RISK ADVISORY SERVICES

Department of Health and Human Services

Review of Tasmanian Disability Services – Final report

GOVERNMENT

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Disclaimer

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The findings in this report are based on a qualitative study and the reported results reflect a perception of the Department of Health and Human Services but only to the extent of the sample surveyed, being the Department of Health and Human Services approved representative sample of stakeholders. Any projection to the wider stakeholder group is subject to the level of bias in the method of sample selection.

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KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

The findings in this report have been formed on the above basis.

Contents

1 Introduction

In October 2007, the Tasmanian Department of Health and Human Services (DHHS) engaged KPMG to undertake a review of disability services.

The Final Report on the Review of Tasmanian Disability Services outlines the core findings and recommendations arising from the review process. The report draws upon a detailed analysis of DHHS documentation and expenditure, consultation with people with disabilities and their families, non-government (NGO) providers, advocacy groups, DHHS staff and other interested parties, and a review of national and international literature.

1.1 About the Review of Tasmanian Disability Services

The conduct of the Review of Tasmanian disability services was guided by the terms of reference developed by DHHS.

The intent of the project was to review Government funded disability services in Tasmania and make recommendations on the strategic direction and service models, in line with national and international best practice, in order for the Government to deliver better outcomes for people with disabilities.

The scope included the development of recommendations that ensure compliance with all relevant legislation, regulatory requirements, professional standards, quality frameworks and guidelines. Specifically, the scope of work included:

- advice and recommendations on the roles of the government and non-government sectors in providing disability services with recommendations on future responsibilities within each sector and best practice models that will provide quality outcomes;
- a review of the efficiency and effectiveness of the present delivery model and business processes of disability services (and the supporting corporate areas of the Department as they impact on the activities of disability services) and recommendations on improvements and efficiencies related to:
    - accessibility, quantity and quality of services delivered;
    - decision making processes and the utilisation, reliability and validity of data, performance indicators and policy frameworks; and
    - organisation, structure and management;
- a review of the services and programs provided by non-government organisations (through individual support packages and service agreements) and recommendations on quality improvements and efficiencies related to:
    - the range, scope, and type of services that are funded and how these relate to present and future needs;
    - overlap of services and functions, and opportunities for partnerships, mergers and other forms of administrative collaboration; and

  - funding models and processes for providing funding to non-government organisations, including service agreements and associated service specifications and accountability requirements.

1.2 Structure of the report

In integrating the work undertaken through the review, the report is structured into the following sections:

- a brief analysis of 'what is important' to people with a disability and their families, as a basis to frame opportunities to improve service quality and system responsiveness. Importantly, this analysis is based on direct feedback from people with disabilities (collected by Advocacy Tasmania, on behalf of the review team), the perspectives of parents and other family members (gathered primarily through submissions to the review), as well as published material;
- the key findings of the research including an analysis of the profile of the disability population, the current system of supports for people with disability in Tasmania, the relative roles and responsibilities of the Government and NGO sectors in disability support, the level of investment in disability services (by service type and regional), mechanisms for planning and resource allocation, accountability, and quality assurance;
- best practice and learnings from other jurisdictions;
- the proposed vision for Tasmanian disability services and the associated implications for people with disabilities and their carers, Government and NGO service providers; and
- key recommendations for the future, in response to the terms of reference of the review.

1.3 Data sources and limitations

An extensive amount of material was requested by the KPMG team throughout the course of the project, which required a significant document management and coordination effort on behalf of both KPMG and DHHS.

KPMG faced a number of challenges in accessing financial and performance data relating primarily to DHHS information systems limitations. DHHS has a number of systems from which data is required for management purposes. However, in the absence of a comprehensive data management system, a high level of manual compilation was required to obtain the data requested.

The findings in this report are based on analysis of the above information received from DHHS. As such, the reported results reflect, and are limited by, the data provided. KPMG have not sought to independently verify those sources unless otherwise noted within this report. While considerable attention was given to the collection and analysis of appropriate data to inform the findings of the report, the analysis provided does not constitute a formal audit.

Client numbers data

Specific to the client numbers data used in this analysis, the following is noted:

- a client is a person with a disability who receives a CSTDA funded service;
- client numbers cannot be assumed to reflect total client numbers as a result of a number of factors including:
    - under-reporting which may arise due to limitations with the existing information management systems; and
    - double-counting, where a client received services from more than one service provider;
- a client may receive more than one service over a period of time or a single day; and
- 2006-07 client data is raw, unpublished data and may be subject to change.

Service funding data

Specific to the service funding data used in this analysis, the following is noted:

- the majority of the data was obtained from one key source, within disability services;
- inconsistencies were noted with this data, and other service data received from Finance within DHHS was used to obtain administrative values. The disability services source was selected for use due to greater breakdowns of this information being available and linked to client numbers;
- Individual Funding (IFU) data could only be obtained on a state-wide basis for 2005/06 and 2006/07. For regional analysis within this document, individual funding and clients are included with the core service types of respite and Administration for all years; and
- data on sources of service funding could not be obtained.

Administration data

Specific to the administrative funding data used in this analysis, the following is noted:

- administration data was obtained from one key Finance source. Inconsistencies were noted with service data included in this source and other service data received from disability services, as noted above; and
- detailed breakdowns of administrative data has not been provided, therefore analysis is limited to overall administrative expenditure.

Benchmark data

Specific to the benchmark data used in this analysis, the following is noted:

- this data was obtained from Section 13A of “The Report on Government Services 2007”, prepared by the Productivity Commission;
- it is noted that the data contained in this report for Tasmania does not directly correlate with the data obtained locally for this analysis. However, general trends appear to be consistent;

- due to the time lag in the release of published data, benchmark comparisons are only available for 2004/05 and 2005/06 for funding data and limited to 2004/05 for client numbers data; and
- no budget data was available; therefore all benchmark analyses are based on actual data.

2 What's important to people with a disability and their families

In reviewing the Tasmanian disability services system, it is important to take a person-centred approach - considering the needs of people with disabilities, outcomes which are meaningful to individuals and families, and assisting people with disabilities to achieve their goals and aspirations.

As such, through the review process, KPMG sought to gain an understanding of 'what's important' to people with disabilities and their families. Advocacy Tasmania facilitated feedback from people with disabilities; parent/family perspectives were gathered via the consultation forums and submissions to the review.

This highlighted the following key themes:

- **Flexible and responsive services**: services should provide the flexibility to meet the individual needs of people with disabilities, rather than adopting a 'one size fits all' approach. They should also be responsive (i.e. with operating hours suited to the needs of working parents) or the capacity to adapt to changing needs (i.e. medical deterioration). This should be underpinned by continuity in care arrangements - wherever possible, a long term, trusting relationship with a provider who understands the complexity of an individual's needs and with whom individuals and families feel comfortable.

What's working with disability services?

"Improved communication, help and input from the Professional Resource Team. Good social worker."

- **Understanding and knowledgeable staff**: people with disabilities have an expectation of receiving support from staff who understand their needs - "value 'me' as a person".

What's important to me?

"People from disability services keeping in touch without me having to constantly ring them – seems a bit lopsided to me".

- **A proactive approach**: there should be the capacity to plan ahead, rather than need to wait until a crisis situation occurs, in order to access disability support services. Services should be encouraged and appropriately resourced to intervene early, preventing functional deterioration and maintaining people within their own homes and communities (wherever possible).

What's important to me?

"For complaints to be resolved in a timely manner".

- **Support for families:** in relation to support for families, parents spoke vocally of the demands placed on families when caring for a child with a disability and of the stress this places on the family as a whole. This is further discussed in *Forgotten Families - Raising Children with a disabilities in*

Tasmania Report, recently released by Anglicare which indicates that, while most families cope, there is a great impact on the quality of family life – including financial disadvantage, strains on relationships, deterioration in terms of primary carers' health status, as well as the negative impact on siblings.[1] As a result, families suggested they need support across a range of domains:

> **What's important to me?**
>
> "Our difficulty in coping impacted on both her siblings, as well as the overall well-being of our family. Earlier intervention (more timely access to support) would really have helped".

- support to maintain the caring role, in the form of respite, coordination of services or other mechanisms which relieve the strain of caring;
- support for siblings of children with disabilities, in the form of peer support, planned family breaks;
- appropriate shared care arrangements, i.e. longer term, stable accommodation for children with disabilities, which works flexibly and collaboratively with parents; and
- assurance that their family member is being provided with the best possible care.

- **People with disabilities and their families should be engaged and supported at all points of the journey** – in implementing policy, in developing new service options, in considering new ways of working, in training the workforce and in evaluating 'what's working well and areas for improvement'. There should be the capacity for families to access early intervention supports, to prevent the occurrence of crisis situations.

> **What's important to me?**
>
> "For my daughter with disabilities to be treated properly."

- There should be an emphasis on **citizenship for people with disabilities** – people with a disability have the same rights, responsibilities and opportunities to participate in life and the community. They should be supported to make their own decisions.
- Services (such as day options and recreation) should **engage individuals in ways which are meaningful to them**, allowing people with a disability to be involved in the choice and planning of activities. Support should focus on skill development and maximising independence, operating from a strength-based approach.

> **What's important to me?**
>
> "To be able to help out in the group home. It's my house".
>
> "Getting paid for going to work".
>
> "I'd like to do some cooking. I used to cook - don't do it anymore".

A number of case studies highlighting current system problems, and how the proposed reforms will address these, are included in Appendix B.

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[1] Anglicare Tasmania (2007), Forgotten Families: Raising Children with disabilities in Tasmania.

3 Contemporary practice in disability services

The following chapter provides a summary of directions for disability services both nationally and internationally.[2]

3.1 Disability services in Australia

The most significant shift in disability support in recent years has involved a stronger focus on 'the individual' with people with disabilities seen as partners, with a greater recognition of their rights and responsibilities.

The emphasis has been on inclusion involving:

- provision of community based support;
- recognising the need for both informal and formal support networks;
- use of individualised planning and support and approaches which are person-centred; and
- increasing the accessibility of mainstream services (enabling disability to focus on specialist support for the most vulnerable).

An environment of increased competition for limited resources has also necessitated a requirement for improved cost efficiency and effectiveness and demonstrated value for money.

3.1.1 Legislation and regulation

In examining the regulatory environment, it was identified that across Australia:

- each State/Territory and the Australian Government has legislation that provides broad eligibility guidance allowing policy directions to determine criteria for specific target groups and programs;
- all jurisdictions have sub program level eligibility and access criteria;
- eligibility can be influenced by joint Commonwealth requirements, particularly post school and transition programs;
- there has been a broadening of eligibility over the years to be more encompassing of disability types in addition to intellectual and physical disability. For example inclusion of people with autism and people with an acquired brain injury; and
- some of the challenges that have arisen in defining eligibility have occurred in relation to conditions such as Attention Deficient and Hyperactivity Disorder (ADHD) and physical degenerative diseases.

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[2] This analysis represents an update of that presented to the NT Government in 2006.

Of note, most jurisdictions have recently (within the last three years) updated their legislation to reflect the emerging challenges in the disability sector and to support clarity of direction into the future.

Example: Review of Disability Legislation – Victoria

A recent review of the legislative framework for disability in Victoria, with the new Act (which came into effect in July 2007) designed to:

- enable a whole-of-government, whole-of community approach to supporting people with a disability;
- promote and protect the rights of people with a disability;
- support the development of a strong and stable disability sector that is sustainable into the future; and
- provide a fairer and more equitable system of disability supports for people with a disability.

3.1.2 Eligibility and priority of access

In relation to core definitions for eligibility and priority of access, the analysis indicates that:

- eligibility is broadly defined by legislation, then defined by program and service type;
- a person's support needs are primarily assessed based on presenting need and degree of need (for example high, medium and low); and
- high, medium and low support needs are commonly rated on a subjective scale that encompasses: type and nature of support required; ability for self care; mobility; and support networks present and available to the person.

Priority of access is primarily based on risk (current and future), immediacy and relative need. Typical factors considered in examining risk included: high and complex needs; health and wellbeing; sole carer; violence, self harm and abuse; homelessness; person with a disability is a carer; stability of the person's situation and circumstance; and significant and sudden deterioration of a person's condition.

3.1.3 Assessment methods

In relation to assessment methods, jurisdictions use standardised forms and questionnaires as part of their entry to service process. These forms typically focus on: demographics; living situation; family and other supports; identification of primary disability; and required frequency of support using scales.

Not all jurisdictions use assessment tools. Where they are used, there is no single common tool; a range of tools are used. These tools are used to determine the nature of need, the level of services response required and the resource base required..

3.1.4 Resource allocation and demand management processes

Demand management

Analysis of trends within other jurisdictions has highlighted that:

- the majority of jurisdictions are experiencing a growing level of unmet demand for services;
- in recognising the longer term cost-benefit for government and impact on the well-being of people with disabilities, there has been a stronger focus on early intervention to maintain (wherever possible) the well-being and independence of people with disabilities, i.e. through carer and family support initiatives, respite and therapy services;
- a number of jurisdictions maintain waiting lists for particular programs, for example accommodation support and day programs. Waiting lists are used to inform ongoing funding applications through State budget processes; and
- other than Victoria and the ACT, no jurisdictions have a specific identifiable strategy for the management of demand levels.

Resource allocation

States and Territories and the Australian Government use a range of resource allocation methods for the distribution of funds for disability support. More progressive approaches include the use of:

- individualised funding - used by many jurisdictions and the Australian Government. This method of funding includes a range of approach such as the allocation of funds to a particular person for a particular service or it can be an allocation of funds to a particular service based on the needs of the targeted service users on a per capita basis at a flat rate, relative needs basis or capped scale. Such funding is often used for disability employment services and also often for respite, day options, personal care and support. Individualised funding provides benefits of flexibility and increased tailoring to the individual, however, it can be administratively burdensome if supporting accountability and risk management processes are not adjusted to accommodate this more individualised approach;
- brokerage funding methods are employed by most jurisdictions. This includes funds being provided to an agency that purchases services on behalf of the person with a disability or carer, or funds being provided to a lead agency who distributes funds on behalf of the purchaser;
- a number of jurisdictions use funding panels, some with external representation for part of the decision making process; and
- some jurisdictions, such as WA or NSW, consider population needs in relation to resource allocation.

Funding reform is high on the agenda for most jurisdictions, driven by a desire to better understand the real costs of service delivery, and to develop more flexible funding methods.

Example – resource allocation – NSW and WA

DADHC in NSW uses a Population Planning Group (PGP) Model to plan service development and distribution equitably across the state. Regional resource allocations of additional funding are based upon each local planning area's share of population, adjusted for a number of factors that influence utilisation of Government funded services.

In WA, the overall approach to the distribution of funding is based on demographic distribution and priority needs.

3.1.5 Quality systems

There is a high degree of variation in the nature and shape of quality systems in place for disability services across Australia.

With the introduction of service standards in the Commonwealth/State Disability Agreement in 1991, there was an increased emphasis on assessing performance of the service provider, service management practices, policy and procedures.

More recently, there has been a shift from standards to a quality assurance approach predicated on performance indicators. This has seen clearer prescription about what is required and a stronger move towards measuring outcomes with an emphasis on continuous improvement.

Most jurisdictions have an annual self assessment process in place, with service providers assessing their performance against the disability standards. All jurisdictions undertake some form of performance monitoring of service agreements. A number of jurisdictions have independent complaints mechanisms in place external to the funding body. The Australian Government, Western Australia and Queensland all conduct independent monitoring of services against the disability standards.

Increasingly, jurisdictions are recognising the need for quality systems that go beyond quality assurance and compliance and focus on quality improvement and capacity building. Victoria has recently introduced a new quality framework, and Western Australia is currently in the process of finalising its revised framework. These frameworks both use outcomes for people with disabilities as one of the core measures of system effectiveness.

Example: Quality Systems – Victoria

The Quality Framework for disability services in Victoria takes a person-centred approach, with a requirement for disability support providers to regularly gather information from people who use services, as a basis to assess organisational performance. Disability support providers are required to measure the quality of their practice by gathering data against both:

- individual outcome measures - areas of life that are important to people; and
- organisational systems and processes - areas of good practice that are important to organisations.

Measurement is underpinned by the Standards for disability services in Victoria (2007) which set out the expectations of better practice for the delivery of services and supports to people with a disability. The Standards attempt to cover all the elements that constitute high quality service for people who use services under the *Disability Act 2006* including individuality, capacity, participation, citizenship and leadership.

3.1.6 Service models and approaches

Traditional models of service delivery (accommodation support, respite and day programs) are still the major focus of all jurisdictions. However, there has been a substantial move towards tailoring service provision to the individual, with a range of approaches focused on in-home support and community based provision. These new service approaches aim to support the person with a disability to live in the community and focus on increasing their informal support networks.

Some jurisdictions are also demonstrating the use of early intervention type approaches. These may include one-off or small amounts of supports which strengthen the family, or the individual's community networking ability.

Differences exist in the operation and clarity of funder, purchaser and provider arrangements between jurisdictions and the extent to which services are provided by government or by the non-government sector.

Example: Early intervention - DADHC NSW

Early Intervention and Family Disability Support services provide support to families who have a child or young person with a disability between 6 and 18 years of age. These services provide assistance with coordination of services, support for parents and siblings, counselling and recreational support. They are intended to complement the role of schools and of therapy services offered by DADHC and other providers.

3.1.7 Approaches to industry and workforce development

The research indicates that the disability sector is facing potential staffing difficulties, similar to other parts of the health and human services sector. Key points identified in relation to the workforce include:

- the disability sector workforce is ageing;
- the projected ageing population will increase demand for services and produce labour shortages for the disability sector;
- ageing profiles and longer life expectancy, coupled with increased pressure to join and remain in the workforce, will affect both workers and people with a disability requiring support, leading to an increased demand for employment support programs for people with a disability, increased length of care needs for people with a disability, and the need to accommodate and support older workers in the workforce;
- increasing family responsibilities for women in older age groups will inevitably lead to a decline in the availability of workers in this traditional supply;
- an increasingly competitive labour force environment is likely to place greater pressure on the disability sector which is already failing to attract qualified workers; and
- fiscal pressures increasing competition for resources within the human services sector.

There are several common areas of action arising from the research that jurisdictions are considering to address workforce capacity issues. These include:

- improving data collection about the disability workforce and establishing workforce planning strategies;
- reassessing the approach to education and training in order to establish agreement to pre-entry standards, induction and on-the-job training;
- the need to raise the profile and increase the professionalism of the sector;
- the need to create stronger organisational supports for staff and to build the sector as an 'industry of choice', both for those in the job market and for those already employed in the sector;
- the need to develop a strategy for managing older workers and for providing options for their gradual exit from the workforce; and
- focusing on remuneration, staff recognition and reward as tools to establish the sector as an industry of choice, to increase retention and to reduce turnover.

Only two jurisdictions have an established Industry Development Plan that in part addresses such issues – Western Australia and Victoria. These plans focus on the achievement of strategic objectives for disability services and long term actions.

Example – Industry Development Plan: Victoria

The Victorian Industry Development Plan highlights workforce planning and management as one of the key issues confronting the disability sector today. Priorities to address the workforce into the future include:

- partnerships (with peak organisations, unions, training bodies and providers) to develop and implement a workforce planning strategy to ensure a skilled and qualified workforce;
- exploration and implementation of opportunities for increasing workforce flexibility, in response to the lifestyle choices of people with a disability;
- a sector wide staff training and development strategy, with a focus on values, skills and competencies for contemporary disability practice; and
- develop the sector as an 'industry of choice' and create career pathways.

3.2 International approaches to disability services

A review of strategic policy directions in Canada, the United States, New Zealand and the United Kingdom was undertaken. This revealed a consistent commitment to achieving full citizenship for people with a disability. This involves a shift away from a paradigm of welfare provision to one that asserts the rights of people with a disability to fully participate in their community.

In these jurisdictions, Government policy directions are therefore focusing on strategies that will assist to achieve an inclusive society and strengthen the formal and informal support networks. In the countries reviewed, the achievement of inclusion is seen as requiring joint commitment and collaboration between specialist disability support services and mainstream services such as health, education, transport and housing. There is also consistent involvement of people with a disability, their families, carers and communities in decision-making about the development and implementation of policy and programs.

3.3 Summary and implications

Overall, the analysis suggests the context for disability support provision is continuing to evolve, both nationally and internationally. This is reflected in:

- an holistic focus on the individual, their family and their informal support network. This recognises the benefit (from an outcomes and cost efficiency perspective) of service models which build and maintain family and community resilience, and strengthen the capacity of families/communities to care;
- working with people with disabilities, as partners (from both a service delivery and planning perspective). This ensures that services are responsive to the needs of people with disabilities, and are effective;
- a stronger focus on early intervention to maintain (wherever possible) the well-being and independence of people with disabilities. In many cases, pre-planning for service needs (intervening early) can result in the use of more appropriate, less intensive and more cost effective supports;
- a focus on citizenship for people with disabilities, including building the capacity of mainstream providers (such as mental health, drug and alcohol treatment services, primary care and child and family services) to respond. In this manner, disability services can appropriately target specialist support to the needs of the most vulnerable;
- an increasing focus on quality improvement, with a strong recognition of the need to go beyond the existing focus on ‘quality assurance and compliance with standards’. This includes an emphasis on outcomes for people with disabilities as one of the core measures of system effectiveness;
- declining emphasis on Government as a provider of services, with increasing expectations that the NGO and community sectors will grow their capacity to provide support. This includes:
    - flexibility and adaptability in service delivery models, response to people with disabilities and funding approaches;
    - encouraging the sharing of best practice and service innovation in order to grow the strength of the NGO sector;
    - adopting a system-wide perspective – working in integrated ways when planning and coordinating support services; and
- funding reform, which is high on the agenda for most jurisdictions, driven by a desire to better understand the real costs of service delivery, and to develop more flexible and cost efficient funding methods.

The Tasmanian Disability System has not kept pace with contemporary disability practice, with limited evidence of consistent development, implementation or use of contemporary policy, procedures and systems in disability support provision. Significant system re-orientation is required to allow Tasmanians with a disability to receive a similar level of support as that received in other jurisdictions such as Victoria and Western Australia.

4 Understanding the Tasmanian Disability Service System

This section provides an overview of the current state of disability support provision in Tasmania.

4.1 Policy context

Within the Tasmanian context, services to people with a disability are guided by a range of legislation, government priorities, budget priorities, strategic plans, policies and agreements. These include:

- *The Disability Services Act 1992* (the Act), which provides the legislative basis for disability service provision in Tasmania. The Act serves to define disability and eligibility for services, and includes people with intellectual, psychiatric, sensory, physical and cognitive impairments. The Disability Services Act (1992) is closely aligned with the equivalent Commonwealth legislation - Disability Services Act (1986). Other legislation relevant to disability services in Tasmania include: *Anti-Discrimination Act* 1998 (Tas), *Guardianship and Administration Act* 1996 (Tas) and *Disability Discrimination Act* 1992 (Cth).

- The *Tasmania Together* Policy aims to achieve a more inclusive and equitable society for all people through the development of long term goals and benchmarks. Many of the goals and benchmarks are particularly relevant to the work of disability services as they require governments, industry and the community to focus on the value, respect and acknowledgment given to diverse groups in our society.

- The Tasmanian Government's *Disability Framework for Action 2005-2010* promotes a vision of a Tasmanian society that values the contributions of people with a disability and continually enhances their participation in all aspects of community life. The Framework is structured around: fostering human rights, providing access to high quality services, increasing safeguards and advocacy and working collaboratively. Underpinning the framework's implementation is the Premier's Disability Advisory Council (PDAC) that has been established to work with Government and the broader community to promote inclusiveness, enhance community participation and reduce barriers for people with a disability.

- The Commonwealth State/Territory Disability Agreement (CSTDA) provides a national framework to support the provision of specialist disability services across Australia. Amongst its roles, the CSTDA outlines the respective and collective roles and responsibilities of governments; provides for accountability to funders; and provides for funds to address key national and strategic research, development and innovation priorities.

- The disability services Business Plan (2007-08) is an operational plan for DHHS disability services, outlining how the Department will contribute to effective disability services. Performance measures include those of: achievement - the number of clients accessing services; quality - proportion of complaints resolved within 28 days*;* and access - the length of the waiting list for various service types. A Minister's Disability Advisory Council has also been appointed to advise on the provision of specialist disability services.

4.2 Government and non-government roles and responsibilities

Currently, Government acts in a range of capacities with responsibility for:

- policy and service system development, with an emphasis on strategic planning and formulation of disability policy in response to Commonwealth/Tasmanian policy and identified community needs. This includes responsibility for new initiatives/service system responses, reviewing service system capacity (including infrastructure such as workforce and the capacity of the Government and NGO sector to meet needs), ongoing monitoring and revision of government policy and seeking new funding;
- regulation, with responsibility for eligibility determination, quality assurance, complaints management and investigation;
- funding, with responsibility for securing service system resources along with responsibility for determining resource allocation strategies to meet needs;
- purchasing, using service level agreements (block funding grants and individual funding) to give effect to purchasing; and
- provision, offering a range of disability services primarily in the North and South, and to a lesser extent in the North West[3]. The focus is on community access, community support and respite, with accommodation services having been progressively transferred to the NGO sector.

In contrast, the NGO sector has the primary role in terms of disability support provision, providing over 72 per cent of services.

In 2006/07, there were 92 funded non-government organisations involved in the delivery of specialist disability services in Tasmania via 176 service outlets. In terms of the regional split, there were:

- 16 organisations that delivered services through 34 outlets in the North West;
- 21 organisations that delivered services through 46 outlets in the North; and
- 37 organisations that delivered services through 63 outlets in the South.

In addition, there were 26 organisations that provided statewide services (including advocacy, information and peak services) through a network of 33 outlets.

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[3] Tasmanian disability services is delivered in three regions - the South (encompassing Hobart and surrounds), the North (encompassing Launceston and surrounds) and the North West (Devonport, Burnie and surrounds).

4.3 Services models and options

Services to people with disabilities are provided primarily in the following broad categories, which represent the more 'traditional' models of disability support provision:

1. Community support - therapy services, early intervention, behaviour/specialist intervention, case management, service coordination and regional support teams;

2. Community access - recreation/holiday programs, day options, and learning and life skills development programs. These services are predominately provided by the non-government sector;

3. Respite - in-home respite, centre-based respite, and host family respite;

4. Accommodation support – institutional care, hostels, group homes, provision of in home support. Accommodation services are provided by both government and non-government providers;

5. Information and advocacy – funds are allocated to 19 non-government agencies; and

6. Research and development – funding to peak bodies for training information and research.

In addition, the Individualised Support Program provides funding packages for people with a disability on an individual basis. Supports may include direct support, respite or equipment, and depend on individual needs and goals. Packages may also offer support to families and carers.

Within each region, there are generally a number of government and non-government provided accommodation support options, in-home supports, day support options, and respite services.

4.4 Demand and need for disability services

It is estimated that at least 111,700 people in Tasmania or 23.5 per cent of the Tasmania population had a disability in 2003[4], representing the highest rate of disability in Australia. This in part relates to Tasmania's older population[5]. Approximately 22,100 Tasmanians under the age of 65 had a profound or severe disability. This group is the primary target group (or total potential population) for specialist disability services.

Comparing the general population estimates by region and the distribution of people with severe and profound disabilities indicates that the total population with severe and profound disabilities is evenly spread across Tasmania. However, it would appear that the South and North West regions are under-represented in terms of service users. In contrast, the North are relatively high users of CSTDA funded services, relative to the population in that region.

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[4] Australian Bureau of Statistics (2003), Survey of Disability and Ageing and Carers (SDAC). Australian Government: Canberra.

[5] Demographic Change Advisory Committee (2007), Demographic change in Tasmania: Challenges and opportunities. Tasmanian Government: Tasmania.

Table 1: General population estimates and CSTDA funded users 2005-06 by region, 2006[6] [7]

General population estimates				
	North	North West	South	Total
Total	138,702	109,570	241,650	489,992
Proportion	28 per cent	22 per cent	49 per cent	100 per cent
Estimates of people with a severe or profound disability aged less than 65 years				
Total	5,919	4,883	10,050	20,851[8]
Proportion	28 per cent	23 per cent	48 per cent	100 per cent
CSTDA funded service users 2005-06				
Total	2195	998	2,540	5,733
Proportion	38 per cent	17 per cent	44 per cent	100 per cent

Profile of CSTDA funded users

On any given day, approximately 3,902 Tasmanians receive services through disability services. Effectively, this means that 17.8 per cent of the potential population are receiving services at any given time[9].

A significant proportion of users are children and young people (children aged 0-14 make up 28 per cent of CSTDA service users, while young people aged 15 to 24 years constitute 17 per cent of the population). Importantly, Tasmania has a greater proportion of children with disabilities than the national average; nationally children 0-14 years make up approximately 21 per cent of the disability client group. Overall, three per cent of service users are older than 65, potentially representing those people with disabilities who are effectively ageing in place.

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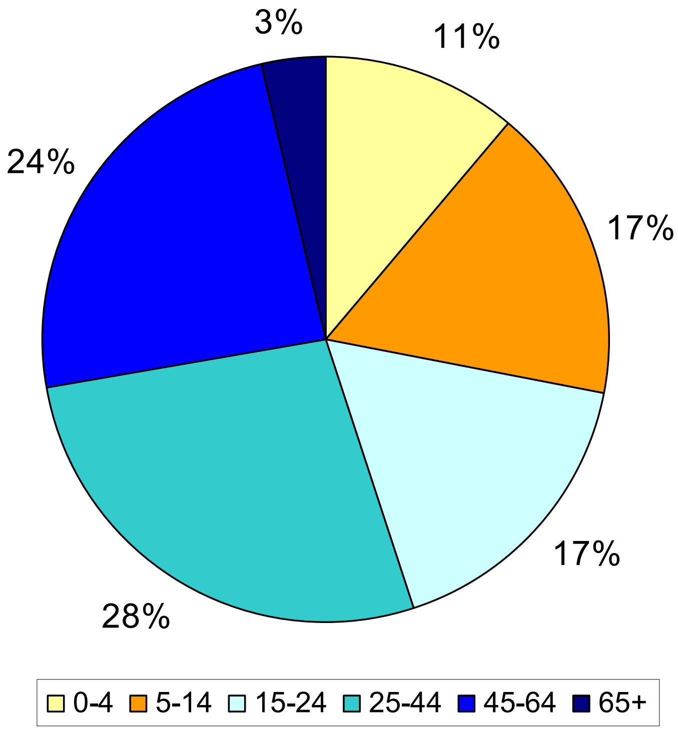
[6] KPMG estimates derived from DHHS data provided to the KPMG Review Team.

[7] Data provided by DHHS. Note: Geographical region is based on service user postcodes (South = 7000-7199; North = 7200-7303; North West = 7304+). Excludes users of education services. Figures do not equate to the number of clients in each region - numbers broadly reflect the number of users by service type, with potential double counting where clients access multiple service types or providers.

[8] Note: The ABS Survey of Disability and Carers (SDAC) is not available on a regional basis. For this reason, ABS Small Area Estimates data has been used to determine the spread of people with severe/profound disabilities by region. This was then multiplied by 2006 population estimates to derive the expected number of people with severe/profound disability by region. For this reason, there will be some inconsistencies with the estimates calculated in the SDAC.

[9] Australian Institute of Health and Welfare (2007) Current and future demand for specialist disability services. AIHW: Canberra,

Figure 1: Age profile of Tasmanian CSTDA service users, 2005-06[10]



Users reporting intellectual disability as their primary disability remain the largest group of people accessing disability services in Tasmania (45 per cent of all service users), with other primary disability groups accessing services including physical disability (15 per cent), Acquired Brain Injury (8 per cent) and neurological disability (7 per cent).[11] Compared to the national average, Tasmania has: significantly more users reporting their primary disability as either an intellectual disability or an acquired brain injury compared to the national average; and significantly less users reporting their primary disability as either hearing or vision related.

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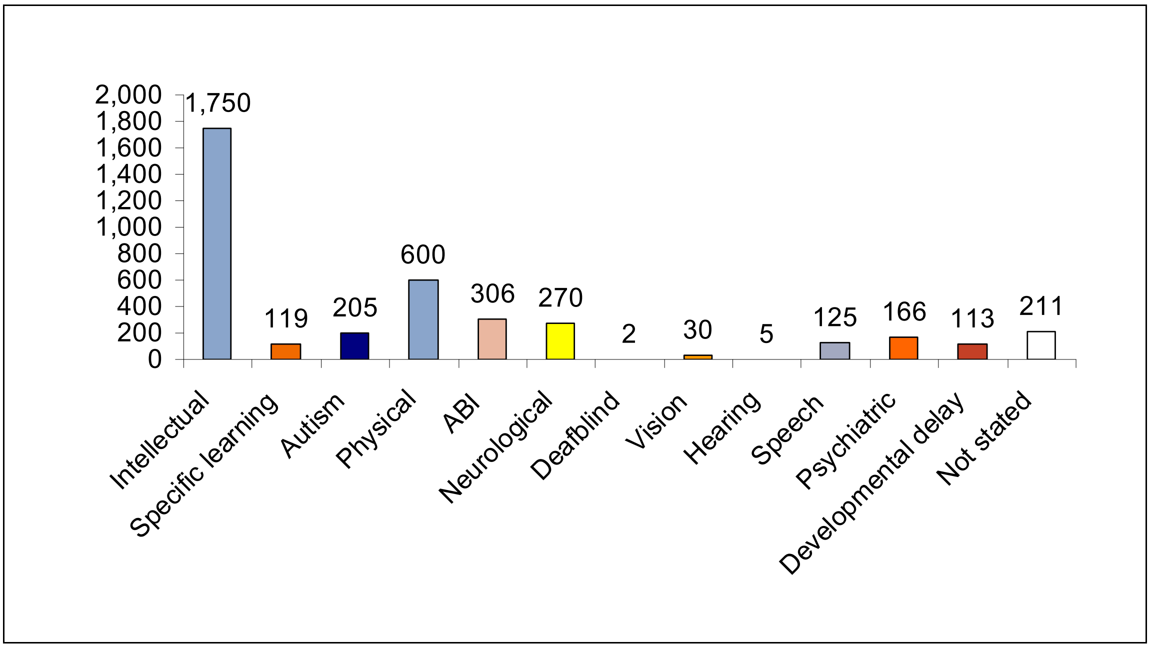
[10] Source: Australian Institute of Health and Welfare 2007, Current and future demand for specialist disability services, AIHW, Canberra, p.127. Note: service user data are estimates after use of a statistical linkage key to account for individuals who received services from more than one service type outlet during the 12-month period.

[11] 2005-06 CSTDA data for Tasmania provided to the KPMG Review Team.

Figure 2: CSTDA-funded service users - primary disability group, Tasmania, 2005-06



Unmet and future demand

There are a number of indicators of unmet and likely future demand for services:

- proportionally fewer Tasmanians with a severe and profound disability access services than in jurisdictions such as Victoria, Western Australia and South Australia[12]
- as at September 2007, there were substantive waiting lists for disability services, with over 490 people waiting for the following service types:
  - 299 people waiting for Individual Support Packages (ISPs);
  - 107 people waiting for day services; and
  - 31 people requiring long term supported accommodation options;
- there are also noted gaps in terms of provision of support for children and families, with unmet need for supports for working parents (i.e. school holiday programs) and appropriate permanent accommodation options for children.

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[12] Productivity Commission (2008): Report on Government Services. Australian Government: Canberra.

Unmet demand for disability services is largely attributable to[13]:

- the introduction of the *Tasmanian Disability Services Act (1992)*, which clarified the focus on all types of disabilities;
- increasing client group, due to the ageing population, and advances in acute medical management;
- increasing numbers of children being born with severe disabilities;
- the increasing complexity of the disability client group, which require multiple service types and access to multiple programs;
- lack of flow through of people with disabilities. People accessing disability services tend to require services 'for life', and have increasing needs with time, as they and their carers age; and
- disability services being seen as the 'default service', consequently disability services support clients that historically may have been supported by other service systems, i.e. Justice, Mental Health, Drug and Alcohol.

4.5 Investment in disability services

Investment in disability services has increased considerably in recent years from $92.12 million in 2004-05 to $112.45 million in 2006-07, representing an overall increase of 22 per cent. This is well above the growth experienced in other similar jurisdictions – over this same period, Victoria experienced growth of 14 per cent, South Australia 11 per cent and the ACT 15 per cent.

Growth in numbers (accessing the main disability services) over this same period has not kept pace with investment, with 8.1 per cent more people with disabilities accessing disability services in 2006-07 than in 2004-05. DHHS has indicated that this reflects increases in the cost of service provision and in relative complexity and need.

Table 2: Actual expenditure in disability services and client numbers, 2004-05 to 2006-07

	2004-05	2005-06	2006-07
Total actual investment	92,128	101,847	112,451
Total client numbers	5,301	5,829	5,733

Investment in Government services has increased at a faster pace (by 27 per cent from $30.6 million to $38.98 million) than non-government services which increased by 19 per cent (from $61.6 million to 73.4 million). The budget for Government provided services has reduced in 2007/08 consistent with the transfer of accommodation support services to the NGO sector.

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[13] DHHS (2006), Review of Disability Services Issues Paper. DHHS: Tasmania.

Table 3 provides an overview of service and provider type for 2006-07.

Table 3: 2006-07 funding by service and sector

	Government services $m	NGO services $m	Total $m
Accommodation support	13,576	47,145	60,721
Community support	5,165	4,682	9,847
Community access	5,046	11,966	17,012
Individual Support	0	6,124	6,124
Respite	4,049	1,153	5,202
Information and Advocacy	0	2,136	2,136
Other support	1,374	139	1,513
Total			**102,555**

Table 4 provides funding and numbers of people with disabilities receiving support for 2006-07. This demonstrates that 59 per cent of funding is allocated to accommodation support, which accounts for 17 per cent of disability clients. Community support accounts for 10 per cent of funding, and 44 per cent of people with disabilities receiving support.

Table 4: Funding and client numbers, 2006-07[14]

	$ million	Percentage	2006-07	Percentage
Accommodation support	60,721	59 per cent	946	17 per cent
Community support	9,847	10 per cent	2,531	44 per cent
Community access	17,012	17 per cent	1,692	30 per cent
Individual support	6,124	6 per cent	288	5 per cent
Respite	5,202	5 per cent	276	5 per cent
Advocacy & information	2,136	2 per cent	Na	Na
Other support	1,513	1 per cent	Na	Na

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[14] Data provided by DHHS.

Comparison of expenditure against other jurisdictions (for the 2006-07 financial year) indicates that:

- all jurisdictions are spending the majority of funds on Accommodation support, ranging from 52 per cent of total funding to 68 per cent, with Tasmania at the upper end of this range;
- Tasmania is below the national average in terms of the proportion of expenditure allocated to community support. About 10 per cent of the disability budget is directed to this service type, compared to 17.6 per cent in Victoria, 20.4 per cent in the ACT and 14. 3 per cent in South Australia; and
- a comparable proportion of the total disability investment is allocated to respite, as in other jurisdictions.

Regional Analysis

Table 5 demonstrates that the proportion of funding allocated to the South (57 per cent) far exceeds both the proportion of the general population (49 per cent) and that with a severe/profound disability within this region (48 per cent). Despite this, the number of people with disabilities accessing services within this region is lower than would be expected given the population profile (44 per cent of all service users).

In contrast, the proportion of funding allocated to the North West (17 per cent) is significantly less than would be expected given the proportion of the severe and profound disability population that live there (23 per cent).

A comparable trend is found in the North but to a lesser extent. Again, in this region, the proportion of funding allocated (26 per cent) is slightly lower relative to the severe and profound disability population that live there (28 per cent).

As such, the way in which funding has been allocated and is utilised across regions has contributed to a number of inequities in access. These include that people with disabilities have less access to community support and community access services in the South and North West (compared to the proportion of the severe and profound disability population residing there), and significantly more access to these services in the North.

Table 5: Service provision - service users[15] and expenditure by region

	South	North	North West	Total
Accommodation support	553	346	312	1,211
Community support	1,053	1,172	306	2,531
Community access	756	613	323	1,692
Individual Support[16]	0	0	0	0
Respite	178	64	57	299
Total clients	**2,540**	**2,195**	**998**	**5,733**
Proportion of CSTDA clients	**44 per cent**	**38 per cent**	**17 per cent**	**100 per cent**
Expenditure ($ million)	*$58,545*	*$26,538*	*$17,472*	*$102,555*
Proportion of funding	*57 per cent*	*26 per cent*	*17 per cent*	*100 per cent*
Comparison to population share				
Proportion of general population	49 per cent	28 per cent	22 per cent	100 per cent
Proportion of severe/profound disability population	48 per cent	28 per cent	23 per cent	100 per cent

Expenditure per person with disability analysis

There is considerable variation in expenditure per person between regions. The South has greater expenditure per client for accommodation support, community access and community support. The North and North West receive considerably less than average funding for all the core services except respite.

These variations are likely to reflect:

- differences in service models and cost structures between regions. Of note, 53 per cent of the Southern region's funding is allocated towards group homes, compared to 40 per cent and 38 per cent respectively in the North and North West. This region also has more clients residing in Government provided accommodation, which operates at a higher cost;
- differences in intensity of service provision and need;
- varying levels of operational efficiency; and
- inequities in the resource allocations across the various regions.

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[15] Data provided by DHHS. Note: Geographical region is based on service user postcodes (South = 7000-7199; North = 7200-7303; North West = 7304+). Excludes users of education services. Figures do not equate to the number of clients in each region - numbers broadly reflect the number of users by service type, with potential double counting where clients access multiple service types or providers.

[16] Individual support numbers and funding were not able to be disaggregated on a regional basis.

Table 6: Expenditure per client by region

Service type	South $/client	North $/client	North West $/client
Accommodation support	67,680	49,032	37,391
Community support	5,804	2,247	3,598
Community access	12,738	7,175	9,238
Respite	13,230	31,391	28,509
Advocacy & information	94	98	322

Relative to other similar jurisdictions (such as Victoria, WA and SA), Tasmania expends significantly more on average per person for accommodation support, community access and respite services. For example, while in 2006/07 the average per person expenditure for a Tasmanian accommodation support person was $59,834, this compared to $40,970 and $32,960 for Victoria and South Australia respectively. In this same year, Tasmania's average per person expenditure for community access equated to $11,575, compared to $7,608 and $4,309 for Victoria and South Australia.

Use of top-up funding

Analysis indicates that 'top-up' funding may be provided to NGOs on request, based on consideration by DHHS of the urgency and quantum of additional funding required. The additional funding provided in 2005/06 and 2006/07 is significant, amounting to between one and two per cent of the total investment in service delivery in each year.

In 2006/07 top-up funding was allocated to 11 NGOs, receiving an average of $112,000 each, totalling $1.2 million. This amounts to 16 per cent of the average total funding ($706,000) received by NGOs during this year. Again, the majority of this went to the Southern region (51 per cent - six NGO's) with 35 per cent distributed to four NGOs in the North and one NGO in the North West receiving 14 per cent.

Administrative expenditure

In 2006/07, approximately 7.5 per cent of total disability expenditure was allocated towards administrative costs. This was comparable with the ACT, Victoria and South Australia, with these jurisdictions each allocating between 6.8 per cent and 8.5 per cent of total expenditure towards administration[17].

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[17] Source: Productivity Commission (2008), Report on Government Services 2008. Table 14A.5 – Government expenditure by type.

4.6 Implications

Overall, this analysis suggests:

- the need to recognise that disability services have a number of clear client sub-groups, with a requirement for differential responses to each sub-group's needs, i.e. children and young people making up a significant proportion of the client population and, as such, services should be responsive to the needs of families. This should also recognise that families' needs will differ depending on the functional impact of the disability and their individual situation;
- likely inefficiency and duplication in terms of the service system, with 92 non-government organisations funded to provided support for 3,903 people with disabilities. Agencies operating with limited staffing may face capacity issues when addressing DHHS administrative requirements, and have limited ability to be flexible in approach to service design;
- a reasonable level of unmet demand for disability services, which is only likely to increase given the trend towards the ageing of the population in general, and of informal carers. Given that 17.8 per cent of the potential population with a severe or profound disability are accessing formal support services, it is likely that informal carers are playing an important role in providing support and care for those with disabilities;
- existing methods of resource allocation as well as differences in service models and cost structures have contributed to significant regional equity issues in relation to access to services. This is reflected in the fact that the proportion of funding allocated to the South far exceeds that with a severe/profound disability within this region, with expenditure per person far higher than either the North or North West;
- opportunities to improve operational-efficiency, with indicators that:
    - the cost of service provision in Tasmania is high relative to other jurisdictions;
    - Tasmania tends to make greater use of more expensive models of support (such as group homes) as opposed to lower intensity supports such as in-home support and other community support options which are less expensive; and
- there is an opportunity to consider a continuum of service delivery models which meet the breadth of individual needs in a cost effective and efficient manner. This should include considering (where appropriate based on individual needs) an increased emphasis on more flexible community based support, with a range of models focused on in-home support and community based provision aimed at supporting the person with a disability to live in the community.

5 Where Disability Services are now and the 'vision for change'

5.1 Rationale

Disability systems – both nationally and internationally – have undergone significant change, underpinned by a more inclusive philosophy and approach to working with people with disabilities, as well as an emphasis on growing the capacity of the sector, and the wider community.

This has been reflected in:

- greater emphasis on people with disabilities and their families as 'partners';
- a greater focus on inclusion – through emphasis on models of community based support, recognising the importance of families and communities, strengthening informal support structures and increasing access to mainstream services;
- a focus on citizenship, recognising that people with disabilities should have information about and access to a continuum of informal and formal service options, from both mainstream and specialist disability providers;
- the emphasis on offering new and often innovative models of home-based support and community based service provision, which aim to support people in their communities;
- declining emphasis on Government as a provider of services, with increasing expectations that the NGO and community sectors will grow their capacity to provide support; and
- increasing emphasis on cost efficiency and effectiveness.

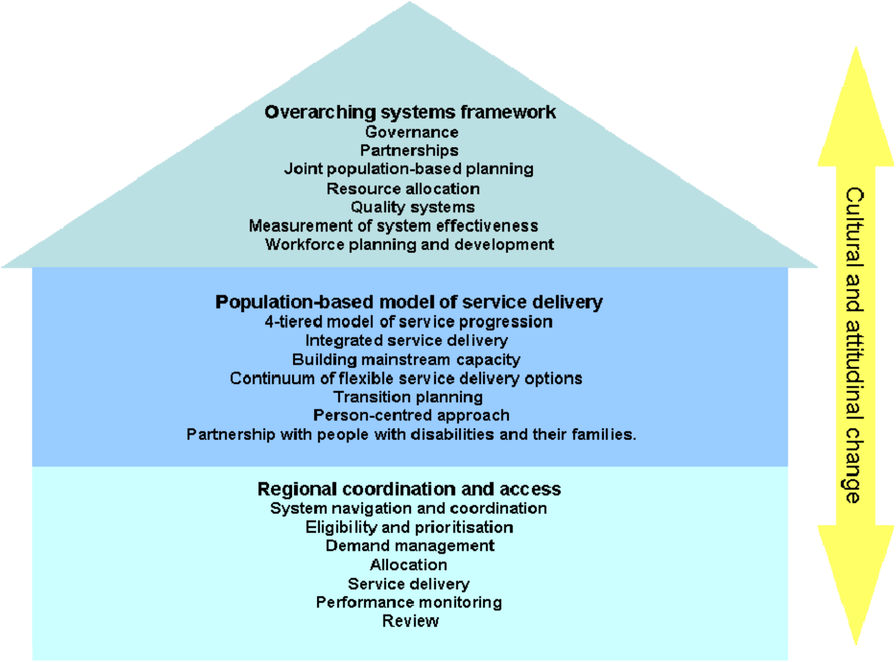
5.2 Opportunity for change

There is now an opportunity to reorient the disability services system to support greater responsiveness to the needs of people with disabilities, and stronger alignment with contemporary practice both nationally and internationally.

As depicted in Figure 3 below, to enable this new vision to be realised, there is a general requirement for structural and practice change, at three related levels:

- creation of an overarching service systems framework;
- establishment of a population-based model of service delivery; and
- improving regional access and coordination.

Figure 3: Vision for change



This will be underpinned by cultural and attitudinal change with an emphasis on:

- raising awareness and challenging barriers;
- encouraging partnerships with non-traditional partners – other service provision arms of DHHS and people with disabilities, alike;
- creating shared responsibility; and
- understanding the value of diversity.

5.3 Key elements of the vision

Governance

This will involve establishing clear governance arrangements – with a focus on clear leadership, shared strategic directions, defined roles and responsibilities and clear accountabilities - to oversight disability services, at both the system-wide and regional levels.

Current challenges

While there are examples of good governance at both the state-wide and regional level, such governance arrangements have not been systematically embedded into the way disability services operates.

This needs to start system-wide with a clear strategic direction for disability services, providing a vision for the future and picture of the 'business' of disability service provision. In this regard, reference was made to:

- the *Disability Framework for Action 2005-10* and the requirement for each Tasmanian Government Department to produce its own Action Plan to underpin this strategy. A number of the stakeholders noted the lack of a publicly available and widely disseminated DHHS plan in this area; and
- the importance of reviewing the *Disability Services Act 1992 (Tasmania)* to ensure an appropriate and contemporary authorising environment.

This should then be translated to the regional level, with clear planning and coordination of services around individuals, communities and their needs.

There is also a requirement for clearer delineation of Government and non-government roles and responsibilities. Currently, Government acts in multiple roles - policy development, funder, purchaser, provider and regulator of services - which creates difficulties at a number of levels.

- The lack of purchaser/provider/regulator split contributes to a perception of conflict of interest in relation to quality assurance, with the DHHS disability services program taking responsibility for auditing provider performance, despite currently acting as a service provider itself.
- A high degree of involvement in direct service delivery is seen to detract from DHHS capacity in terms of strategic leadership, contemporary policy development and service system planning.

As such, there was seen to be an opportunity to strengthen the system's governance arrangements (including policy and service system development, purchasing and regulation capacity), by continuing the work commenced in accommodation support and to devolve direct service provision to the NGO sector.

Vision for the future

Effective governance systems will provide clarity of direction, strong management and integrated leadership for the disability services system – at both the state-wide and regional levels.

At the state-wide level, the governance arrangements should be led by DHHS, in conjunction with key advisory groups (e.g. Minister's Disability Advisory Council), sector stakeholders and peak bodies (including specialist disability and mainstream providers).

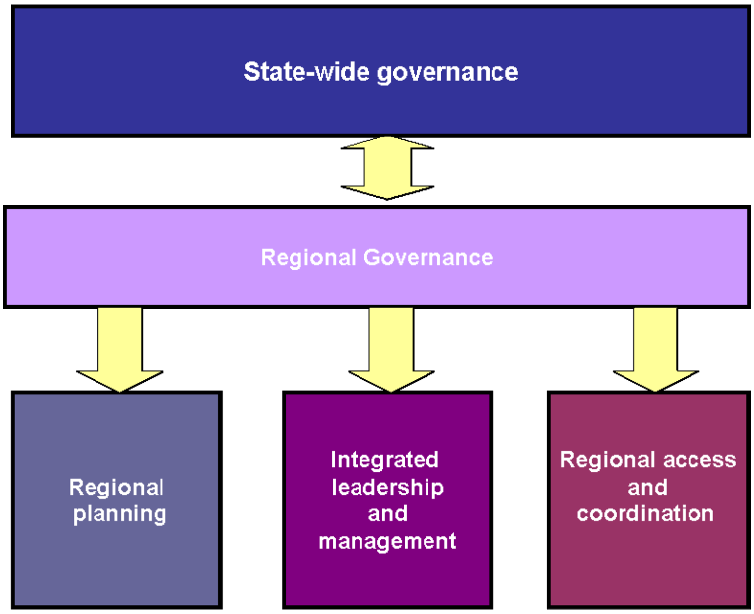
State-wide responsibilities will comprise: developing and monitoring the DHHS strategic plan for disability services; monitoring and reporting DHHS and NGO progress to achieving 'A Framework for Action'; developing and administering quality frameworks for disability services; developing state-wide plans for 'growing' service system capacity; facilitating planning at a state-wide and regional level; and developing the capacity to more effectively identify trends in disability services at a state-wide level, and to evaluate outcomes.

Governance structures should also operate at the regional level, with regional offices and NGO providers to determine the operating model for each region. 'Networks' should be established at a regional level and will include partners from funded disability services, people with disabilities, carers and their families, DHHS regional staff as well as regional agencies that provide related health and human services supports (e.g. health, primary and community health, mental health housing, HACC, child and family and aged care).

Regional networks should perform a range of functions including planning by location.

Example of where this is already occurring: *DHS Victoria - Child FIRST, Child and Family Information, Referral and Support Teams*

Figure 4: Governance arrangements



Partnerships

This involves working collaboratively with people with disabilities and their families, as well as other universal, secondary and specialist services, to support full citizenship for people with disabilities (and effectively place disability services on a continuum of service delivery options).

Current challenges

Due to limited collaboration with the mainstream services sector, disability services can become the default service option – people who have multiple needs (such as mental health, drug and alcohol issues, or high medical needs) are generally being catered for within the disability system, often inappropriately with limited support from other related services.

In addition, the limited nature of partnerships and cooperation with other health and human services were seen to be affecting the appropriateness of the service response to people with disabilities. For example, stakeholders cited instances of the DHHS Housing Division proposing group homes and accommodation sites for people with disability in inaccessible areas (thereby reducing community involvement, inclusion and capacity for independence).

Parents and service providers impressed the importance of partnerships with families, recognising that outcomes for people with disabilities are highly dependent on both the skills and commitment of family members, as well as disability support and specialist staff. For these reasons, the systemic provision of education for family members, in-conjunction with direct support staff, was seen as important.

Vision for the future

The future for disability services involves integration across a broad range of health and human service sectors. In addition, other organisations outside the 'traditional' service sectors - such as local government, schools, housing, community clubs and businesses – should be treated as key partners in the development of effective approaches to improving outcomes for people with disabilities at the local level.

As such, this framework will also consider the needs of families, fostering collaboration between formal and informal supports.

Planning

Planning will focus on the establishment of joint population-based planning mechanisms to determine regional service needs for mainstream and specialist disability services and inform resource allocation.

Current challenges

Current planning processes focus on resource allocation processes attached to funding agreements where agencies receive recurrent grants. At present, there are no demand management processes to inform how resources are distributed and allocated to the specialist disability support system.

Effective planning is hampered by a number of factors, including that:

- people with a disability may enter the service system either via disability services or individual funded agencies; and
- there is a lack of collaboration and information sharing, making it difficult to assess demand on a locational basis and to plan for those people with disabilities likely to be transitioning into the disability service system.

Vision for the future

Planning will focus on all the related services and supports that an individual with a disability and their family is likely to require. As such, planning will occur on a joint basis, drawing together all the major programs within DHHS, including health, primary and community health, mental health, housing, HACC, child and family and aged care.

Planning for an integrated system will be enabled through the use of a range of key planning principles.

Planning principles for an integrated framework

- Planning will support effective demand management, and responsiveness to the requirements, goals and aspirations of people with disabilities
- Planning will support equity in the distribution of resources/services, based on the identified characteristics and needs of regional populations
- There will be a strong focus on developing and consolidating a continuum of services, as well as improving the range, flexibility and quality of services delivered
- Planning will enable ease of access to services, undertaking service development based on population needs analysis, starting from the preferred options of community based services
- Planning will be conducted within each region by a regional planning network, made up of DHHS regional offices, NGO service providers (both specialist disability and mainstream), people with disabilities and other stakeholders. This will inform state-wide planning processes.

At the regional level, planning will involve:

- population needs planning, with an emphasis on understanding the profile of the community including demographics, prevalence of disability, burden of disease, economic disadvantage and environmental analysis;
- service mapping, to determine the current level and mix of services available to address population needs;
- locational assessment, reviewing the service system to establish a view about what is required into the future (based on the population profile); and
- systems integration, with regional networks working together to plan for effective service coordination, workforce capacity building, change management and other identified priorities.

This will be underpinned by state-wide planning, with DHHS holding the key responsibility for decision making to support equitable resource distribution by location.

This joint approach to planning would focus on the appropriate mix of resources for a region across the relevant DHHS programs.

***Example of where this is already occurring**: Western Australia - disability services Commission, Local Area Coordination (LAC)*

Resource allocation

A more robust approach will ensure that resource allocation is based on relative population risk and need, to support equity between regions. This will be underpinned by a range of appropriate mechanisms for funds distribution, and for managing the effective allocation of resources.

Current challenges

The majority of funding (apart from Individual Support Funding) is provided to NGOs on an historical basis. Providers are allocated a funding amount (in block grants) based on their previous year's allocation, which is then adjusted for indexation. There is limited understanding of the original basis upon which agencies were funded, with no review of providers' funding levels or assessment of the value for money associated with service delivery. As such, block grant funding provided may not reflect the true cost of services.

There are inequities in the distribution of funding between regions, driven by differences in service models (e.g. greater use of costly group homes in the South) and cost structures. This is reflected in the fact that funding allocated to the South far exceeds this region's overall population share and severe/profound disability population.

There is limited accountability for Government resources, as funding (through service agreements) is not tied to the achievement of clear output and outcome based targets.

From a person with a disability perspective, the focus on block grant funding can limit the degree of portability – both the capacity to move between service providers for reasons of choice, as well as in response to changing and emerging needs.

Vision for the future

Regional planning will provide a core source of information for DHHS to make decisions about funding allocation at a regional level. This planning mechanism will become an important means for the Department (in collaboration with funded agencies) to determine resource allocation for new initiatives and growth funding, to respond to changing and emerging population needs.

As such, this will represent a shift to resource allocation which is very much based on:

- relative population need and risk (as based on the level of social and economic disadvantage, burden of disease, prevalence of disability etc); and
- differences in terms of service delivery costs between regions (taking factors such as the extent of travel required to access services into account).

In this way, a population-based resource allocation can assist to ensure equity; namely:

- that disadvantaged populations have comparable access to effective services; and
- that service system development is promoted in regions that are relatively under-serviced or have experienced rapid/unexpected population growth.

Underpinning this will be the need for transparent means to allocate resources amongst the NGO providers within a particular region. Best practice mechanisms used include:

- *Unit pricing*, which allocates a 'price' to each service type on the basis of the cost of service provision (considering salaries, infrastructure, brokerage and other operational costs). Reporting is on the overall service, and typically covers the number of people receiving a service and the total quantum of services received. However, there is an opportunity to add outcome based measures to this approach, with providers responsible for reporting on 'what service is achieved for the individual'.

- *Individualised funding*[18], which allocates funds to a particular service, based on the relative needs of individuals within the service. The service manages the funds but resources are allocated on an individual client basis, based on an agreed plan.

  This method of resource allocation provides flexibility for the service provider allowing the application of resources to the best effect at the individual level. The service provider is required to establish local protocols to guide decisions on who (from the identified population) receives a service and how much each receives.

  Portability of funding is allowed, however it requires a re-assessment of the target groups. The re-assessment can adjust funding levels as a result of people moving across service boundaries.

  Reporting is on the overall service, and typically covers the numbers of people receiving a service and the total quantum of services provided per individual. Again, outcome based measures could easily be added to support a greater focus on the individual.

- *Individually tied funding*[19]*,* which allocates funds to a particular person for a particular service(s). The allocation of that service is preserved for the person, and there is an ongoing option for the funds/service to be transferred to another service provider (the principle of portability) if, and when, that person chooses.

  Service providers can manage a number of individually tied funding packages within a given funding program (eg. accommodation support, employment support). The service provider is granted the flexibility to temporarily reassign resources to manage fluctuations in need across people within a funding program, although some conditions may apply.

  Reporting is required on an individual basis (for example hours of services, expenditure of funds and target of services).

  Any recurrent funds no longer required are reported to the funding body for reallocation to critical and unmet need.

  Example of where this is already occurring: Ministry of Health New Zealand, District Health Boards

Quality and system effectiveness

Quality management systems which support the achievement of outcomes at the person, organisational and system level. The emphasis is on a framework which embeds the elements of quality assurance, risk management, continuous improvement and capacity building into the way agencies work, both with people with a disability and from an operational perspective.

This will be highly aligned to system effectiveness, which will be determined through the use of outcome based performance measurement.

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[18] This section builds on work completed by KPMG to develop a National Resource Allocation Framework for disability services.

[19] Ibid.

Current challenges

Quality systems are embryonic, and have historically been perceived as problematic in terms of:

- the limited meaningful engagement of people with disabilities in quality improvement;
- lack of consistent processes to ensure that people with disabilities (including children) understand their rights and are protected from the risk of abuse; and
- opportunity to improve the skills of those DHHS staff members conducting the performance audits.

There is also clear absence of processes to ensure that providers are suited to, and have the required skills and competencies to work in, the disability sector. This included the lack of:

- processes of pre-qualification to attain preferred provider status;
- key performance criteria in contracts/service agreements which create accountability for achieving agreed output and outcome based targets; and
- annual self-assessment against the Commonwealth Disability Service Standards, with a requirement for external/independent audit every 3-5 years.

As such, there is clear requirement for quality and performance management systems to be embedded into the way the disability services system works, and drive outcomes for individuals.

Vision for the future

Contemporary quality systems focus on not only an assurance but effective risk management, quality improvement and capacity building.

In terms of risk management, there is a need to recognise the vulnerability of people with a disability (in terms of neglect and abuse) and ensuring staff have been deemed appropriate to work with people with disabilities, including children (i.e. use of pre-employment checks) and effective complaints management systems are in place, to respond to complaints and allegations of misconduct.

Quality systems should also enable effectiveness to be measured in terms of:

- supporting the achievement of the individual's goals; and
- capacity building, with an emphasis on supporting the abilities and potential of both individuals and organisations to achieve positive outcomes.

Outcomes sought from an agreed approach to the monitoring of quality needs to occur at three levels[20]: the person with a disability (i.e. the benefits individuals can expect to gain), the organisational level (i.e. embedding quality into all management practices, and ensuring

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[20] The three level outcomes framework has been adapted from work completed by KPMG nationally, to develop a quality and outcomes framework for disability services in Western Australia.

compliance against agreed standards) and the system level (i.e. focusing on system wide improvement strategies, and 'systemic-health').

Some of the benefits (outcomes) that providers should aspire to achieve for people with disabilities include[21]:

- *Wellbeing* – supporting a satisfying life as a whole including material security, health, safety, a chance to achieve key aspirations, safety, and meaningful relationships;
- *Lifestyle* – supporting people with a disability to develop their own sense of self and express their personal identity;
- *Home* – creating 'a home' in an environment which offers security, warmth and happiness;
- *Relationships and social connection* – developing connections with people who can help us on our journey; finding a place in the world;
- *Independence* – enhancing the capacity of people with a disability to live and work independently; respecting and valuing the experience that people with disabilities possess, supporting them to make choices about the way they want to live their lives;
- *Welcoming communities* – inclusive, supporting diversity, and accepting people with disabilities on their own terms;
- *Social participation* – supporting people with a disability to fully and equally participate in Tasmanian life;
- *Capacity building* – fostering ongoing learning, growth and the capacity to participate in life in ways which are meaningful; growing the capacity of families, informal support networks and communities to support people with disabilities;
- *Community connection* – feeling a part of the community, a sense of belonging in community life; and
- *Citizenship* – recognising that people with disabilities are citizens and supporting the right to be respected and the right to have equal opportunities to participate in all aspects of life. As citizens, people with a disability also have equal responsibilities towards Tasmanian society and should be supported to exercise these.

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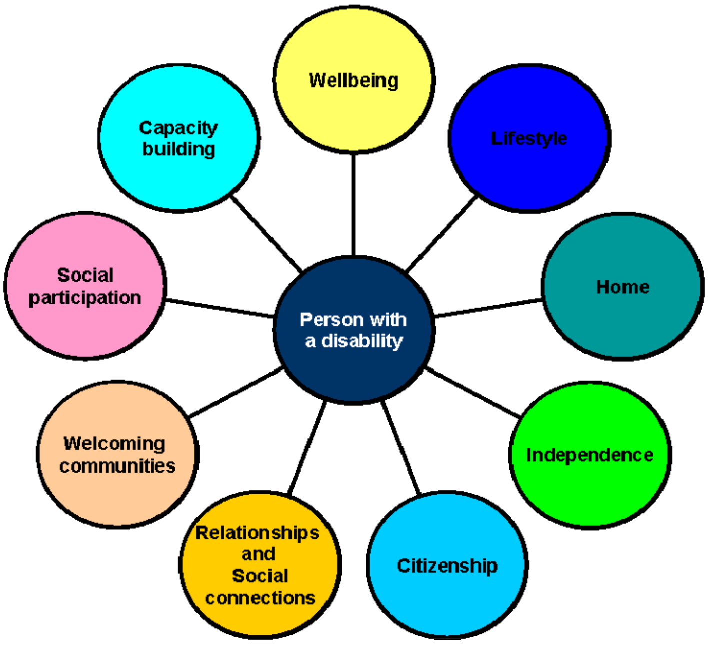
[21] The preliminary outcomes suggested above are suggested to prompt thought about a new way of framing disability services provision. In order to adapt these outcomes for a Tasmanian audience (or develop other applicable outcomes), KPMG would suggest the need for rigorous consultation with service providers and people with a disability within Tasmania.

Figure 5: Outcomes for people with a disability



Importantly, this outcomes focus should be translated to all levels of the service system. Within the service delivery model, there is the capacity to describe service options with an outcomes focus, thereby enabling greater flexibility, innovation and responsiveness. Agreed outcomes can also be clearly specified in service agreements, encouraging agencies to reorient their quality systems and performance monitoring frameworks to consider 'what is being achieved from an individual's perspective'.

Example of where this is already occurring: *DHS Victoria - Standards for disability services*

Workforce planning and development

The use of formalised workforce planning approaches will ensure that there is a skilled and competent workforce to support people with a disability, including strategies to strengthen the capacity of the mainstream service system.

Current challenges

Current challenges relate to:

- workforce skills, with an opportunity to improve the professionalism and knowledge of the disability support workforce, to respond to the needs and aspirations of people with disabilities. This includes ensuring disability service staff have the skills to develop appropriate programs for people with different types of disability as well as appropriate qualifications and knowledge in child development;

- attraction and retention, with general difficulties in attracting and retaining disability support staff, and a high degree of investment in training and development; and
- the limited nature of career pathways within the disability sector.

Vision for the future

Given Tasmania's ageing population, increasing demand for services and the proposal to develop new models of service delivery, it will be important to refine the existing workforce planning strategy for the sector, to ensure that there is a skilled and competent workforce to support people with a disability. There will be a need to consider:

- the size, composition and shape of the workforce required to give effect to the forward direction for disability services;
- a minimum entry qualification framework for workers with competencies and skills;
- the establishment of a broader, more diverse workforce and associated career structure; and
- development of partnerships with other health and human service providers with regard to attraction, recruitment, training and development. This should include sustainable partnerships with child and family services to support skills transfer and shared capacity to respond to meet the needs of children with disabilities.

Population based model of service delivery

The focus of a population-based model of service delivery is ensuring that service options are reflective of the needs of people with disabilities, and that both specialist disability services and mainstream support services are accessible.

Current challenges

Tasmania's population is fairly small and decentralised when compared to other jurisdictions and services are seen to be unevenly distributed between regions. There are perceived to be gaps in service provision across many services including respite and personal care, with a particular emphasis on the North West.

Service types available are traditional in nature (e.g. group homes, day programs), with an opportunity to create a continuum of new service delivery offerings which respond to differing individual needs. Examples included: funding for children upon leaving school; supported accommodation for children living with severe disabilities, including group homes; support for families to enable them to continue to care (and generally recognise the stress involved for all family members); viable accommodation options for people with a reasonable level of functioning; more flexible respite options (and the general availability of respite); later-life services. i.e for those feeling the effects of rheumatic fever, polio later in life; and services that are early intervention focussed, enable capacity building and life skills development.

Access to mainstream services (such as mental health, drug and alcohol treatment or medical services) can be limited. As a result, disability services often becomes the default service option.

Vision for the future

As citizens of Tasmania, people with disabilities have an equal right to participate meaningfully in society and to access a broad range of services and supports from health, to education and employment.

While some individuals will require specialist disability services, there is also a need to take a person-centred approach, looking beyond the specialist system to address an individual's underlying needs, recognising that individuals with a disability may benefit either from mainstream services alone, or a package providing both mainstream and specialist options.

The *population-based model of service delivery* (see figure 6) will provide:

- integrated service delivery, whereby people with disabilities can access and receive appropriate services and supports through the mainstream service delivery arms of the health, education and community service sectors within Tasmania;
- the capacity to build the mainstream service response. Service providers with specialist skills in the provision of disability support services will work in partnership with the generic service system to strengthen the level of responsiveness to needs;
- a continuum of flexible service delivery options, with a focus on 'supporting outcomes for people with disability' in ways which are responsive to individual needs and are strongly evidence based;
- transition planning, overcoming the 'gap' between early intervention, child, adolescent, and adult services, through adopting a 'life course approach' to service eligibility and provision. In practice, this may include providing services across the life span or, alternatively, where life stage specific services are operating, longer periods of transition and collaborative provision of service (see appendix A for details); and
- person-centred approach, with a focus on inclusion, enhancing resilience and in the way people move through the service system.

Example of where this is already occurring: *Integrated Chronic Disease Management in the National Health Service, UK*[22]

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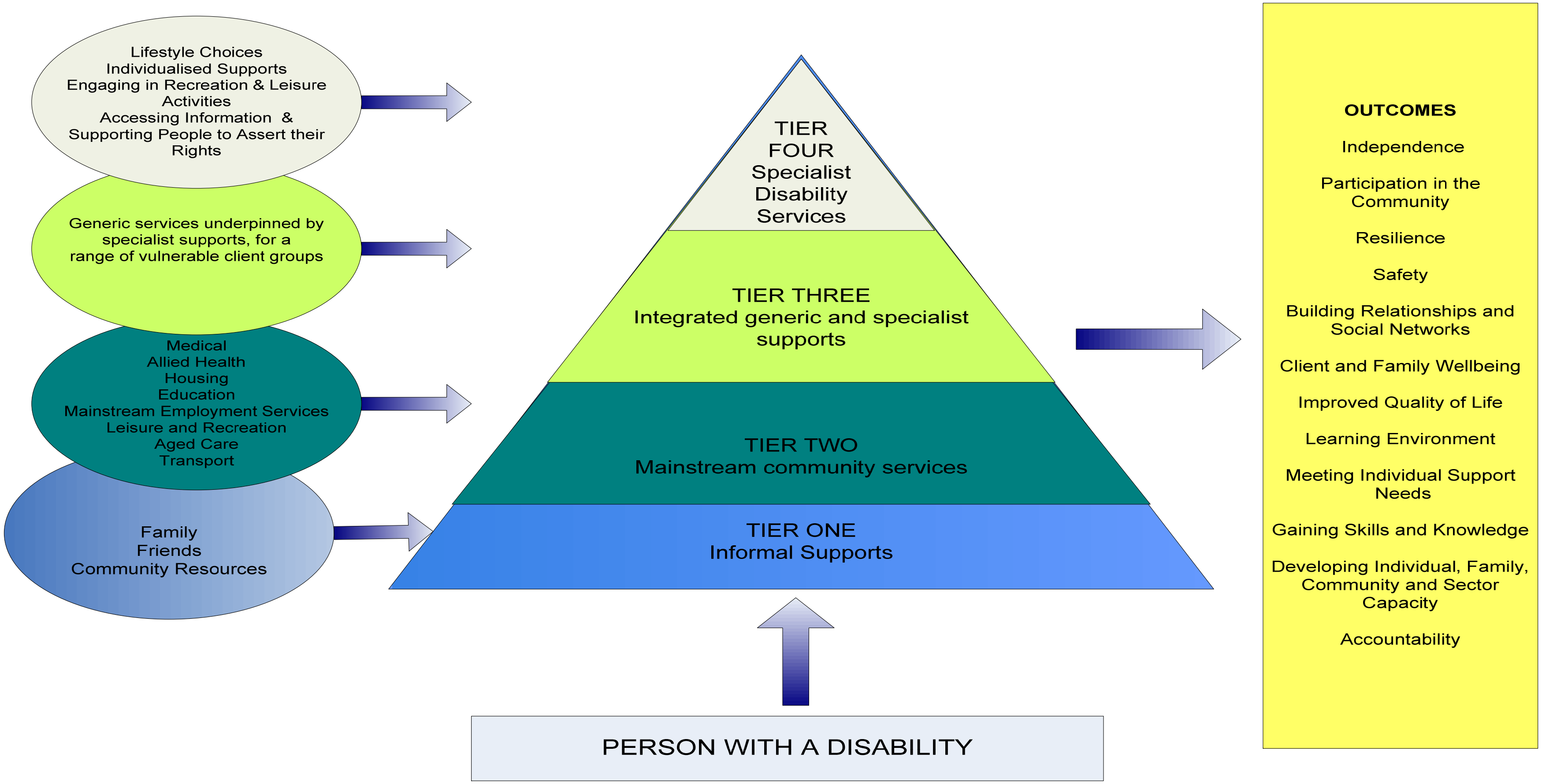
[22] Ham, C. (2006). Developing integrated care in the NHS: adapting lessons from Kaiser. Viewed at: http://www.hsmc.bham.ac.uk/LTCnetwork/KaiserbriefingpaperMay2006.pdf Accessed January 2008

Figure 6: Population-based model of service delivery



5.4 Tier one – Informal supports

These are the supports that a person with a disability may access through links with family, friends and participation in their community. Informal networks may provide personal supports, housing, transport, childcare, and emotional support to a person with a disability.

Within Tasmania, such informal supports provide an important role, with less than 20 per cent of the population with a severe or profound disability accessing specialist services.

5.5 Tier two – Mainstream community resources

The range of services available in the mainstream service system for people with disabilities are the same services available to all Australian residents. Services are not specifically designed for people with disabilities, rather, they are services that have been designed to meet the needs of all people, including people with disabilities.

Access to mainstream services are determined by the nature of the services offered and the specific characteristics of the individual seeking assistance:

Some of the generic community and healthcare resources that may be accessed include:

- primary health and allied health;
- specialist medical;
- education;
- employment;
- housing;
- transport;
- aged care services;
- drug and alcohol services;
- mental health; and
- local government and federally funded services e.g. HACC, Residential Aged Care.

However, the requirement for service coordination to facilitate planning, selection and access to such services may be different for people with disabilities.

Service coordinators at a regional level can contribute to inclusion through partnership and collaboration with individuals and families, local organisations and the broader community. The focus is on providing accurate information to support effective decision-making; providing practical support in clarifying goals and strengths; to clarify their goals, strengths and needs; promoting self-advocacy; encouraging the use of personal and local networks to address goals/needs; and supporting service access.

5.6 Tier three – Integrated generic and specialist supports

Evidence suggests that people with a range of different support needs (be that disability, mental health or medical conditions) can be effectively supported in more generic settings, so long as the settings are appropriately resourced and that staff have the capacity to work in an interdisciplinary team manner (sharing their knowledge of the needs of people with disability, and enhancing the capacity for others to respond).

As such, tier three includes a range of 'integrated and generic supports'; that is services that perform a generic function (such as providing accommodation), but will require collaboration with specialist services or the use of interdisciplinary teams, with expertise across multiple disciplines (e.g. disability, mental health, drug and alcohol).

In this manner, economies of scale are promoted, allowing providers to cater to a wider group of people with disabilities. This approach also encourages inclusion for people with disabilities.

Integrated and generic supports include services which can address:

- accommodation needs - provide a home environment for individuals;
- personal care;
- need for respite – providing support informal networks and building the capacity of families;
- support employment or other occupational options; and
- create opportunities for leisure and recreational activities.

The large majority of people with disabilities (who are unlikely to meet the threshold for specialist support and have this intensity of support needs) could benefit from the inclusive approach.

5.7 Tier four – Specialist disability services

The aim of the Specialist Disability Support System is to protect the most vulnerable. Services are generally targeted at people with profound or severe disability and aim to increase the level of independence. Examples of Specialist disability services are Lifestyle Choices that provide a learning environment and meaningful activities targeted exclusively at the disability population and individual support, designed to meet the care needs of people.

Individuals requiring access to specialist disability services or more intensive community supports undergo eligibility determination and prioritisation via regional network, who act as a gateway to determine and provide:

- eligibility;
- prioritisation;
- service coordination and/or case management; and
- planning and review.

Service approaches

The service approaches should be described in relation to the key outcomes that they aim to achieve for the person with a disability. In describing them in this manner, this is an opportunity for: innovative program design; development of flexible options to meet individual needs; and achieving outcomes which are meaningful for people with disabilities.

Two examples of more flexible services include:

- *Creating a 'home' (outcomes = a home, relationships and social connection)*

  Persons with a disability, like all people, want to live in an environment that is comfortable, safe and welcoming to them, their family and friends. People with a disability, where appropriate, should be able to choose where they want to live, who they want to live with and in what configuration (e.g. group setting, living alone in the community, sharing with a friend etc.).

  The current service system often provides a home setting for individuals that is unwelcoming and institutional. Individuals are forced to fit in with support routines which impact on their ability to make their own life choices (for example, the capacity to decide when they go to bed). Client mix is an important factor in creating a home for individuals, where possible community norms should be mirrored with homes shared by people of a similar age with common interests.

  Providing people with a disability with a home requires careful planning and assessment of needs. Innovative home options exist in other jurisdictions and should be considered when aiming to meet the needs of people with a disability.

- *Support for individuals and families (outcomes = maintaining health, well-being and capacity building)*

  Support services that may be accessed to provide:

  - planned breaks for family members caring for a person with a disability;
  - peer support for families (including parents and siblings);
  - other flexible supports that recognise the demands of the caring role, the stress this places on the family and offers flexible means to address this; and
  - assistance with making the decision to and plan for relinquishing care.

  Through the development of individualised and innovative support services, the aim of the service is to sustain people with a disability in their home environment (wherever possible) by relieving carer strain, and building the continued capacity of an informal support network.

  New approaches to service development may be considered to make accessing these programs more attractive to people with disabilities, their families and carers. This includes providing services in a range of settings and the integration of the individual's and family wishes. Services should be tailored to meet individual needs and range in duration from a few hours (e.g. accessing childcare, or participation in a peer support group) to a number of weeks (e.g. residential options or one-off funding for a holiday).

More details of the life-course approach to service delivery is included in Appendix A.

Regional coordination and access

Regional coordination and access will enable between system navigation and coordination at the region level, with transparent processes for eligibility prioritisation and demand management.

Current challenges

NGO providers and others described a service system which involved crisis driven responses, with little forward planning for changing and emerging needs (e.g. the likely deterioration in health condition, or transition from school) and services being provided to people with disabilities on the basis of 'what's available', rather than based on the best fit to assessed risk and need.

There is no consistent approach to assessment and prioritisation of need/access within the disability services program. In the majority of cases, individuals enter the system through the disability services (the Service Coordination team). However, some individuals gain access to services through direct approach to an NGO service provider.

In addition, assessments undertaken by the Disability Services Service Coordination Team generally indicate eligibility for a disability service, with a lack of clarity about 'priority'. Inequity may arise as a result.

There is little evidence of ongoing review of individual needs. Under existing processes, individuals gain access to services and supports, and seem to maintain such access ad infinitum.

System navigation is also problematic, with a lack of information about services and supports available to people with disabilities and their carers/families. The onus was generally perceived to be on the service user/family to determine the relevant service options, understand the differing roles of service providers/service types and gain referrals.

Vision for the future

The key focus of regional access and coordination is to implement and coordinate service delivery on a regional basis. A single agency within each region (or a consortia of agencies) will take responsibility for managing the regional access and coordination function.

To enable effective collaboration, regional network partners (that is DHHS and funded disability providers) will identify staff to participate. Importantly, this will also engage other mainstream DHHS services including health, primary and community health, mental health, housing, HACC, child and family and aged care. Effective partnership-based arrangements will enable the network to achieve its identified priorities.

Such partnerships are required to enable person-centred service delivery to individuals. As such, this work will focus on the use of common prioritisation and referral practices, coordinated intake arrangements for community-based services, and the development of local protocols based on an individual's journey through the service system.

The focus will be on:

System navigation and coordination

A single, visible point of access to services on a regional basis, offering a single telephone line or well advertised points of contact (so there is clarity about 'how to access services'); and consistent, up to date information about the choices people may have for disability and other health and human services, advice about eligibility and availability, and about 'next steps' in accessing services. This will act as an initial gateway to the disability system, and to mainstream services for those with a disability.

Importantly, there will be a capacity for the access point to act in a service coordination and/or case management role, depending on the level of individual needs. Relative roles and responsibilities may include:

- service coordination: providing information and assistance in identifying and accessing community-based services and informal support networks; and
- case management: for those with more complex needs, case management will take an ongoing role in developing a case plan which informs a process of effective and accountable service provision based on specified and desired outcomes. This may involve arranging and coordinating services both formal and informal and monitoring/evaluation of the process. This will also encourage 'shared responsibility' for care, amongst providers, i.e. between disability and family services.

Both will focus on ensuring that individuals with disability are able to achieve their full potential and attain a quality lifestyle within the community of their choice.

Eligibility and prioritisation

To support equity of access to disability services, regions will be required to implement a consistent process of eligibility determination and prioritisation.

In terms of process, an individual's eligibility and priority of access for support determines the nature and level of support to be provided. The focus should be on considering the availability and appropriateness of mainstream service options in the first instance, before considering specialist disability alternatives.

As the focus of the specialist disability support system is to protect the most vulnerable, access to the specialist disability support system is based on a determination of an individual's relative need.

Eligibility for specialist disability support occurs at two levels, with the third level determining a person's priority of access[23]. This includes:

- Tier 1 – entry to the specialist disability support system. In all instances, the legislative framework that underpins the specialist disability support system in Tasmania determines the potential population that can access the specialist disability support system.

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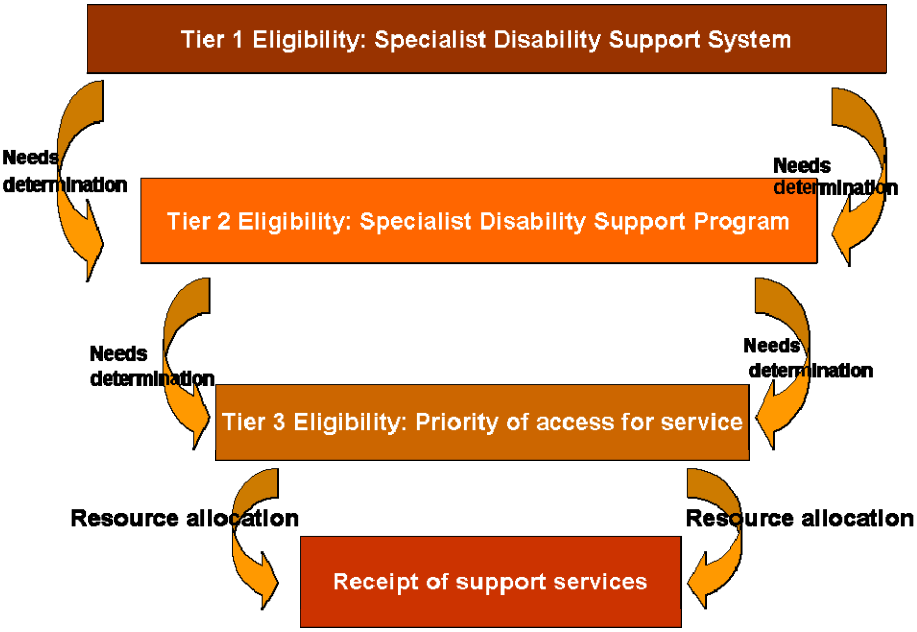
[23] This section builds on work KPMG is completing nationally in relation to the development of a National Resource Allocation Framework.

- Tier 2 – entry to specific programs. Within the potential population, the nature of the program to be accessed and the functional impact of a person's disability and the resulting need for support determines the potential sub-population eligible for service from a specific program.
- Tier 3 – priority of access. Within the population of people eligible for a program, priority of access determines who receives support. Priority of access is based on functional impact, need, risk and benefit [24].

Figure 7: Eligibility and prioritisation for specialist disability support services



KPMG (2005), Adapted from the Development of National Resource Allocation Framework.

Early intervention, monitoring and follow-up

Regional access and coordination should also have the capacity to perform an early intervention, active monitoring and follow-up function, particularly for those people with disabilities who are generally self-managing (and do not have an ongoing relationship with a service provider) but may be at risk for a number of reasons, e.g. concern about the sustainability of care arrangements.

This could occur in the form of a regular (e.g. monthly telephone call) just to touch base, and ensure that all is well with the individual.

Key functions include:

- monitoring of self-management;

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[24] This sections builds on work KPMG has completed in relation to the development of a National Resource Allocation Framework.

- promoting healthy lifestyles;
- identifying changing needs and emerging risks;
- improving the communication and coordination between care services;
- facilitating skills for coping with changes in circumstances; and
- facilitating access and referral to appropriate services to address need.

As such, monitoring and follow-up represents an early intervention response, pre-empting crises. This approach will ensure a planned response to changing needs[25].

Demand management

At the individual level, key principles of demand management will apply across the regional networks. The focus will be on ensuring that referrals are acted upon based on priority of need and actively engaging people with disabilities and their families at the point of referral and, if appropriate, providing short term supports which address immediate needs (potentially preventing a crisis situation from occurring).

From a planning perspective, demand management will focus on identifying areas of unmet demand, including:

- needs unable to be met by the existing services (either mainstream or disability specific);
- areas where existing systems (including funding or policy guidelines or the lack of shared responsibility for care) is preventing access for those with a defined need; and
- system gaps, such as a lack of early intervention services or employment options.

There should then be the capacity to build this information into the regional planning process, re-deploying existing resources appropriately or developing a case for additional funds to enable new service development and innovation.

Performance monitoring and feedback

Performance monitoring and feedback at the regional level will inform the quality of service provision, support continuous improvement and support a focus on outcomes for people with disabilities.

Regional networks will perform a number of roles with this focus. Members of the regional governance body (comprising DHHS, NGOs and people with disabilities, their carers and families) will be responsible for monitoring the performance of agencies in the region from a responsiveness and individual outcomes perspective, to ensure each agency is meeting its requirements as a member of the regional network.

Regional network partners will also be encouraged to identify opportunities for organisational capacity building, supporting the transfer of skills, knowledge and experience, as well as best practice and innovation in service delivery, between agencies to build the sustainability of the sector into the future.

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[25] For example, Local Area Coordinators play a similar role in the WA context.

This should be underpinned by a focus on continuous learning. This recognises that learning enhances capacity building, and provides opportunities to be open to different ways of responding to needs.

Example of where this is already occurring: *DHS Victoria - Child FIRST, Child and Family Information, Referral and Support Teams*

6 Benefits of a new approach

This new approach will have tangible benefits for people with disabilities (and their families), service providers and the government, alike.

Benefits to *people with disabilities and their families* include:

- easier access to services – both mainstream and specialist;
- increased satisfaction as their needs are identified and responded to in a consistent and timely manner;
- consistent prioritisation processes focusing on individual needs, rather than by 'what services are perceived to be available';
- timely information and advice about the availability of local resources and the means to access these; and
- earlier intervention enabling support before a crisis situation has been reached (planned transitions).

Benefits to *service providers* include:

- the capacity to work in partnership with Government from a system governance and planning perspective. As partners, NGO providers will have an unique opportunity to inform service system development;
- a plan to support a sustainable and skilled workforce into the future, meeting the demands of labour and workforce shortage and the ageing population;
- access to a larger database on client activity, interventions, and service delivery patterns;
- incentives for effective performance;
- capacity to work more effectively with people with disabilities:
  - relationships developed with local agencies will support better knowledge of the service system and the capacity to more easily facilitate joined-up responses;
  - there will be capacity to identify the full range of services and supports being provided to the person with a disability, and therefore improve coordination of care; and
  - there will be an emphasis on working proactively with individuals rather than delivering a crisis response.

For government:

- joint planning across DHHS program areas will support better use of scarce resources, both now and into the future;
- greater clarity about value for money and service system effectiveness;
- an ethos of partnership between DHHS and NGO providers, with opportunity for joint sector capacity building initiatives;
- consistency in eligibility determination and prioritisation, enabling equity of access;

- the development of new and innovative models of service delivery, which support meaningful outcomes for people with a disability;
- transparent quality systems, which enable continuous improvement in outcomes at the individual, organisational and systemic levels; and
- a plan to support a sustainable and skilled workforce into the future, meeting the demands of labour and workforce shortage and the ageing population.

7 Recommendations

The following recommendations address the terms of reference for the review, in terms of outlining:

- a clear strategic direction for disability services and new model of service provision, which will reflect contemporary practice in health and human services, and will enable outcomes for people with disabilities;
- the roles and responsibilities of the Government and non-government sectors;
- opportunities to improve operational efficiency and effectiveness of the disability services business model; and
- opportunities to improve non-government service provision.

Recommendation 1 – Overarching strategic direction and model of service provision

That DHHS endorses and implements the entire 'vision for change', within the next three years. This vision should include:

- the creation of an overarching service systems framework – shared governance, planning, measures of system effectiveness, quality systems, resource allocation and funding models, and workforce plan;
- the establishment of a population-based model of service delivery – service options that are reflective of the needs and aspirations of people with disabilities, and include both specialist disability and mainstream services; and
- improving regional access and coordination – system navigation, eligibility and prioritisation, demand management, early intervention and shared regional performance monitoring.

Recommendation 2 - Roles and responsibilities

That into the future, the DHHS role will involve:

- strategic policy and service system development, purchasing, funding and regulation; and
- building the capacity of the NGO sector – placing an emphasis on the development of contemporary disability policy to guide effective service provision, encouraging inter-agency partnerships, and the sharing of excellence and innovation in service delivery.

To achieve this end, all responsibility for direct service delivery will be devolved to the NGO sector over a three year period.

Recommendation 3 - Operational efficiency

That in order to improve the efficiency of the present delivery model and business processes of disability services, the DHHS should develop and implement:

- **Streamlined contract management processes:** a single regional DHHS contact point for each agency, with a clear responsibility for oversighting issues and providing ongoing support of a programmatic and funding nature.

- **Planning by location** processes to ensure resources are better targeted to community needs, with the capacity to re-deploy resources as required. This should be underpinned by: an understanding of the community profile (including the prevalence of severe and profound disability), the current level and mix of services available to address population needs, a clear view about what is required into the future and clear demand management strategies to assess whether existing resources are used to an optimal level. A core part of this process will involve improving the level of data available at the regional level to inform service system development.

- **A new resource allocation and funding model which considers:**
    - relative population need and risk;
    - historic inequities in service access. i.e. the need to promote service system development in the North West which is relatively under-serviced;
    - reasonable costs of service delivery, taking potential differences between regions (i.e. level of geographical dispersion and socio-economic) into account;
    - the capacity to make more efficient use of disability funding, considering opportunities to use lower intensity models of service provision – such as in-home support and community-based models – where these are the most suitable form of support for the person with a disability and their family, and maximise the person's level of inclusion and independence;
    - a transparent and consistent means to allocate funding amongst the providers within a region.

- **Eligibility and prioritisation** procedures that ensure: that mainstream service options are considered in the first instance, before exploring specialist disability alternatives; and access to the specialist disability support system is based on a determination of an individual's relative risk, need, functional impact and the benefit that will be derived.

Recommendation 4 - Effectiveness

To improve the overall effectiveness of the present service delivery model, DHHS needs to:

- **implement clear shared governance arrangements to oversight disability services** – at a state-wide and a regional level. New regional arrangements will encompass a partnership between DHHS, NGO providers, mainstream health and human services and people with disabilities and their families;
- work with people with disabilities and their families to establish appropriate **service outcomes and measures of effectiveness which are measurable and meaningful to individuals.** This will allow for accountability to the individual, the community and Government in terms of the effectiveness of individual services and the broader service system, in achieving 'benefits' for people with disabilities and their families;
- **refine the existing quality systems** to focus on monitoring of performance and quality improvement in terms of outcomes for clients, organisational compliance with standards of good practice, and sector-wide health, innovation and growth. Importantly, this should clearly define risk management systems, including policies and procedures to ensure people with a disability receive high quality support, have their rights respected and all possible action is taken to prevent abuse;
- implement appropriate output **and outcome based performance accountabilities** within funding agreements, underpinned by a clear system of incentives for effective performance (i.e. demonstrating the achievement of outcomes) and sanctions for failing to meet agreed standards. By its very nature, this is likely to create a degree of industry consolidation, with

those providers unable to meet agreed standards of performance exiting the sector or seeking opportunities for merger or formal partnership arrangements;

- **enhance the capacity of the workforce** ensuring the size, composition, shape, skill-mix, knowledge and values of the workforce is appropriate to give effect to the forward direction for disability services;
- implement **single points of entry to the disability system** to enable improved access to specialist disability supports for people with disabilities, knowledge of services available and appropriateness of the service response received;
- adopt a **centralised approach to the management of the systems capacity and demand at the regional level**. This will assist in the identification of unmet demand, the requirement for appropriate re-deployment of existing resources or to the need to develop a case for additional funds to enable new service development and innovation;
- encourage **regional collaboration** – ongoing opportunities for organisational capacity building, supporting the transfer of skills, knowledge and experience, as well as best practice and innovation in service delivery, between NGO providers to build the sustainability of the sector into the future.

Recommendation 5 - Responsiveness of existing suite of services and supports

To improve the responsiveness of services funded to present and future needs, DHHS should:

- implement a population-based model of service delivery with its emphasis on:
  - supporting informal networks and community to ‘care;’
  - facilitating appropriate access to mainstream services;
  - moving beyond the current traditional array of fixed service offerings, to those which best address the needs of individual regions (and are identified through the shared governance and planning arrangements); and
  - developing a continuum of services based on a life-course approach - overcoming the ‘gap’ between early intervention, child, adolescent, and adult services.

Recommendation 6 – Implementation

- That DHHS (in-conjunction with NGO providers, and people with disabilities) develop a detailed plan to support the implementation of the vision for change over the next three years. The implementation plan should include the identification of key areas of action, timeframes and milestones, responsibility for implementation, and how implementation activity will be monitored.

- That the implementation of the proposed reform program is managed though processes and utilising resources that are separate to the Disability Services Program.

- That, in order to support implementation, DHHS should develop a clear and ongoing communication strategy to inform all stakeholders about the vision for change. This should comprise:
  - the rationale for the change;
  - what the change will involve and the timeframes over which the process will be implemented;
  - how stakeholders can contribute to the implementation process;

  - the benefits for people with disabilities, their families and carers, service providers and DHHS staff; and
  - next steps and opportunities for ongoing involvement in implementation planning.

Recommendation 7 – Government investment[26]

That DHHS appropriately invest in the implementation of the vision for change, with an emphasis on:

- investment to address areas of unmet demand;
- investment to drive practice change creating new models of support and structural efficiencies; and
- investment to support development and implementation of governance, quality systems, workforce planning, IT and other related supports.

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[26] This is subject of a separate analysis process.

A Service continuum

The following diagrams serve to describe the pathway of an individual with a disability through services required at different life stages. The five life stages are the journey of:

- an infant with a disability;
- school aged child with a disability;
- person transitioning from secondary school;
- person transitioning accommodation; and
- considering moving to a residential aged care facility.

Whilst the diagrams do not mean to identify all the services a person with a disability may require at the designated life stage, it illustrates that services may be accessed from all four tiers of the population-based model of service (informal support, mainstream community support, integrated generic and specialist support and specialist disability support).

1. Infant with a disability

This diagram illustrates the path a family of a child with a disability may take. The family seeks emotional support which is accessed through informal supports (family and friends). Mainstream services support the family through the provision of medical, allied health, schooling and childcare. Specialist services aim to support the family by providing them with opportunities for planned breaks. Services are planned and coordinated through a partnership of the parent and a regional coordinator with expertise and comprehensive understanding of how to access services appropriate to the child's identified needs.

2. School aged child with a disability

This diagram depicts the services that may be required for a school-aged child. Ongoing health concerns are managed by the general practitioner through 'mainstream services'. Recreational supports provide opportunities for developing social and community networks, and a chance to relax. Specialist supports are utilised to develop strategies to assist the child's parent and teachers to better manage challenging behaviour. Generic specialist support, informal networks and mainstream services are all accessed to give the family a rest through the use of paid childcare, friends babysitting, and planned respite.

3. Person transitioning from secondary school

When transitioning from secondary school, the individual is faced with a choice of accessing further education, engaging in employment, or finding some other meaningful activity. Community support can assist in the move to further education with friends and family having a role to assist transition. Community support may also be used to access employment through the use of community networks to identify a suitable opportunity. Services that may be available to help at this time include schools, university, or if gaining employment is the individuals goal, then Centrelink or mainstream employment agencies may be utilised. Specialist support services may work together with mainstream services to facilitate the transition through the funding of support work or engaging a specialist employment agency for those individuals eligible for disability services. A planned activity group or individualised supports my be accessed for individuals not wishing to engage in further education or employment. A program may be developed through the coordination function that matches the individual's interests and needs.

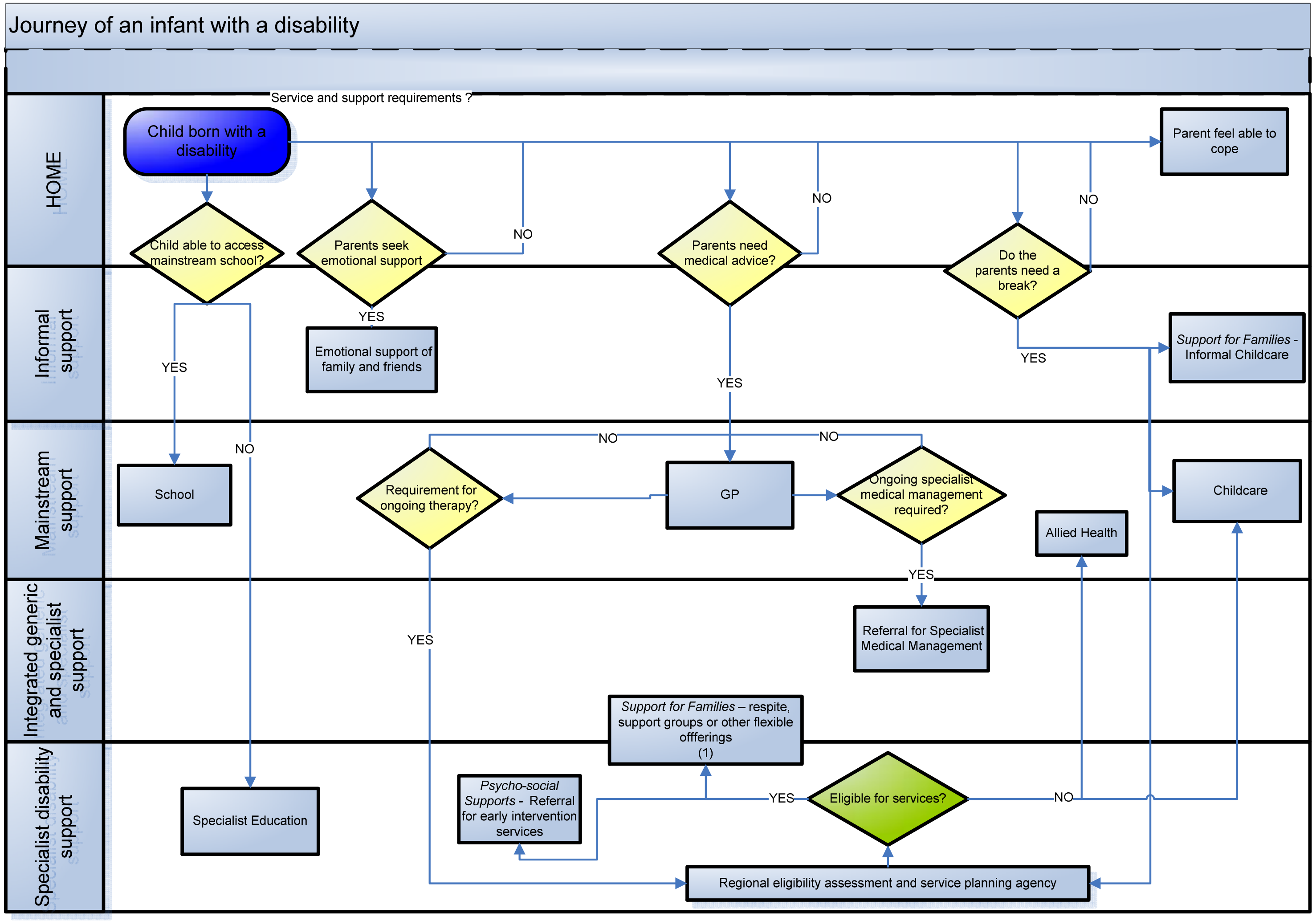
4. Transitioning accommodation

This diagram depicts the transition from a young adult living at home with their family and deciding to live independently. The individual may want to consider living with other family or friend or seek rental accommodation. Community support may be harnessed through accessing friends and families networks to identify an appropriate accommodation option, friends to live with, and to provide informal supports (e.g. assistance with shopping and paying bills). Mainstream supports such as the Office of Housing may be used to identify a home with appropriate access. People eligible for disability services, through accessing a coordination and planning function be given access to funding to purchase supports required to live independently in the community, or identify a home setting that matches the persons desires and needs, such as a group home setting.

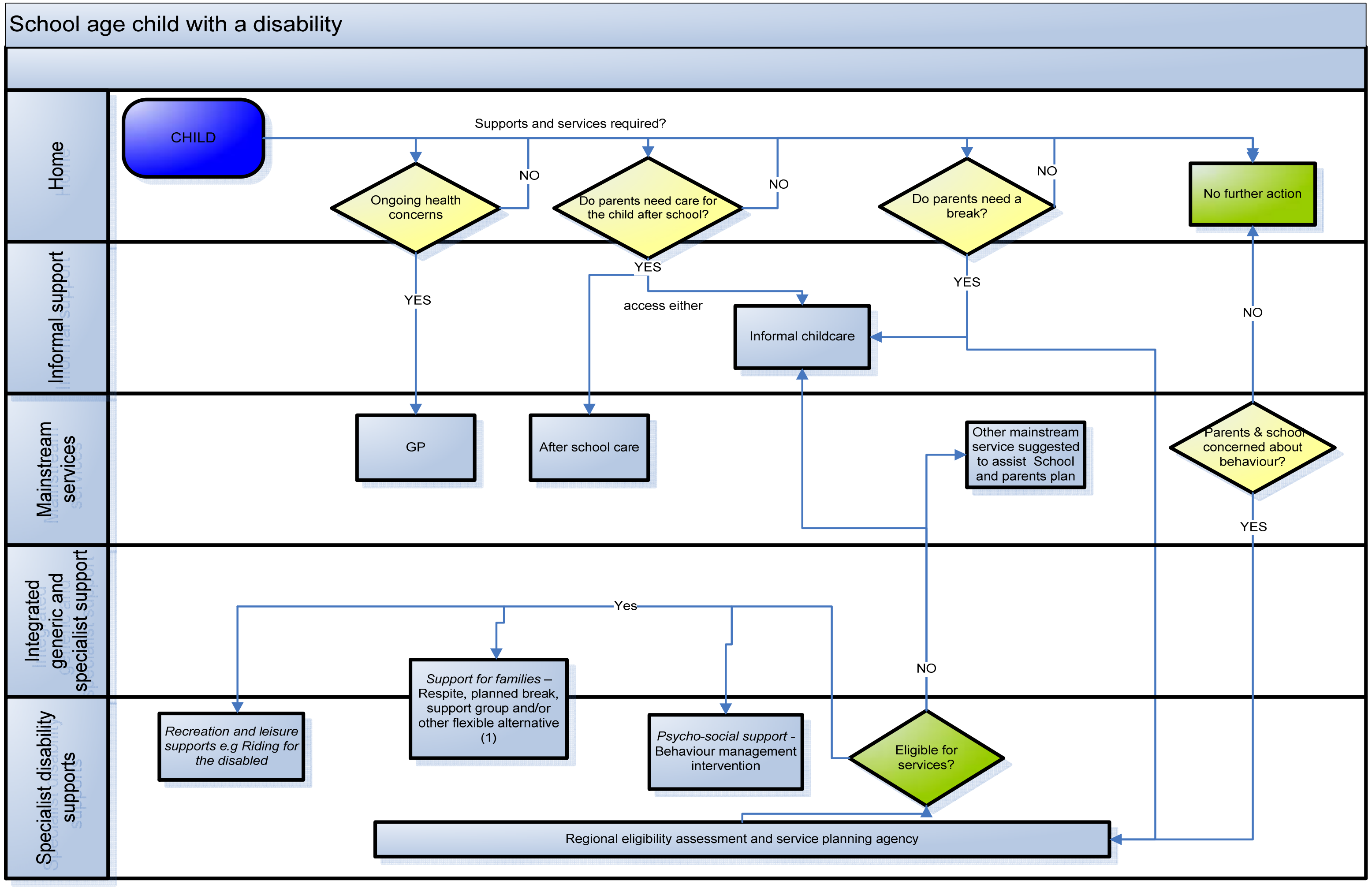
5. Moving to a residential aged care facility.

In considering a transition to a residential aged care facility those people who are eligible for disability services can engage with a coordinator to facilitate the planning proves. An assessment process will identify whether the person may be supported to continue to live in their own home through accessing extra services such as equipment, respite, recreational activities and personal care, community resources may be used to provide informal supports. If continuing to live independently is not possible then an ACAT assessment may be facilitated and an appropriate residential aged care facility identified. Specialist supports may be utilised in the form of advocacy to locate appropriate accommodation.

Journey of an infant with a disability



1. This service could either be provided as a tier 3 service (integrated generic and specialist support) or a tier 4 service (specialist disability support) depending on outcomes of regional eligibility assessment and prioritisation



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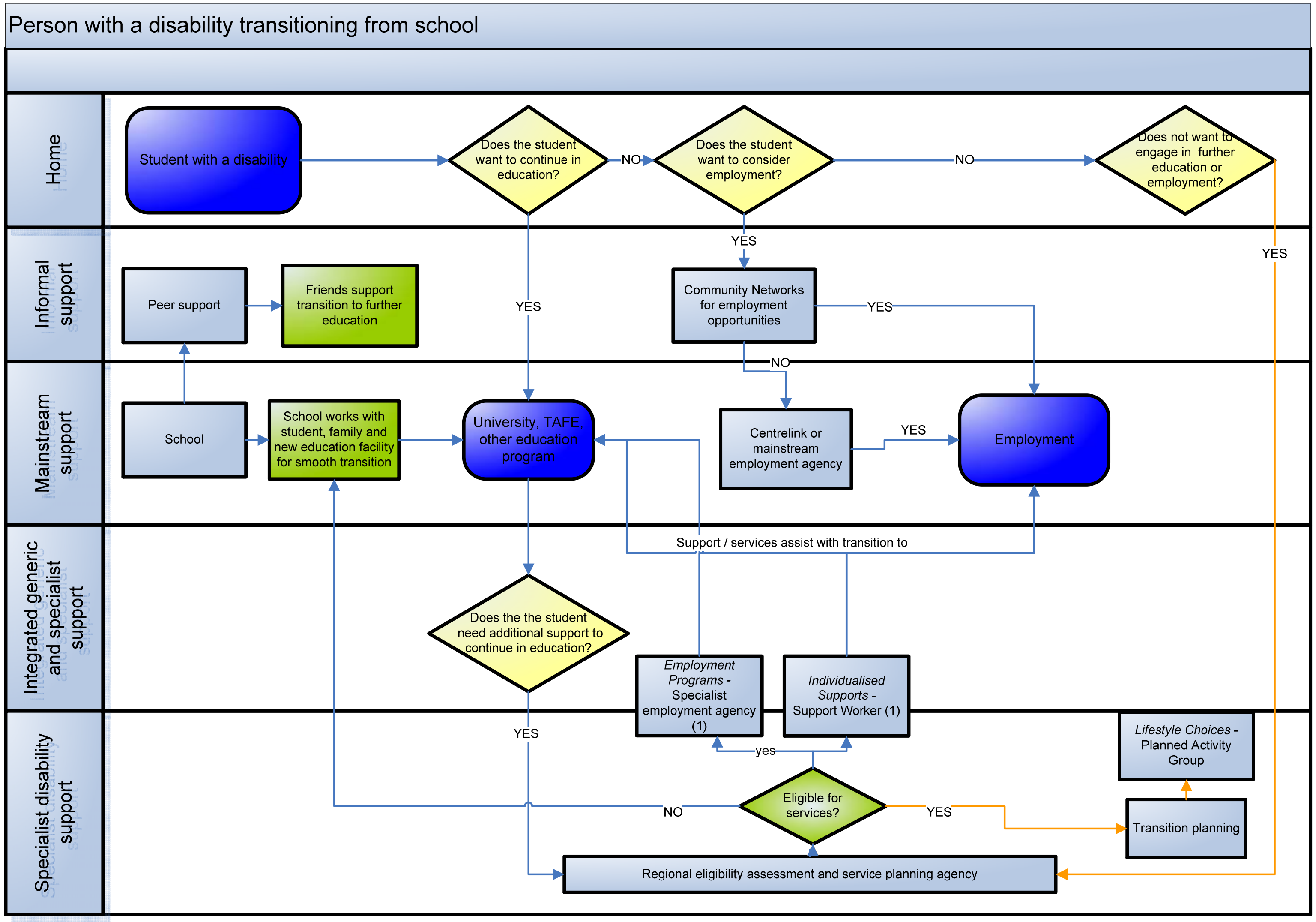

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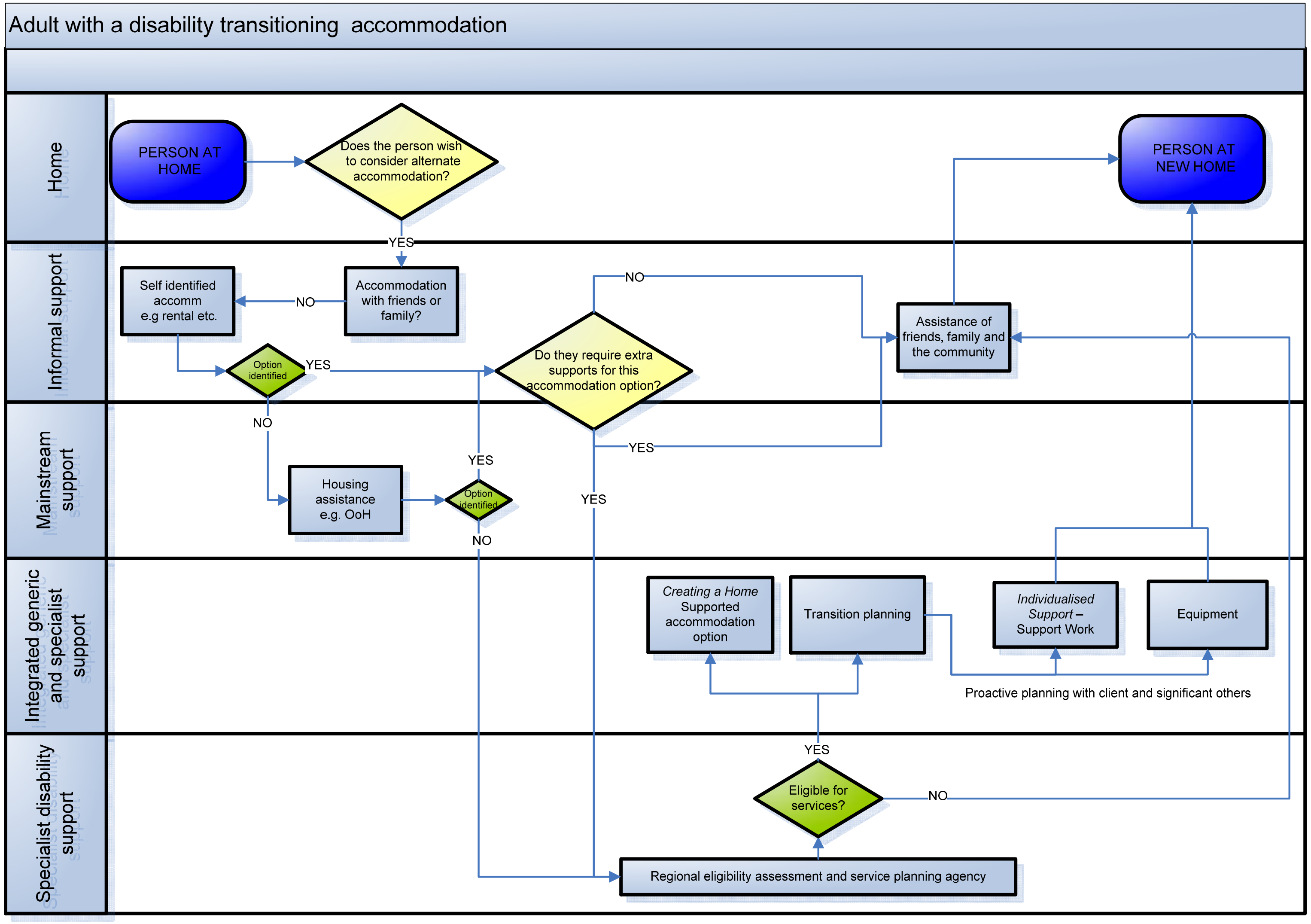
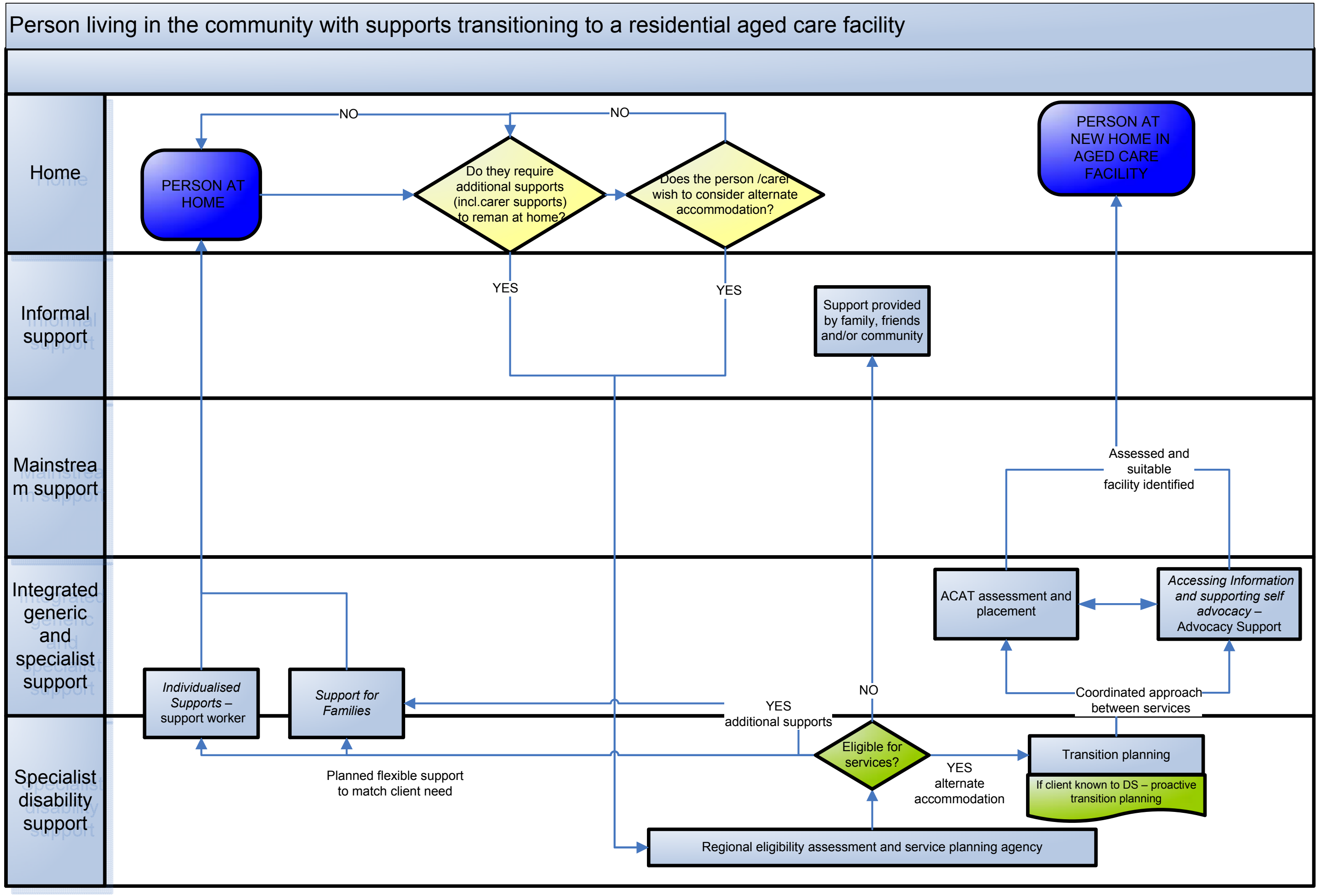

Adult with a disability transitioning accommodation
Home
Informal support
Mainstream support
Integrated generic and specialist support
Specialist disability support
PERSON AT HOME
Does the person wish to consider alternate accommodation?
YES
Accommodation with friends or family?
NO
Self identified accomm e.g rental etc.
Option identified
YES
NO
Housing assistance e.g. OoH
Option identified
YES
NO
Do they require extra supports for this accommodation option?
NO
YES
YES
Assistance of friends, family and the community
PERSON AT NEW HOME
Creating a Home Supported accommodation option
Transition planning
Individualised Support – Support Work
Equipment
Proactive planning with client and significant others
YES
Eligible for services?
NO
Regional eligibility assessment and service planning agency



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B Case studies

The following case studies demonstrate:

- the issues highlighted in section 2 in relation the existing disability services system; and
- how the proposed vision for change, will improve the service response to individuals, families and carers.

Case study 1: Erica

Erica is 9 years old and has a severe physical and intellectual disability. She is unable to walk, and requires assistance with feeding and showering. She also has difficulty in communicating. She is one of a family of five children, and her parents are struggling to meet her needs in the family home, with the support of in-home care and a few days of respite each month.

Realising that the care arrangements are not sustainable, and that they cannot possibly care for both Erica and her four siblings, her parents have sought urgent help.

Outcomes under the existing system:

Erica has been placed in a respite centre, which has become her home for the last two years. Her family maintains frequent contact and she comes home often.

This facility is not suited to meet the long term needs of a child with a disability.

Outcomes under the proposed system:

Erica's parents contact the regional gateway and are seen by the Regional Service Coordinator. Together they discuss the best alternate options for Erica and the family, engaging DHHS Child and Family services in the process. Erica and her family are able to choose from a range of different options including appropriate shared care arrangements - longer term stable accommodation for children with disabilities, which works flexibly and collaboratively with Erica's parents to address her needs.

Case study 2: Greg

Greg is 16 years old and will be leaving secondary school in 18 months time. He had a bike accident at the age of 14 and has an acquired brain injury. Overall, Greg is a motivated teenager and is looking at the various options for transition to appropriate day activities or assisted employment.

Outcomes under the existing system:

Greg receives access to the closest day options program which has a vacancy. There is limited discussion about other alternative services, and what outcomes he would like to gain.

Outcomes under the proposed system:

Greg and his parents approach the regional gateway within the Northern region for assistance, where eligibility assessment and prioritisation is undertaken. Importantly, the Service Coordinator talks to Greg about what he wants to achieve from disability services establishing that independence, capacity to participate in the community, and the opportunity to maintain and develop social connections and relationships is important to him.

As an outcome, Greg is linked into an appropriate day program, which allows him to develop basic woodwork and carpentry skills which are an interest of his. The program also assists him to develop skills in money handling, and to use public transport, so he can get around independently. Greg's Service Coordinator also links him into the local sporting club, where he is able to participate in bowling, tennis and other activities.

Overall, Greg and his family, were happy with his post-school lifestyle, with Paul's knowledge and independence growing each day.

Case study 3: Thomas

Thomas is 38 year old man living at home with his parents. He has a moderate intellectual disability and a number of other conditions including a mild sight impairment. He would like to move out of home and be more independent, but he is not sure what support is available to him. He also loves the outdoors and likes to be physically active. He is mad about sports and particularly loves AFL. He would like to look at extending his social network, making a range of new friends.

Outcomes under the existing system:

There are limited accommodation options for Thomas in the North West which focus on building and maintaining his independence. However, he is linked into a day options program allows him to participate in a range of sporting activities.

Outcomes under the proposed system:

Thomas and his parents approach the regional gateway within the North West for advice. While undertaking an eligibility assessment and determining his needs, the Service Coordinator asks Thomas about why he wants to move into accommodation and the sort of support he thinks he requires. The Service Coordinator also talks to him about the types of accommodation available and together he and his parents decide that a supported accommodation unit (i.e. independent living with a carer visiting daily) would be appropriate.

Overall, Thomas is happy with the outcome – supported accommodation has provided him with newfound independence. He has also recently sought access to a day program that will teach him other life skills, such as cooking. He looks forward to inviting his parents to dinner!