Submission

No 63

Outsourcing Community Service Delivery

Organisation: Public Service Association of New South Wales

Name: Mr John Cahill

Position: General Secretary

Date Received: 4/05/2012

Public Service Association of New South Wales
General Secretary: John Cahill President: Sue Walsh
160 Clarence Street, Sydney
GPO Box 3365, Sydney NSW 2001
Telephone: 02 9220 0900
Facsimile: 02 9262 1623
E-mail: psa@psa.asn.au
Internet: http://www.psa.labor.net.au
ABN: 83 717 214 309

Our ref: 1250-ALvv

4 May 2012

Mr Kevin Anderson, MP
Chairman,
Legislative Assembly Committee on
Community Services
Parliament House
SYDNEY NSW 2000

Dear Sir,

The Association wishes to present to the Committee the attached Submission for the Inquiry Into Outsourcing Community Service Delivery. The Association is the Industrial Organisation which represents the interests of employees working in the Department of Family and Community Services in the provision of Housing, Disability and Home Care Services.

The Association is prepared to address the Committee in support of our application.

Yours faithfully

JOHN CAHILL
GENERAL SECRETARY

SUBMISSION OF THE PUBLIC SERVICE ASSOCIATION

OF NEW SOUTH WALES TO THE INQUIRY INTO

OUTSOURCING COMMUNITY SERVICE DELIVERY

The Public Service Association of NSW (PSA) is an industrial organisation registered under the NSW Industrial Relations Act. The PSA has 5,000 members who work in housing, disability and home care services provided by the Department of Family and Community Services. In these divisions of the Department we represent all employees with the exception of Nurses working in Large Residential Centres and Care Workers in the Home Care Service of NSW.

Following the announcement of the inquiry on 6 March 2012 the PSA initiated consultation with its members on the terms of reference of the review.

The PSA, through this submission, seeks to put before the Committee the issues raised by our members in regards to the outsourcing of community services from the Government to the non-Government Sector.

In our submission, the reference to the non-Government Sector (NGO) means the not for profit sector. We wish to make a clear distinction between the NGO sector and the private for profit sector (Private Sector).

The PSA is strongly opposed to the Private Sector providing community services for profit.

This submission is based on information provided by our members and delegates at meetings and through written correspondence. Where we have quoted our members directly, we have not identified them as they are current employees of the State Government.

Our members are concerned that the Government will make a decision to not be involved in direct service delivery.

Our submission is predominantly centred on services currently provided by Ageing, Disability and Homecare (ADHC) as this is the area that has experienced an expansion of NGO involvement over recent years. The submission therefore focuses on this issue.

The PSA believes that, in order to ensure the availability of quality community services for all people, irrespective of where they live or their socio-economic background, the Government must maintain its position as a significant provider of services in housing, disability and home care.

The PSA recognises the vital role played by the NGO sector in the provision of these services and that there are NGO's that deliver quality services and are committed to providing the support that they are funded to provide.

The PSA does not wish to engage in unfavourable comparison between the Government and the NGO sector, however, in supporting the critical role played by the Government as a provider, there will be examples given and issues raised that come from our members and their experiences working with the NGO's. Our members are very clear in their opinion that NGO's have always been, and will always be a major provider of these services, however, they do not have the capacity and required infrastructure to take over the whole of the work currently provided by Government Agencies.

Capacity of the Non-Government Sector (NGO)

It is certainly the case that the NGO sector and their role in providing community services have expanded significantly over the last ten years. In Disability Services this was due mainly to the enhanced funding received under Stronger Together and Stronger Together 2.

There is, however, extreme concern expressed by our members regarding the capacity of the NGO sector to provide these services. In particular, whether there is a sufficient number of NGO's with the capacity to take on the provision of services in rural and remote areas. The lack of NGO's in these areas could lead to a single organisation providing whole of life services. This has often been used as the reason behind the outsourcing of ADHC operated services, i.e. to allow people to receive services from a variety of sources, and to allow them a choice of service provider. The

Government, by remaining a provider in rural areas, will allow people to have a choice.

The comment below sums up the concerns expressed by ADHC staff;

> *"In my experience the very complex people that we provide service to can not always be managed by non government agencies. There have been many instances where clients come back to the community access team and ADHC accommodation because NGOs have been unable to continue providing services to these clients."*

And from another;

> *"ADHC traditionally takes on the more difficult clients, the funding of NGOs does not take into account the number of vacancies in the NGO sector at any given time. I have known a number of NGOs who have had funded vacancies for 12 months or more, and continually decline clients ADHC refers to them usually because their needs are perceived as too high or they are 'incompatible'. A number of clients get evicted from NGOs for the same reasons.*
>
> *I know of at least one respite service which flatly refuses to take clients with 'challenging' behaviours – in effect they cherry pick easy to manage clients. Can you see an ADHC respite service doing that?"*

And from another;

> *"NGO's may decline a client on grounds of complexity and that it will exceed the level of funds... or they will provide some service to the limit of the funds and these may not be enough to address the issue of behaviours or client safety."*

Our members working in NSW Housing tell us that there are existing issues with the current community housing providers delivering housing services in a different way and on occasion with a different expectation of clients and/or understanding or interpretation of policy and guidelines.

During our consultation process, many members came to us who had worked in both the Government and NGO sector. It is important that their personal experiences as front line workers are put before the Committee.

The following are examples of comments we have received:

> *"I have worked in Disabilities for 28 years, and over this period worked in both Government and NGO Services.*
> *I have always returned to DADHC; the main reason being, DADHC has a much more sophisticated system of accountability, resulting in a much better Service to clients, and more organized Service delivery. If a problem arises there is always a reference point to refer to solve any disputes, as to the 'right way' to deal with matters.*
> *NGOs do not have such efficient systems in place.*
> *This also results in a safer more reliable delivery of Service."*

And from another:

> *"One thing that worries me between non government and government positions is the level of skill. I have worked in both non government and government positions. The only training received in non government is internal training. This is not of a high standard at all. In the Home Care industry staff in administration do not follow policies like government departments. Often they are told this is how it is done, not necessarily what is correct procedure.*
>
> *I also worked as a service co-ordinator for an agency and was told, it doesn't matter if the staff aren't qualified, we will lose the job if we say no. In this position I was also told you don't need to have written instructions on medication that needed to be crushed. Because of my experience at working in the government and how you are drilled with policies and procedures, non government organisations do not always comply with this. I left this position after several arguments on what is legal and what is not, but know whoever held my position after me may not have known any better."*

And another:

> *"I have worked in the disability sector for the past ten years as a disability support worker. The first five years with two NGOs and the past 5 years with ADHC.*
>
> *And so the main difference that I found working with ADHC was that everybody is accountable. And if there is a change of manager, the routines and structures remain in place regardless. As a result, there is consistency in service delivery and little or no impact on the client."*

Allied Health Services

The Government currently provides Allied Health Services which, no one will dispute, provides a critical support for people with a disability. The Allied Health Services include physiotherapy, occupational therapy, speech pathology, social work/case management, diagnostic services including medical and psychological, and behaviour intervention.

Working in disability is a specialist field which takes many years of training and experience. Attracting Therapists to work in the disability field is difficult. Our members tell us that working in an NGO is undesirable due to the conditions of employment and so NGO's often pay mainstream Therapists for services. Our members are aware of some Therapists in private practice that increase their fees when they know a client has Government funding.

As Allied Health practitioners working with people with an intellectual disability (PWID), our members have provided the following in support of this submission.

Allied Health practitioners believe that Government operated services provide the following:

- Opportunity for researching best practice in disability service delivery - weekly therapy in clinical settings has been shown to not be as effective as implanting interventions into everyday life practices.
- Standardised level of care - if you travel around the state you can tap into a service that is recognisable from centre to centre.
- Regional peer support - access to a corporate body of knowledge through colleagues. In rural or regional areas, it is difficult for therapists to have access to the breadth of experience that is available from a state wide team if they are working in isolation.
- Supervision - systems in place to monitor effective clinical interventions which are not grounded in supporting a profitable practice but on the needs of the client.
- Ensure all PWID have access to the same standard of care through the geographical location of community support teams.
- Close scrutiny of costs and outputs versus inputs through the various systems in place to monitor client throughput, file audits, and community development projects.

- Maintenance of standards of excellence - no system in place to ensure private practice maintains appropriate current skill level. Audits by professional bodies may count professional development hours but not the quality of training and whether participants put the training into practice. This is done in ADHC.
- Person centred practice - as a service delivery style, this is being delivered across all ADHC streams, including accommodation and respite and community support teams.
- Trans disciplinary intervention approaches - ability to work with multiple therapy disciplines to achieve a common goal; it is harder to coordinate members from a variety of organisations to attend common meetings to achieve a common outcome.
- NGO's have a variety of focus, some of which target different client groups, not intellectual disability. E.g. The Cerebral Palsy Alliance strongly focuses on cerebral palsy in those under 18 years, but not for adults.
- ADHC has a focus on "through the life span" with support across the life span, catering for adults and ageing PWID.
- Support expertise in disability across the lifespan, with systems in place to ensure staff have appropriate training.

Our members working as Allied Health Practitioners have identified the following problems in dealing with the NGO sector:

- Supporting a change in culture from a deficit based service to a person centred strength based service.

  One example given by members was of a private Physiotherapist assessment of an adult woman with intellectual disability and physical limitations. The assessment report highlighted her weaknesses without any reference to her strengths, the things she can do and should be encouraged to do to maintain her independent mobility and physical fitness. This resulted in a home based care plan where she became totally sedentary with the risks associated with a sedentary lifestyle. An ADHC physiotherapist later assessed her limitations and what she can do in order to develop a plan to improve her abilities and reduce the risk of a sedentary lifestyle. Doing exercises per se for this individual would not be effective, but encouraging her to participate in simple household tasks and to move around the house on a regular basis throughout the day would improve her engagement, mobility and range of interests, and reduce her frustrations, thus lessening the burden of care for the residential care workers.
- Difficulties in getting a range of service providers with differing modus operandi and core business, staffing models and expectations to centre on the needs and wants of the individual to develop a person centred plan. Each area has its own group or lack

of services, and as services are centred in different regions, each cluster will have its own issues. Therefore, when families move around it will be harder for them to link up with appropriate services with the same standard of care, direction and support, if no or limited government services are available.

- Difficulties accessing specialised equipment across the person's lifespan.
- Difficulties in coordinating home medication services and addressing accessibility concerns i.e. assessing client mobility needs, assessing the space where the person lives, or spends a considerable amount of time during the day.
- Difficulties in coordinating funding options where the basic Enable equipment does not meet the needs of the client.
- Covering the costs associated with attending meetings, assessing environments, writing reports, attending case conferences for complex and critical clients, and transitioning clients through significant life points - whereas these are built into the services provided by ADHC therapy and case management interventions, they will take a significant portion of an individual's funding if they are to be achieved effectively in the NGO sector.
- The Cerebral Palsy Alliance in regional areas only supports complex clients up to school age. There are no direct care services apart from government services to support clients once they leave school. There are advocacy services provided by NGO's, but if ADHC is no longer a provider of direct care, then there may only be generic health

services to meet the needs of PWID. These have been shown to not be able to accommodate the various other issues raised by a person's disability which can include limited communication skills, challenging behaviour, and an associated lower level of understanding of what is happening.

- Developing pre-emptive health promotion programs for PWID is not covered by NSW Health or NGO's as they say they are not skilled in this area. There is little research that is inclusive of these programs where PWID are involved; therefore one can only imagine that if the health status of people without disabilities is less than ideal, the situation will be worse for PWID, who research shows have an increased sedentary life style.

Allied Health Practitioners in ADHC believe that the Government should not outsource to the NGO sector. Complex and multi-faceted cases where the support required changes over time cannot be framed in limited occasions of service only, but need to be readily available and have the ability to vary as needs change. Assessment and case coordination, where knowledge of intellectual disability is critical to developing an effective intervention plan for infants, children or adults, should also not be outsourced.

The following suggestions are made on the role of the Government in supporting the NGO's with the work they do:

- Access to training in relevant interventions – currently ADHC group homes can access ADHC Community Support Team staff for specific training opportunities to support specific clients e.g. access to augmented communication systems, mobility strategies, or respiratory care. NGO's do not have access to this specific training locally and must buy in the training. Currently, there is resistance by NGO group homes to access the appropriate support they need from ADHC to support people with Autism Spectrum Disorder. As a result, there is no way of knowing the quality of training NGO's provide, or if the staff put that training into practice. The systems ADHC have in place as an audit tool to monitor the NGO's may look at the amount of training provided (i.e. the quantity), but not at any change in performance as a result of it (i.e. the quality).
- Developing tools to review effectiveness of interventions - NGO's would not have the breadth of client sample to develop tools to review practice on a large scale.
- Implementation of broad based changes in practice to enhance the lives of PWID – NGO's may develop local practice guidelines to suit local situations without looking at the broader context e.g. meal time management tools, lifestyle plans, physical activity plans, etc. Tools that measure the effective implementation of supports are often tick and flick and can be done by NGO's on an annual basis

without indicating daily compliance, and without the understanding of why the tool should be used, how it is to be used, and what it is meant to indicate in terms of enhancing the life of the PWID.

- Government can develop stronger community links to support PWID - Currently ADHC in Queanbeyan is developing a group to link the Department of Education and Training, NSW Health, and Cerebral Palsy Alliance to facilitate effective access to intervention services for children. They are also developing links with community based recreational programs to facilitate inclusive communities. The local sporting bodies are keen to participate but are unable to take the lead in the community to develop this. Many of these initiatives require development and promotion between Government Agencies. NGO's can look after a small group of clients, but cannot support a large sector of people across disability types to promote the changes needed in the local community.

Home Care Service of NSW

PSA members in the Home Care Service are employed in the classifications of branch managers, service co-ordinators, and administrative staff located in the branch and service outlets.

The Home Care Service of NSW (HCS) is the largest provider of support services to help people live independently in their own home. In a recent survey of clients the HCS received a high score of 97% of satisfied clients.

The service, according to our members, is able to provide more appropriate services that are tailored to the needs of clients.

Examples of how this is achieved are:

- The ability for clients to have services for less than 1 hour (i.e. 15 minutes, 30 minutes etc.), whereas at present non-government services have a minimum of 1 hour.
- HCS embraces the Person Centred Planning approach to service provision.
- HCS provide two staff for the provision of services where work health and safety deems it necessary.
- HCS provides out of hours services when they are required.
- HCS train staff to meet the needs of people with especially challenging behaviours.
- HSC liaise closely with other professionals in ADHC e.g. behaviour clinicians, psychologists, case managers, occupational therapists, physiotherapists, speech therapists, etc.

Our Home Care members are concerned about the capacity of the NGO sector to provide the same level of support that is currently provided by the Government.

The following examples come from members in the HCS:

> *"During my time with Home Care, I have a client with progressive MS (young woman paralysed from the neck down living on her own with two very small children). For many years until the children were old enough to help to care for their mother, this client required over 200 hours of service per month. This service involved 2 person hoist services, 4 times a day, which included early starts and put to bed (out of hours).*
> *Quite a few private sector agencies had tried to deliver service to this client, but it proved too costly for them and did not have the resources or careworker experience to provide a satisfactory service. Home Care service is the only service prepared to pick up the out of hours work and provide a satisfactory service with well trained and experienced careworkers."*

And from another:

> *"Recently a client 68yrs old was in a nursing home as initially no private sector agency would provide her services. The husband appealed to the local Member of Parliament and a Catholic Agency was prepared to provide service. Client was brought home and after delivering service for a short time it was deemed that this service would require a 2 person hoist for the 'Get out of bed service' and "Put to bed service'. This agency informed the client that they no longer can provide service as it was too costly to their organisation and that she would need to go back to the nursing home. Home Care is now the only provider who is currently providing service to keep this client in her own home".*

Conditions of employment for staff in HCS

The PSA has been advocating for our members working as service co-ordinators, branch managers and administrative support staff in the HSC to be transferred to the employment of ADHC.

This is because the staff working in HCS are employed on a different award to their co-workers in ADHC. In a number of areas they have inferior conditions and are payed less than ADHC staff while performing similar duties and having similar responsibilities.

This would allow full integration and better coordination of service provision. It would also allow more flexibility of the workforce as the current barriers would be removed.

This was achieved when the HCS Central Office was integrated into ADHC, providing efficiencies and enabling a coordinated approach to the management of client services.

Accommodation and Respite Services

The PSA is strongly opposed to the outsourcing of ADHC operated Group Homes and Respite Services.

In 1999 the then State Government decided to, over a period of three years, outsource approximately 75% of Government operated group homes.

The public outcry was unprecedented. This led to a Legislative Council Inquiry into residential and support services for people with a disability. The Inquiry produced two reports. The first report was published in

December 1999 and looked at the proposal to outsource the group homes. The second report was published in November 2002 and looked in detail at the provision of services.

As a result of the recommendation of the Inquiry, the Government Agency at the time, Department of Community Services, was required to compete with the NGO sector for the identified group homes. The first round of tendering involved 41 group homes.

A significant component of the tendering process was that the residents and their families would have a choice as to their service provider.

At the end of this process, all but two group homes remained Government operated. Any further 'rounds' of outsourcing were then abandoned.

There are two significant outcomes that were learned from this process that the PSA believes still apply today and must be considered as an important factor in any future consideration of outsourcing:

1. That Government run services can successfully compete with the NGO sector to provide efficient and good quality services;
2. That the residents and their families, when given a choice, prefer Government operated services.

The decision at the time, and the profound effect on residents and families, is well documented in the December 1999 report 'The Group Home Proposal'.

The PSA believes that it is appropriate that the Government, through its agencies, controls the funding for community services as well as being a major provider of direct services.

At present, in Disabilities, ADHC policies are written to apply across the whole sector. This was not the case ten years ago when the funding and monitoring arm and the service delivery arm were under separate Departments.

The PSA believes that in order to continue to develop good policy and practice, ADHC must have a significant role as a provider of direct services so as not to lose its knowledge and expertise.

To be able to effectively monitor and evaluate the whole sector, the Government needs to provide the best possible service, to be a role model, and to influence and monitor the sector using knowledge and practice.

The Government has a clear role in providing direct services to people when needs cannot be met by the non-Government sector. The PSA does not however believe that this means that Government should only provide a service of last resort.

At present the Government operated services include specialist accommodation services such as the Community Justice Program and the Integrated Services Project.

These rely on collaboration between a number of Government Agencies and should remain as Government run services.

Of particular concern to the Association is the reluctance of the Government to provide growth funding for the Government sector.

In Stronger Together 2 the growth money is allocated entirely to the non-Government Sector. The PSA is advised that there is on-going funding to provide care and support to existing clients, but that there will be no allocation for growth.

This is particularly concerning to all our members who are caring for clients that are ageing and whose needs are becoming more complex.

Impact on the outsourcing of Government Operated Day Programs to the Non-Government Sector

Up until September 2007, the then Department of Ageing, Disability and Homecare (now ADHC) operated approximately 30 Day Program Services across NSW. Two thirds of the people attending these services also lived in ADHC operated group homes.

A decision was made in 2007 to re-auspice these Day Programs to the non-Government sector.

The reasoning behind the decision, as advised to the PSA, was that the Department was under pressure by the Government to make efficiencies and so they had decided to 'get out of its smallest area'.

In a letter to staff, however, the Department justified its decision by stating that 'a key reason or making this change is to ensure that residents of DADHC operated group homes have a great diversity of service providers giving them support.'

Over the next two years, all Day Programs were outsourced to the NGO sector.

PSA members working in Disability Services have raised numerous concerns regarding the re-auspice of day programs, these include:

- Repeated incidents of clients not being accepted for minor health complaints such as a 'sneeze' or a 'headache' or if they were given a dose of movical or coloxyl as part of their regular bowel management. Staff in group homes are, in these cases, required to stay back in the group home to cover the unexpected increase in client support. This results in a large increase in costs for the group home.

- Repeated incidents of clients returning to the group home covered in dried faeces or with faeces stained clothes in their bags.

  > *"the response that we get is that 'we can't be supervising every client on the toilet' despite our request for the Day Program staff to monitor and record bowel charts"*

- The most frequent and common problem is that Day Program providers require strict adherence to drop off and pick up times. Our members have raised concerns that clients have been refused access if they arrive late with no alternative activities to support the client for that day. This again results in an increase in costs for the group home. Some clients travel independently to the day programs, so this issue does not solely apply to clients that are dropped off by group home staff.
- There have also been many examples of where Day Program staff have not communicated to Group Home staff if the client has been involved in an incident.

From a PSA Delegate:

> *"some members have expressed to me that clients have been in a distressed state when collected from NGO run day program services or they have witnessed other clients having behavioural episodes and staff not being able to deal with the situation.*
> *I myself have been in a situation where one of my clients was playing up at day program and when I went to collect them the day program had been unable to use PRN as they could not get hold of the delegated approving officer, where I was able to use PRN with out this."*

From an ADHC Case Manager:

> *"It is already becoming clear that under the service of NGOs provider, the clients and their families are experiencing serious problems. Some of these include loss of entitlement attendance hours due to breach of condition of service agreement on behalf of NGOs, reluctance or even refusal to accept clients with behavioural issues and exiting of these clients from their services. The privatisation of the day programs has clearly resulted in loss of services where it is most needed causing family breakdowns and crisis.*
>
> *The role of ADHC involves consulting with the NGOs to supervise their financial activities and daily quality assurance for the case of the clients. Although ADHC is responsible for supervision and monitoring of NGOs, it appears that ADHC has little control over preventing these problems from occurring."*

Person Centred Approach

The PSA supports the Government policy initiatives that provide people with disabilities and their families' access to good quality services. Our members have adopted the person centred approach to providing care and support to people with disabilities. Staff have and continue to be trained in policies and practice methods to implement the person centred model of care.

The PSA is however strongly opposed to any policy initiative that allows private-for-profit service provision for these community services.

The recent announcement by the Government that 'for the first time, the private sector will be allowed to compete directly with the Government and

non-profit Organisations in the provision of services' is of extreme concern.

A clear and noticeable difference between Public and Private sector services is the ability for staff in the Public sector to access training, peer support, senior clinical guidance, and ultimately services provision "Best practices" from the Office of the Senior Practitioner. This model of Public system service delivery, supported by a strong management structure, ensures that the services clients receive are stringently controlled. Employees providing the services are guided by experienced staff at all steps of the service delivery process. Methods of practice are up to date and follow evidence based practice methods. Private sector employees currently do not have access to such a stringent and guided service. Under a Private sector industry, profits and cutbacks will be an inevitable element of service provision as competition will breed an attitude amongst the Private sector of cutting all unnecessary costs. Peer support, senior clinicians or Practice Leaders will not be as easily accessible. Ultimately service provision to the client will suffer as the level of evidence based practice will diminish. Currently NGO's do not have the level of staff development the Public sector enjoys. There are no signs in the government's public to private shift that shows whether the NGO's or the private sector will have better practice support methods.

CONCLUSION

Service provision to people with a disability needs to be done under a system that has multiple points of quality control, accountancy and practice support. Public sector service provision does this because services are provided as a whole of agency system. Government employees are able to work collaboratively with other professionals. Collaborative practice is best practice. Under a Private sector system, collaborative practice will be inherently more difficult as intercommunication between Private businesses will be stifled by the onus of service competition and the protection of tender acquisitions as price becomes a considerable or sole determinant.

The Government plays a critical role in all areas of direct service delivery and the PSA believes that the impact of any decision to not provide direct services needs careful and thorough scrutiny.