implement policy progressively over time, some has genuine resource implications and as such cannot be placed as a burden on independent providers or other parts of the HSE as funders.
- We generally have an obligation to apply resource and deliver service equitably across the population with a significant focus on access.
- Some disability sector activity is largely determinable year in year with a set number of residential and day places as an example with generally identifiable resource requirements.
- There is a lifecycle of change in support needs. These can be associated with changes in resource requirement, the issue is however that over a reasonably large population of people supported this balances out.



- Some smaller organisations with community resource workers and the likes are funded year on year for a similar level and type of activity.
- All organisations can and should be consulted around need and on best and most viable approach to service delivery, both at individual service arrangement meetings and throughout the sectoral consultative processes which can feed into the estimates and budgeting cycle albeit in the full knowledge that resources are finite and will never meet all need.

APPENDIX 5

Differences between SA and GAA

General points regarding the differences between a Service Arrangement (SA) and a Grant Aid Agreement (GA)		
➢ **S39 of the Health Act, 2004 provides for the HSE to set down the terms and conditions through which funding is released.** ➢ **These terms and conditions are set out in the SAs and the GAs.** ➢ **These are contractual documents which operate on the principles of contract law.** ➢ **For Voluntary Agencies the GA is used to underpin funding of up to €250K and an SA is used to underpin funding over €250K** ➢ **The HSE currently funds 394 voluntary Agencies through an SA** ➢ **The HSE currently funds circa 1,110 voluntary Agencies through a GA and 67% of these Agencies receive less than €50K annually**		
Key Aspects of the Documentation	**S39 Service Arrangement**	**S39 Grant Aid Agreement**
Layout and contents of Documents	The SA consists of a Part I and II. The Part I includes 37 detailed contractual Clauses and the Part II comprises 10 Schedules.	The GA consists of 13 different sections and an attached *Schedule Grant Details (SGD).* The SGD sets out the annual funding received and the services to be provided.
Duration	Traditionally the Part I has been signed for a period of four years and the Part II is signed annually	All GAs are renewed annually
Services	Relevant Clauses of Part I and Schedule 3 deal comprehensively with the quantity and quality of services to be provided by an Agency, and related matters.	Services are dealt with in one section only of the Schedule Grant Details.
Rights of HSE to take actions	The HSE has rights in terms of audit, review, investigation and performance matters.	There are no comparable rights in the GA.
Financial controls	The HSE has extensive financial monitoring requirements set out in relevant Clauses of the Part I and Schedule 6. Additionally, all Agencies are required to submit audited AFS.	Financial controls are limited to one section of the GA. Additionally, only Agencies funded over €150K are required to submit audited AFS.
Insurance	Relevant Clauses in Part I and Schedule 7 deal comprehensively with Insurance	Insurance cover is "appropriate to size of agency and nature of activities"

Indemnities	The SA contains a number of indemnities in favour of the HSE and in some instances in favour of the Agency	Indemnities are not specified
Complaints	Relevant Clauses in Part I and Schedule 8 deal comprehensively with the handling of complaints. Agencies are required to have policies in place in this regard	A short section requires the Agency to keep records of complaints received.
Quality	Relevant Clauses in Part I and Schedule 2 deal comprehensively with quality and clinical governance	Quality is only referenced once in the GA
Information requirements	Relevant Clauses in Part I and Schedule 5 deal comprehensively with Information Requirements regarding the Services	One sub-section deals with the requirement to provide information.
Agency employees	Relevant Clauses in Part I and Schedule 9 deal comprehensively with matters relating to Agency employees	A short section of the document deals at a high level with the matter of an Agency's employees.
Dispute Resolution	Clause 33 sets out in detail the four different Stages of the dispute resolution procedure.	One sub-section deals with the matter of dispute resolution but no dispute resolution procedure outlined.
▪ Capital funding, ▪ "Set-off", ▪ ICT, ▪ Performance Notices, ▪ Third Party Contracting, ▪ Re-organisation or Restructuring, ▪ Access, Referrals, Admissions and Discharge Policy ▪ Risk Management ▪ Clinical Governance and Audit	All of these matters are covered in detail with specific individual Clauses.	No equivalent sections

APPENDIX 6

This Appendix provides examples of best practice consultation, engagement and collaboration identified in the National Economic & Social Council (NESC) report on the system-wide response to the COVID-19 crisis.

Example 1: The Disability Forum—Collaborative Problem-solving

Early in the crisis, the HSE put in place a formal structure for weekly (online) meetings between senior HSE officials and representatives from the disability sector. The purpose of these meetings was to facilitate the early identification and resolution of the key issues affecting frontline service providers in the disability sector. These formal weekly meetings were augmented by almost daily contact between the senior officials in both sectors.

The disability groups on the forum were asked to reach out to their member organisations and identify and collate the issues that they were grappling with in the context of Covid-19. These issues were then raised at the meeting and the participants sought to resolve them through problem-solving deliberation. If no resolution was possible at this stage, the HSE committed to exploring matters further with the relevant statutory bodies and bringing the answer back to a subsequent meeting.

> *It was like a figure eight with information flowing up and down between organisations at different levels… we would bring a spreadsheet which outlined the issues and tracked progress… and we would work through the issues together, and if it couldn't be solved here the HSE went back to individuals in the appropriate statutory bodies to see if a resolution could be found, and/or additional information provided (Research interviews).*

Disability groups were afforded responsibility for relaying agreed solutions and any relevant supporting information back to their member organisations. Based on this interaction, the sector and the HSE started to produce regular FAQ documents to assist member organisations by providing clear and targeted guidance on specific issues. Among the tricky issues this group addressed were: the procurement, distribution and use of PPE; staff redeployment including insurance-related issues (public-sector liabilities); the dissemination and customisation of public health guidance; funding challenges, and initiatives to improve testing and tracing.

Example 2: The Palliative Care Forum—Problem-solving Deliberation

At the beginning of the crisis, the HSE established the Palliative Care Forum, which comprised senior HSE officials and representatives of the main service providers. This group met on a weekly basis to discuss issues such as accessing PPE, communications, and the development and clarification of public health guidelines for their organisations and service users. Importantly, irrespective of the origin of the issue, they were treated as shared problems, which helped the open exchange of information and enhanced the group's ability to work collectively in devising practical solutions.

> *The forum provided a much needed space for communication and a support structure for all providers. It created the sense of 'a united front and approach', where we felt that we were being heard and the group was able to get things done quickly (Research interviews).*

This structured and regular form of engagement gave voluntary groups direct access to the key decision-makers and policy centres in the HSE. This was a valuable resource, which had not been available to service providers. In particular, it gave direct access to the expertise and guidance of the national clinical team, which was then disseminated to member organisations.

> *Our direct access to policy areas such as infection control, occupational health and HR services allowed immediate measures to be put in place, with the shared learning disseminated quickly to the organisations in the Voluntary Hospice Group (Research interviews).*

Building more collaborative and productive relationships at the centre, along with increased active engagement and involvement in local CHOs, enhanced the responsiveness of individual organisations to addressing challenges in the palliative care sector.

Example 3: The Eldercare Group—Information Exchange and Collective Problem-solving
Early in the crisis an Eldercare Group was set up, consisting of senior HSE officials and representatives of relevant voluntary organisations including Age Action, Alone and Dementia Ireland. This weekly forum's aim was to exchange information, provide updates and agree actions in relation to the eldercare sector. A key feature was the emphasis on the active collection of data and experiences, and the two-way flow of information between various levels and organisations. This enabled the voluntary organisations to bring the main issues arising on the ground to the HSE's attention. The new national helpline, funded by the HSE and operated by Alone, was a particularly important source of timely information, as it was used to identify weekly the four or five major issues for older people. A senior HSE representative considered the timeliness and quality of the information generated by this process invaluable in identifying problems and facilitating practical solutions (Research interviews).

This regular and structured dialogue had a strong action-orientated focus, which produced tangible benefits for all participants in resolving issues in a practical and swift manner.

> *If issues were raised and the fault was on the HSE side, we [HSE] would seek to address it and we would then report back to the group the following week, identifying where we had made progress and also in an open manner what issues could not be resolved… we might also identify actions that the voluntary groups should undertake to help address issues (Research interviews).*

Example 4: Mental Health Services—a Partnership-Style Approach
The National Office for Suicide Prevention (NOSP) works with a broad range of statutory, non-statutory and community partners engaged in suicide prevention to achieve the outcomes of Connecting for Life 2015–2020 (HSE, undated). Following the outbreak of the crisis, NOSP started a dedicated weekly meeting with agencies working in this area. The HSE established a similar weekly forum for other non-statutory providers of mental health services and supports.

The purpose of these weekly calls was to develop a co-ordinated approach to the challenges associated with Covid-19, particularly in ensuring continuity in service provision. These now bi-weekly calls enabled the HSE to give stakeholders up-to-date information and guidance on the Government's public health response. Equally, they enabled frontline actors to provide feedback on their experiences and raise concerns directly with senior decision-makers.

A recurring theme at these meetings was the extent to which the collapse in fundraising income in the sector was constraining organisations' capacity to meet commitments in their service-level agreements. Although serious financial challenges continue to exist in the sector, the HSE's commitment to underwrite pre-existing funding arrangements gave organisations the space and confidence to migrate to remote forms of service delivery.

From the outset, the meetings were characterised by transparency and an open exchange of information and experiences. This fostered greater trust and co-operation between participants. This formal and structured engagement effectively facilitated a de facto disposing of boundaries as the HSE and non-governmental organisations worked together to address shared problems (Rogan, 2020a). The interorganisational interaction has fostered greater awareness of 'what each other is able to do', and is encouraging a greater focus on the need to enhance service co-ordination and better harness collective resources (Dáil Eireann, 2020b). It also revealed how the sector can face major issues when it works together (Rogan, 2020a).

Example 5: The National Consultative Committee — Deepening Dialogue and Productive Relationships
The positive experience of peak-level collaboration during the crisis has encouraged the HSE to reinvigorate and repurpose the National Consultative Forum, which had lacked a clear function and become relatively ineffective. Rebranded as the National Consultative Committee, the aim of this new body is to further deepen dialogue and productive relationships to help address key challenges in the sector. The committee's terms of reference were co-produced by the HSE and voluntary organisations. This is viewed as a signal that the former is clearly committed to deepening dialogue and collaboration. The first meeting of the committee focused on identifying the values and practices that had worked during the height of the crisis.

The membership of the committee is to be broadened to include service providers, family representatives, the HSE and the voice of people with disabilities. This reflects the view that *'if we are serious about collaboration everyone has to be on board… we need to have representation of people with disabilities in this committee' (Research interviews).*

The themes the committee will engage with are still being discussed. However there is a consensus that, to be effective, it must deal with the main issues shaping the future of the disability sector. These could include:

- Reforms in relation to how services are funded, procured and provided;
- The relationship between the State and service providers;
- Collaboration, integration and mergers in the sector;
- Rethinking regulation in the sector; and
- How to move from a culture of compliance and inspection to a focus on quality and continuous improvement.

APPENDIX 7

Project Milestones and Dates 2023