Submission

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Outsourcing Community Service Delivery

Organisation: Association of Doctors in Developmental Disabilty (ADIDD)

Name: Dr Robert Leitner

Position: Chairperson

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ADIDD
Association of Doctors in Developmental Disability

c/- PO Box 90
Kogarah, NSW 1485

Outsourcing Community Service Delivery (Legislative Assembly Inquiry)

The devolution of services from the government to non-government sectors is viewed as being consistent with current government policy and in that sense inevitable. Apparent service enhancements and cost savings are envisaged. This devolution should be viewed in the context of any proposed National Disability Insurance Scheme, which could allocate portable funding packages to each individual to use discretionally. Hence some of these comments are speculative should these initiatives come to fruition. As the proposed devolution to NGOs of services to people with disabilities is to be a long term restructuring, then consideration of ALL possibilities outlined below seems to be appropriate and relevant.

Whilst cautiously supportive of these initiatives, the following comments are offered for the consideration of the Parliamentary Committee.

NO	ISSUES	COMMENTS
a)	State Government processes, outcomes and impacts of transferring housing, disability and home care services from Government to non-Government agencies;	**Complexity of Client Needs:** • There is a risk that the Non-Government Organisations (NGOs) may selectively tender for people who have less 'complex needs', as they require less expertise and infrastructure support. People with more 'complex needs' may fall back onto Government Services such as acute health services to provide support. Conversely, some NGOs may tender for the provision of services to those with complex and challenging needs without a clear understanding of the nature and extent of resources necessary. Decentralisation of service provision may result in adding further complexity to existing pathways to access those services. **Outcomes and Processes:** • Existing collaborative partnerships and networks may be lost and the process of re-establishing these may impact negatively on the capacity to provide timely and equitable access to services. • In regional and rural areas, current levels of service provision do not meet levels of demand. There is a danger that devolution of existing services may disrupt existing networks and further compromise service provision. Strategies may have to include financial incentives for the improvement of service delivery to these regions.

b)	The development of appropriate models to monitor and regulate service providers to ensure probity, accountability and funding mechanisms to provide quality assurance for clients;	**Governance:** • There is a wide disparity of client needs and therefore models of service provision. Good governance will require flexibility with accountability and models of regulation will need to vary from very close Government supervision to more self or industry determined regulation. Key performance indicators of good care may be staged or stepped according to categories of need. • Service providers may be forced to compete and market their services. Marketing strategies will be necessary. Small NGOs will possibly amalgamate with larger NGOs. This may lead to the insertion into the marketplace of 'for profit' companies, such as Aged Care providers, Private Hospitals and Pathology Service providers. These could compete with the not-for-profit agencies with predictable results. • Once the level of service for an individual has been assessed, it could be extremely difficult to have that revised, even if with age and debility, those needs change. Those with a current record of service utilisation and establishment of needs could continue to get that level of funding. It could be harder for someone with low levels of utilisation of services to increase those services, and hence funding, once their level has been established. There needs to be flexibility in funding packages. • If industry is indeed waiting to privatise care, will there be sufficient supervision and governance to ensure quality of care and that key performance indicators are preserved? • Who will be the gatekeepers for entry into service packages? Will they be specialists, general practitioners, nursing, allied health and other clinicians or the service providers themselves? Will there be specifically trained Local Area Coordinators? • Existing best practise guidelines are designed for the existing service framework and will have to be adapted. Incentives may have to be built into new service agreements to ensure implementation particularly if this may impact on resource requirements and thereby reduce the potential for profit. • The current diverse and decentralised nature of the NGO sector will present significant policy and governance challenges. There is presently only limited capacity to regulate standards and management guidelines for those with disabilities in the NGO sector. **Quality Assurance:** • NGOs may be allocated funding to provide services for specific client groups, disabilities and age groups, and the structure of these services may vary depending on the geographical area. In view of this lack of consistency, navigating and locating appropriate services would be extremely difficult for client families, carers and clinicians, particularly during transition phases (preschool to school and school to adult).

		• Quality assurance activities may have a local administrative focus whilst clinical quality improvement may not be prioritised over systemic and business related priorities. The culture of continuous quality improvement within the NSW Health services is established, supported and prioritised. Regular and clear supervision on guidelines, funding and availability of clinical supervision may be compromised due to lack of access to larger departments and networks. Clinical involvement with local knowledge must be maintained and enhanced. • In a sector where access to services for diagnosis, assessment, therapy, respite and accommodation services is often a complex process, and where early intervention is a priority, it is important that the quality of the service is closely and regularly evaluated. It is also important that if the service ceases to be offered by the particular NGO provider, that there is a means of this being efficiently communicated, data transferred and that the gap and disruption to ongoing services provision for people in need, is minimised. Prevention and early intervention should be prioritised as part of service provision. • There should be a set of standards applicable to NGO services which are mandatory and subject to regular reviews. NGOs should be monitored externally on a regular basis, have a well identified consumer complaints process and have consumer involvement at a governance level. There should be a process for NGOs to benchmark across a range of quality markers, including health issues, approaches to person-centred care and community access opportunities. • Funding should be allocated for detailed evaluation, research and information dissemination. **Accommodation Services:** • Housing and respite services provided by NGOs need to be able to have appropriately trained staff to ensure that the complex health needs of those people with severe disabilities and dual diagnosis are met. Core competencies and mandatory annual education should be in place for all support care staff. Trained nursing staff should oversee accommodation services and be involved in the medical review of the clients. • There should be a standard of care for NGOs which is based on health promotion and prevention. This would be around identified areas such as diet and nutrition, regular health check-ups, mental health support, exercise regimes, hygiene etc. There should be a Disability Action Plan in place for each facility and for each individual accessing services through the facility, to ensure equity of access. • Barriers to access for clients with complex health and mental health conditions within existing accommodation and respite services managed by the non-government sector were extensively described in the Inquiry into ADHC services in 2011. Initiatives to ensure continuity of quality programs following devolution must address the concerns raised and recommendations made at that time.

c)	The development of appropriate levels of integration among service providers in rural and regional areas to ensure adequate levels of supply and delivery of services;	**Service Framework:** • NSW Health in conjunction with Ageing, Disability & Home Care (ADHC) has developed a *Service Framework for the health care of people with Intellectual Disabilities*. There should be a process for developing a model of care within the NGO sector, which ensures it operates **as a part of this Service Framework** and is included in its evaluation process. • Sharing of resources between NGOs or service providers could be encouraged particularly in regional areas. Several NGOs servicing a region could pool resources and employ jointly Allied Health, Program Coordinators, or Nursing staff. Interagency integration should be a key performance indicator for ongoing funding. • A spirit of cooperation should be encouraged between NSW Health, ADHC and NGOs with investment in resources to maintain strong partnerships and clear communication practices.
d)	Capability frameworks ensuring that community agencies are not overly burdened by regulatory constraints;	**Administration:** • The NSW Health NGO Program Review Recommendations Report, published July 2010, discusses opportunities for 'reducing red tape' for NGOs, by improving NGO Program administration including revising the Ministry of Health procurement processes and developing Information Communication Technology (ICT) systems. **Accountability:** • Notwithstanding the above, it is important to strengthen accountabilities and improve the performance monitoring and service evaluation of the NGO programs. Without consistent, and enforceable accountability, the need to generate profits could, as it has in the past, in many NGOs lead to the use of poorly trained staff, recruited at low rates of pay, and perhaps even to reduction in health outcomes or life activities and opportunity for those in care. Sub-optimal care is highly likely if regulation is allowed to slip. The industry cannot always be relied upon to self-regulate. Any current regulation designed to ensure the quality of services currently provided by ADHC should continue to be applied to NGOs service provision. Relying on consumers to 'vote with their feet' and thereby regulate service providers by default does not take into account the vulnerability and disadvantage of carers burdened by the fear of loss of service.

e)	Enhanced capacity building and social integration in the delivery of services by local providers;	**Capacity Building:** • The Metro-Regional Intellectual Disability network pilot (MRID.net) of the NSW Health Service Framework provides a template for a partnership model for enhancement of capacity in regional and remote areas in collaboration with local Government and non-Government services. • The implementation of this framework requires strong leadership and a not insignificant investment of human and fiscal resources. The development of educational resources and modalities required to build local capacity must be funded and linked to performance indicators and client health and well being outcomes.
f)	Future employment trends, expectations and pay equity for women employed in the non-Government sector;	**Employment Opportunities:** • Workers in the NGO sector need incentives to be trained and up-skilled in this field. Staff training should be included as an essential item in every tender by an NGO for the provision of services to each new client. • Non-Government agencies have different pay scales and awards to government agencies. Every effort should be made to maintain equity with government award standards including baseline training requirements. • Any move to the NGO sector must support stable and enduring relationships with clients as an integral part of its health and welfare policy. The development of long-term career pathways for its workers, rather than a dependency upon a short-term transitional work force is imperative. • With the growth in the numbers of aged Australians requiring either in-home or nursing home care the need for workers employed in this sector will compete with the need for workers employed in the disability sector. Educational and vocational strategies are required to attract young people by providing a career pathway with mentoring from experienced staff.
g)	Incentives for private philanthropy in the funding of community services;	**Philanthropy:** • Obviously tax deductions are incentives. Awareness of the needs of those with experience of disability can be enhanced, as can be the promotion of projects privately funded. Educative and media programmes targeting potential business and corporate partners have not yet been explored in the disability domain. Public/NGO/Private partnerships can be mutually beneficial to all partners.

h)	The use of technology to improve service delivery and increase cost effectiveness;	**Videoconferencing:** • The Metro-Regional Intellectual Disability network pilot (MRID.net) provides a template for technology to enhance and augment service provision in collaboration with local services. The MRID.net will utilise the National Broadband Network (NBN), where available, or other broadband networks to improve the existing health care services for this disadvantaged population. Video consultations with an experienced clinician, training for health professionals and support for local health and disability systems will be offered. The pilot will promote community engagement in the design, implementation and evaluation of the program to best meet the needs of client families and carers. Information systems will support the provision of coordinated care, program evaluation and ongoing service development at a local level. **Data Linkage:** • Currently, there are significant difficulties experienced related to confidentiality, consent, systems compatibility when attempting to link data between Government Departments such Health, Family & Community Services and Education & Communities. The introduction of NGOs that utilise diverse and decentralised data and management systems will add to an already complex process. It is essential that a system of electronically sharing of essential client health information be developed. The launch of the Personally Controlled eHealth Record may provide a solution.
i)	A comparison of the management and delivery of similar services in other jurisdictions; and	**NGO Grant Program Operational Guidelines:** • The NSW Health NGO Grant Program Operational Guidelines (PD2011_049) sets out the administrative framework for the operation of their NGO Grant Program, for provision of health services across the state by NGOs in partnership with the Ministry of Health.
j)	Any other related matters.	**Therapy Services:** • In the current system, various agencies including ADHC, NSW Health and NGOs are funded to provide therapy services for persons with developmental disabilities. As a result, there is confusion in responsibilities, significant variations and frequent changes in service criteria and therapy models, increased complexity for families/carers and teachers navigating the system, inequity of access and gaps in services.

		• Many parents report that the level of therapy intervention services declines dramatically once their child reaches school age. Many teachers highlight the long waiting lists for students with intellectual disabilities - in some cases for up to two years - and the lack of continuity and responsiveness of ADHC and ADHC-funded therapy services. Again, there is a need for coordination at both at an individual and population level to ensure person-centred service delivery. • For persons with complex medical and therapy needs, an integrated multidisciplinary team approach, where the actions of diverse professionals are melded into a team, is likely to achieve better outcomes. The development of such teams aligns with the *NSW Service Framework for the health care of people with Intellectual Disabilities* and the existing multidisciplinary Diagnostic & Assessment Teams. This conceptual model outlines the benefits of specialist health (and therapy) multidisciplinary teams and the potential for significant cost savings through early intervention, diagnosis and assessment and ongoing management of health conditions related to their disabilities. These specialist health teams provide leadership, capacity building, liaison and support for the private, public and NGO sectors, particularly for persons with complex health needs.

Dr Robert Leitner
Chairperson, ADIDD