Submission on More Effective Social Services

By

Spectrum Care Trust Board

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Introduction

Thank you for the opportunity to make submissions on the *More Effective Social Services* paper. Spectrum Care is a not-for-profit charitable trust providing care and support services to people with disabilities, particularly intellectual disabilities, in the Auckland, Waikato and Bay of Plenty Regions. We have a broad range of community and residential services that support people who commonly have challenging behaviours or high and complex needs.

We hold a residential property portfolio of some 86 homes, and employ approximately 550 FTE's which when disaggregated to part-time staff and casuals equates to a workforce of some 970 staff.

Our leadership team are represented on the boards of:

- New Zealand Disability Support Network
- Careeforce (IT)
- Australasian Society for Intellectual Disability
- New Zealand Business Excellence Foundation

Our senior management team participate on:

- University of Auckland, Dept of Psychology, Applied Behavioural Analysis Programme – post Masterate
- University of Auckland Faculty of Education, Diploma of Needs Assessment and Service Coordination
- University of Auckland, Bachelor of Human Services – Faculty of Education
- Manukau Institute of Technology, Mental Health Diploma.
- Children's Action Project

Across the disability sector we have collaborated and shared data and information on

- Enhancing quality performance using the New Zealand Business Excellence Framework (We are only one of five NZ organisations to be awarded a Gold Award effectively placing us in a global category of "World Class" (2013)
- Regional Business Continuity collaboration and response
- Applied Leadership

In the health and disability sector we are unique in that we:

- Are only one of two providers using the Council for Quality and Leadership, Personal Outcomes Framework.
- Are introducing the Basic Assurance Framework as recommended by the David Russell led MoH Quality Review (2014)
- Provide services to support more profound disability
- Have the highest number of ITO graduates as a percentage of enrolments for level 2 and 3 qualification in the National Certificate in Health, Disability and Aged Support
- Lead collaboration across the sector, sharing our training and award-winning systems with other providers
- Make training opportunities available for other providers
- Provide the lead and training pilots for our sector ITO

- Pioneered research into learning transfer through our training effectiveness review
- Run an international student internship programme for students from Germany, Netherlands and Denmark
- Provide a range of non-funded services in support of our person-centred value to ensure wrap-around supports. E.g. Outcomes Brokers, Behaviour Support, Speech Language Therapist to enhance communications (contract), Pharmacist to reduce risk of poly-medications (contract)
- Are anecdotally the largest pasefika provider of intellectual disability services in NZ while remaining a mainstream provider.

  We have read the submission made by the New Zealand Disability Support Network, the sector peak body group, and fully endorse its position as stated. While coming primarily from an economic perspective, its submission does not capture the politics of procurement, or the inconsistent nature of the processes involved in this.

We are financially dependent upon government funding, primarily from the Ministry of Health.

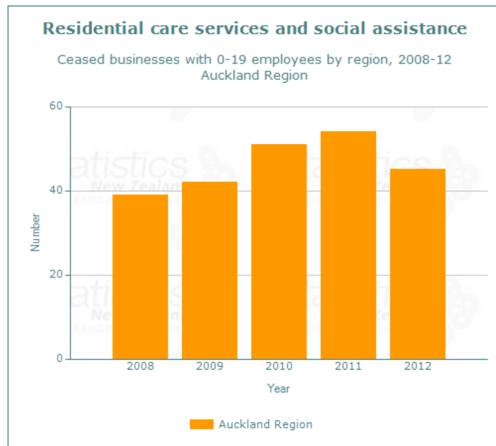
This creates some business issues for us which are unhelpful to our service delivery.

- Repeated audits of the same areas of interest by multiple auditors
- Constant underfunding and risk shifting by MoH
- Policy application based upon the personality of the incumbent contract relationship manager
- Constant changing of the contract relationship manager
- Complete absence of ground-rules for the purchasing of services (refer Q9)
- The latest PIF report on the MoH indicates a range of performance discrepancies that impact the relationship the Ministry has with the sector and are at their most evident in the procurement context. We have repeatedly contemplated legal challenges to mitigate organisation risks caused by MoH approaches to procurement decision-making and process.

Commentary:

At p.1 the statement, “A system that delivers expanded or improved services at the same cost (or equivalently, the same services at lower cost, will promote well being, all else being equal’, clearly sets the intent of the enquiry. What is of concern is that this central premise is not universally agreed. It does not naturally follow that well being, will be a result of lower funded services. Training, recruitment standards, infrastructure are all compromised by lower costs, and these are inherent elements of a quality system.

The Issues paper discusses at p.2 that clients of social services want the service they require to be effective in dealing with their specific circumstances, and to assist them towards a healthy, safe, self-sufficient and fulfilling life. In general , they want those services to be available in the place they live. The DSS Clinical Demographics Report identifies regional variations where support service provided in the South Island are significantly more accessible and available than in Metropolitan Auckland. Because the Needs Assessment Service Coordination agencies are in the primary role of rationing funding, there is differential service delivery and therefore inequitable treatment of clients based upon location.



At p.3 it is noted that agencies want their commissioning and purchasing processes to be cost-effective. They want to understand the performance of their contracted providers. Over time, they want to encourage the development of, and expansion of, the better providers, and reform or exit some of the poor performers. Spectrum Care regard these comments as 'aspirational'. The reality is that smaller providers cannot leverage the economies of scale of larger providers. Therefore government spend on smaller providers as a matter of fact means less is spent on supporting the client. Competition will create a context for reducing the quality of services, wage constraint, accommodation shortfalls, training cuts and providers will try to reduce costs by having less staff. Competition therefore is likely to compromise quality and increase risks for people supported. Because funding is at the margins of sustainability re-investment in organisations from modest, if any, surpluses can expect to be minimal.

There is an interesting invisible statistic from the 2013 census data as represented at the graph at left. This graph indicates that 39 businesses in our broad sector in Auckland Region ceased trading in 2008, 42 in 2009, 51 in 2010 and so on. Note that these are the smaller providers of up to 19 employees who probably struggle with an effective service spend given the high economies of scale small enterprises struggle with; exactly the provider profile that the sector previously believed the MoH was trying to weed out of the sector but which the MoH refuted.

In a contrary piece of work, the 2013 Census data indicates that the healthcare and social assistance industry expanded 19.6% since 2006 and replaced manufacturing as the most common industry. In 2013, 1 in 10 employed people (191,694 people) worked in Healthcare and social assistance industry, which includes hospitals and medical care, residential care services, child care, and other social services. This may be because of the increasing aging population going into residential care. Ryman health care is intending to build eight new aged care facilities in NZ, five of them in Auckland and is purchasing land banks for future growth.[1]

The Russell report on Disability Support Services Quality Framework recommends increasing the number of providers to increase competition and therefore quality. This graph indicates a decline in the number of providers in the broader sector. Unfortunately there is no data on new start-ups in the sector. The pattern is proportionately similar for Waikato and the Bay of Plenty. The question remains, where did these contracts go? Were they up for tender? Or were they dealt out quietly? That we are unable to answer these questions points to a clear lack of transparency.

[1] Ryman healthcare website

Note: Not all questions have been answered as responding to the submission in full is a major undertaking and we have selected the questions most relevant to us to provide brief responses.

1. **What are the most important social, economic and demographic trends that will change the social services landscape in New Zealand?**

- Ageing population
- Disability demographic bulge in youth
- Non-regulated or inadequately skilled workforce to address future demand
- The effect of alcohol and illegal drugs (during pregnancy) on children – likely to create some high and complex demands, long term affects unknown.

3. **What role do iwi play in the funding and provision of social services and what further role could they play?**

- Iwi should be fully involved in delivering, advising and be part of the provision of all fields in social services. Kaupapa Maori Services are important, but also integrated services are also of equal importance, this gives Maori people choice in service providers or how service should be provided, with the ability to influence. All providers should be treated consistently in the event of performance deficits.

4. **What contribution do social enterprises make to providing social services and improving social outcomes in New Zealand?**

- Limited experience, but provides opportunities to develop services/equipment and/or responses that may be more timely and life enhancing, gives people options**.**

5. **What are the opportunities for, or barriers to, social-services partnerships between private business, not-for-profit social service providers and government?**

This is a difficult question as the nature of the partnership will naturally determine the opportunities or the barriers. For- Profits usually have to return dividends to shareholders. Not-for-Profits are also Not-for Loss and need to be sufficiently in surplus to reinvest in capacity and capability. The government clearly wants to reduce cost and political risk in any such arrangement. The thrust therefore is for For-Profits to '*lean-out*' processes and overheads to generate surplus out of reduced funding, potentially reduce quality or capacity as part of that process, while at the same time not entertaining any increase in risk. Where ministries overspend their allocations through poor management, the providers often suffer funding cuts or changed rules despite their financial performance not being an issue. They become the consequence of a funder's poor spending performance.

The tripartite arrangement is not ideally suited. There is a diminished business advantage for the For-Profits, little advantage and only risk for Not-For-Profits, and the only party that is clearly advantaged is the government.

6. **What scope is there for increased private investment to fund social services? What approaches would encourage more private investment?**

Suspect the scope is limited, since investment implies a realistic return on investment unless the organisation operates as a social enterprise or as a social bond transaction. Few organisations would invest in a business opportunity characterised by inconsistent application of systems and decision making based upon the incumbent personality of the funder. For an organisation to undertake a social bond arrangement the ground rules and operating environment need to be transparent and not subject to uni-lateral decisions by the funder to change the environment.

7. **What capabilities and services are Mäori providers better able to provide?**

Maori providers are able to place their care and support in a cultural context, using language, symbols and concepts as part of the social, spiritual, emotional and physical environment. Other mainstream providers are also able to do this is parts of their services where tikanga Maori is present.

9. **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?**

Analysis of this issue is hindered by a complete lack of any information from the Ministry of Health, or any consistent rules on the field of play. The disability market is essentially controlled by the MoH, but their approach to engagement with the sector is case-by-case, without reference to precedent, existing policy, best practice guidelines, or strategic considerations. Some of the premises that providers have assumed in the past as markers of accepted practice have recently been overturned with no explanation. A number of brief thumbnail anonomised case studies provide *prima facie* evidence of inconsistency in the market.

1. A private company has purchased a social enterprise along with the contract to supply services. Previously it was not possible to acquire an organisation and its contracts. Normally the contract would be put up for tender. It is understood the organisation struggled with certification.

2. Differential treatment of providers by the MoH on performance discrepancies based upon culture.

3. The national BSS contract exemplifies the MoH's inability to adequately control a project. Like most of its tendered offerings, the timelines, rules, communication undertakings and RFP protocols are sometimes severely compromised. MoH has attracted little confidence from the sector in terms of its, credibility, leadership and competency. This RFP process lacked credibility from the outset with many providers believing the decision was 'fait accompli' from the beginning of the process.

Current Contradictions

There are also a range of unconnected market dynamics that further confuse the terrain.

- Government wishes to reduce its spend and/or leverage greater efficiencies from its spend. There has been much talk across the sector of the government intention to reduce the number of particularly smaller providers to reduce the load of contract management, and also because smaller providers are less efficient in service delivery because of the economies of scale. Contrarily, the David Russell review of the MoH, recommends increasing the number of providers to increase competition. We are therefore not sure whether the number of smaller providers is likely to increase or decrease, or whether the purchasing of contracts will create a situation where acquisitions or mergers become more likely or whether the existing contracts can be part of the acquisition. There are simply no rules, and the protocols are established 'on the run'.
- The MoH has repeatedly notified providers of a freeze on residential referrals to contain spending, yet we continue to get referrals and currently have some 28 on our waiting list. The distance between the rhetoric and the reality is again evident.
- The market is not only about the provision of services it is also about shifting risk. The MoH offer formal contracts with specific service delivery provisions within them. When circumstances either for an individual or a service shift, e.g. Choice in Community Living there is an always undocumented agreement with the MoH to extend the scope of the contract. Both parties are unofficially aware that in the event of an adverse incident, the MoH will revert to the original contract leaving the provider to carry the risk, responsibility and public explanation.

1. **The funder has most of the bargaining power** – largely a take it or leave it negotiation strategy which is often used to play one provider off against another. This is enabled because the MoH is a large funder purchasing a sizeable portion of the sector's output. In a virtual monopoly there is little room to negotiate. The latest ASD addition to the contract without consultation is a prime example of the attitude of a monopoly funder and their dismissal of our response consistent with their previous responses. The cost to the Ministry of switching to another provider is relatively low, and in any event they are government funded and can absorb the cost. A large range of similar providers also provides a cushion for the MoH to deal with a single provider who won't cooperate. We also know that a lack of cooperation can see funding or relationship penalties. There is little one can do in the face of this bargaining power except to provide a range of products, services, skills that other providers cannot emulate thus making it difficult for the funder to accept a lesser service, or a more risky one for them. The only other strategy is a union of providers that is prepared to refuse any offer until it is made transparently, compliant with the undertakings given and engaging with some integrity. The funder then has no choice and no power. Lower funding offers should be met with higher risks attendant upon the MoH or lower quality of performance, but Spectrum Care's own values mean that this is not a response that fits with our culture and work practices – and the MoH knows this.

12. What are the barriers to learning from international experience in social services commissioning? What are the barriers and risks in applying the lessons in New Zealand?

Transitioning people from one service to another or sharing supports provided by multiple providers does not necessarily ensure a quality service. A competitive and low funding environment will pressure providers and incentivise them not to share their services as the consequence will be a loss of funding. An environment that allows providers to cross-support without being penalised needs to be created first.

16. Which social services do not lend themselves to client-directed budgets? What risks do client-directed budgets create? How could these risks be managed?

Client-directed budgets or individualised funding works better more commonly for people with physical disabilities as they retain the ability to analyse and make more effective decisions about how they ration their financial support. People with an intellectual disability are less able to do that and require additional supports. People who have communication difficulties are less able to articulate their needs. Many people with an intellectual disability are not able to rationalise their funding or prioritise or even fully understand the range of services available. For the same reasons, those affected by acquired brain injury, dementia and related illnesses are less likely to benefit from individualised funding and are more exposed to exploitation by those managing funds on their behalf.

Low to intermediate needs and those families that are willing and competent to provide consistent support.

18. How could the views of clients and their families be better included in the design and delivery of social services?

- People receiving services and their families should be involved in all aspects of designing and reviewing services and should be part of working groups and advisory panels to feed directly into the service and should be on Boards.

19. Are there examples where government contracts restrict the ability of social service providers to innovate? Or where contracts that are too specific result in poor outcomes for clients?

- All current government contracts are very risk adverse, not client outcome focussed, and require a huge investment by providers to set up structures for reporting, and are restrictive rather than encouraging of innovation. Contracts are not person centred.

21. How can the benefits of flexible service delivery be achieved without undermining government accountability?

The move away from measuring performance in terms of inputs, in process measures, and outputs in favour of the Results Based Accountability (RBA) model provide measures of progress against individuals and groups actually increasing government's ability to hold providers accountable. It's less important that the number of trainees is counted, or the number currently enrolled in courses, it's more important about how the training has changed their behaviour and how their changed behaviour has impacted the person they support. It's outcomes that need to be measured, by individual and group.

22. What is the experience of providers and purchasing agencies with high-trust contracts? Under what circumstances are more relational contracts most likely to be successful or unsuccessful? Why?

The MoH PIF reports suggests that the health sector is some distance from high trust contracts with its funder. The proposed recommendations within the PIF are also not aligned to supporting such a relationship.

24. 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?

- Agreed with this, not sure how this is changed though, apart from service providers diversifying. Most NGO's are dependent upon government funding to some extent and the dependency does cause problems when the relationship and rule making are unequal or there is a perception of favouritism.

25. What are the opportunities for and barriers to using information technology and data to improve the efficiency and effectiveness of social service delivery?

- Measuring outcomes, understanding populations served, able to compare results, gather data, inform government policy.

29. For which services in which parts of New Zealand is the scope for contestability limited by low population density?

- Services outside the traditional main centres, particularly rural and southern NZ.

31. What measures would reduce the cost to service providers of participating in contestable processes?

Declaring when a preferred supplier has already been identified will allow providers to decide whether to invest time and money into an RFP or tender process when the outcome has been predetermined.

32. What additional information could tender processes use that would improve the quality of government purchasing decisions?

- Estimates of costs of actual service delivery, including administrative requirements to deliver the service.

34. **For what services is it most important to provide a relatively seamless transition for clients between providers?**

- This is relevant for all services, transition should be seamless and happen in the background. Requires really good planning and the ability of providers and government agencies to work in the best interests of the person.

36. **What are the most important benefits of provider diversity? For which services is provider diversity greatest or most limited? What are the implications for the quality and effectiveness of services?**

- Provider diversity allows for people to have choice about who they wish to provide the service – can meet the needs of different people. People can choice based on shared values and beliefs.

42. **Are there examples of outcome-based contracts? How successful have these been?**

- MOH or MSD currently do not have any outcome based contracts. MSD have high trust contracts which seem to work.

43. **What is the best way to specify, measure and manage the performance of services where outcomes are not easy to observe or to attribute?**

- A proven, reliable and recognised Outcomes Measurement tool e.g. CQL's Personal Outcomes Measures, Results based accountabilities.

44. **Do government agencies and service providers collect the data required to make informed judgements about the effectiveness of programmes? How could data collection and analysis be improved?**

- I am sure there is all sorts of data collected by a range of government agencies and providers but I am not sure how well this informs effectiveness of programmes.

45. **Are you willing to meet with the Commission? Can you suggest other interested parties with whom the Commission should consult?**

- Yes