Submission to the Productivity Commission's Inquiry into Delivering quality care more efficiently

Young People In Nursing Homes National Alliance

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> *[Collaboration] offers the potential to devise interventions that are not only superior in quality and innovation through the combined knowledge, expertise and resources of different agencies working together, but also facilitates the delivery of solutions through mechanisms and frameworks based on participation, ownership and stakeholder involvement.*[1]
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> *These reform directions require a shift from seeing the disability service system as the source of all support for a person with a disability, to seeing the disability service system as one part of a broader service response that complements other informal and formal supports (including health, education, housing, employment and income support). This shift towards more inclusive mainstream services and a greater emphasis on informal supports is in line with progressive thinking that is at an early stage internationally.*[2]

Introduction

The Young People In Nursing Homes National Alliance is pleased to provide this response to the Productivity Commission's inquiry into *Delivering quality care more efficiently.*

We begin by acknowledging that Australia's human services system urgently needs reengineering.

Its current arrangement of siloed programs that operate in isolation from each other is inefficient, costly and unable to deliver the suite of services that Australian citizens and those with disability need.

Reengineering the human services system to enable programs to work with one another on shared problems and develop responses that benefit all stakeholders will

- Share resources
- Reduce service duplication
- Deliver integrated services and improved health and well being for all services users including Australians with disability.

Making a difference

Australians with disability often require concurrent support from multiple human services programs. The three programs adults commonly access in parallel are disability, housing and health services. Children with disability will often require access to disability, health and education services. Older Australians with disability may require assistance from the health, housing and aged care arms of the service system.

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[1] Williams P, "Special Agents: The Nature and Role of Boundary Spanners", ESRC Research Seminar Series *Collaborative Futures: New Insights from Intra and Inter Sectoral Collaborations*, University of Birmingham, February 2010: 3.

[2] KPMG *The Contemporary Disability Service System*, Final Report, Prepared for the Victorian Department of Human Services, May, 2009.

Enabling service programs such as health, disability, education, justice, employment or housing to work together to undertake 'collaborative commissioning' that delivers 'joined up' or integrated service responses will

- Improve the health and well being of all services users including Australians with disability
- Enable Australians with disability to better activate their citizenship
- Identify opportunities for collaboration between currently disparate arms of the social care system
- Target scarce resources more effectively
- Improve the working knowledge of human services programs, each with the other
- Promote partnership and collaboration as the most effective method of engagement and addressing service gaps and barriers
- Improve the human services system's capacity to better support Australians with disability
- Develop joined up services that deliver benefit to all stakeholders.

For our members and others we work with who have complex health and disability support needs, the Commission's endorsement of 'collaborative commissioning' as the way forward makes perfect sense. How else can the integrated multi system service responses they depend on, be articulated?

With some caveats, we offer in principle support for Draft Recommendations 1.1, 2.1 and 3.1.

About the Alliance

As the national peak for younger Australians living or at risk of placement in residential aged care (RAC), the Alliance has provided a range of individual and systemic services to our members since its inception.

Characterised by individuals with complex disability and health issues that can include physical, neurological, cognitive and psychosocial impairments, these individuals commonly require negotiation with programs provided by different government agencies and service sectors to create the integrated service responses they need. A growing number are individuals living with young onset dementia.

As well as working with the disability services system and the NDIS, we work with and across such non disability service systems as health, mental health, aged care, housing and justice to achieve the outcomes these younger people and their families require.

The Alliance has drawn on its extensive engagement with stakeholders to deliver the systemic advocacy needed to resolve the Younger People In Residential Aged Care (YPIRAC) issue and contribute to other policy development.

We have also worked extensively at the interfaces of the NDIS with health, rehabilitation services and aged care and have strong working relationships with state health programs and services.

Reform of quality and safety regulation to support a more cohesive care economy: Response to Draft recommendation 1.1

The Australian Government should pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users

In responding to this draft recommendation, the Alliance makes the following points.

There is clearly benefit in improving quality and safety regulation to support a more cohesive care economy. This includes taking a unified approach to worker registration by developing a national screening clearance program for workers in care sectors including aged care, NDIS, veterans' care and early childhood education and care.

Such a national program should

- indicate the worker's current registration status and the sector(s) they are registered to work in
- provide a work history outline that includes where and for how long the worker was employed and the employer's contact details and
- record any adverse responses or 'red flags'.

With key aims of strengthening oversight and improving overall safety for both care recipients and care workers, maintaining this national database reduces the possibility that workers dismissed for adverse actions by one employer can simply re establish themselves with another employer and/or in another state, without prospective employers being aware of past work performances.

Worker Registration

Of critical importance to people living with disability who require assistance with health maintenance as well as disability support, is the registration of service providers and the registration of individual support workers. The supports required can include assistance with co-morbid diabetes, pressure care, heart health and even basic hydration and nutrition.

Health literacy in the disability workforce is patchy and a constant challenge for participants and providers. With no mandated post Certificate 3 or 4 training, whether workers will have the requisite skills to work with people with particular support needs has become a lottery. The decentralization of the disability workforce, the increase in sole traders, off market contracting and platform providers has made worker skills impossible to guarantee or even measure.

Yet individuals living with such complex needs can routinely require highly skilled assistance to deliver tracheostomy care, bowel care, in dwelling catheter and/or PEG feed care… activities that have the potential to cause fatalities if managed inappropriately.

Workers providing care and support to people with this level of need are expected to have undergone the requisite training and undertake regular refresher training, but we have no way at present of confidently checking on the worker's bona fides in this respect.

In its *Final Report*, the Disability Royal Commission also addressed the issue of a national disability worker registration scheme, calling on the Australian Government to establish such a scheme by July 1, 2028.

The Commission's Recommendation 10.8 addresses this at some length.

In advocating for such a worker registration scheme, the Disability Royal Commission is concerned to improve the quality and safety of disability services by ensuring that only suitably qualified and experienced workers deliver supports, while also increasing the professionalism and overall accountability of the disability workforce.

Recommendation 10.8 calls for a national disability worker registration scheme that

- defines the concept of a disability support worker and includes support coordinators
- establishes a code of conduct and sets minimum standards for registered workers
- mandates NDIS worker screening checks for all disability support workers
- recognises the qualifications, experience, capabilities and skills of registered workers
- requires all registered disability support workers to undergo continuing professional development
- allows workers registered with other relevant professional bodies to be automatically eligible for registration with the disability worker registration scheme
- provides an accessible worker profile portal that allows people with disability, families and support networks to
    - view worker profiles, including qualifications, skills and experience and their registration status
    - track requirements for ongoing professional development
    - improve transparency and accountability across the workforce
- addresses barriers for First Nations workers entering the sector
- explores portable training and leave entitlements for disability support workers.[3]

[3] Disability Royal Commission *Final Report, Vol 10: Disability Services* Canberra, 2023: 18.

In incorporating these comprehensive activities, we support development of a cross-sectoral registration system for care provider accreditation, registration and audit as outlined in Draft Recommendation 1.1.

Caution needed

While the Alliance provides in principle support for a single set of practice and quality standards across aged care and NDIS services, these sectors are inherently misaligned.

A key issue with the alignment of regulation and moving to a single set of standards is the different funding and service delivery frameworks that exist across the sectors in question. Although aged care is about to embark on a more rights based system with its new legislation, aged care industry practice, workforce and regulation is hard wired to institutional service delivery, particularly in residential settings. While critically important, the empowerment of older people and their families in this system will be a significant challenge over time.

In contrast, the disability services sector is now highly individualised and market driven. But there is still a long way to go to equalize power across the demand and supply sides of the disability services market. This key area of safeguarding in the NDIS system is yet to be fully addressed.

Veterans services can cross both of these systems as well as mainstream health and housing systems, with funding administration and workforce playing influential roles; while child care is largely centre based and has its own service delivery and safeguarding imperatives.

Regulation

Regulation must clearly be done in the context of the system it is regulating and be driven by the values and outcomes that the system exists to achieve.

Ideally, these service systems are not ends in themselves but are ways to deliver individual and social outcomes. Despite this, service systems and their regulators too often prioritise process over outcomes and values, breaking the links between investment and outcomes.

A single regulator must therefore be efficient as well as agile enough to not simply be a process hawk, but enable service systems and other actors to deliver the outcomes the various systems were established to deliver. It should not be a one size fits all monolith.

Each of the sectors have features that are instructive to other systems. A single regulator will therefore need to encourage cross-system communication and learning. This will be particularly important as the aged care system moves closer to the disability system in terms of its aspiration to promote rights and choice for older Australians.

With moves to market based systems, regulation is not as straightforward as it used to be when there was a single funder only and centralised service design. Standards and quality

measures must therefore include evaluations as well as audits, prioritisation of user experience and also include scrutiny of commercial transactions and service agreements.

Sector specific expertise

All programs and systems have sector specific expertise that has been developed over many years and is highly valued. The challenge in establishing a unified registration system is to incorporate the best aspects of each sector's knowledge and establish this conjoined expertise as part of a newly aligned regulatory system.

Engaging with consumers with disability and codesigning the new system with them, must be an inherent part of developing any new practice and quality standards and regulatory system that enforces them.

Statutory duty of care

Finally, the critical importance of the practice and quality standards and adherence to them, must be declared and supported by provision of a statutory duty of care that is applicable to all providers, regardless of the sector in which they operate and includes self employed workers.

Such a statutory duty incorporates and is itself supported by significant civil and criminal penalties for breaches of the standards and should be modelled on Work Health and Safety (WHS) legislation. This would require the addition of a duty of care in the NDIS Act, and the strengthening of the Aged Care Act with the addition of criminal liability to the current civil penalty regime.

Work Health and Safety regulators also have a larger role to play in the care economy. With an established duty of care in their legislation that extends to recipients of funded services, they have an important role in educating service providers about risk management and good practice, and the need to play a stronger role in enforcement and prosecutions.

To date, the WHS regulators have been reluctant to become involved in care and support industries that have their own regulators. As a result, they have neglected to pursue breaches of their own legislation when people in receipt of care services are injured or die.

In facilitating this change, the definition of the duty of care should be more clearly defined to include contemporary concepts of choice, decision making and co-design that feature in the disability and aged care systems.

Embed collaborative commissioning to increase the integration of care services: Response to Draft recommendation 2.1

Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings

The Alliance supports collaborative commissioning across the health system as described in the Interim Report.

However, we recommend that the practice of collaborative commissioning extend beyond the healthcare sector and be a feature of funding practice across agencies in the care economy.

In the case of the disability service system, the siloed nature of the NDIS is a major barrier to it achieving its objectives. To do its job comprehensively, the NDIS needs to partner with other service systems that are utilised by NDIS participants.

Improved economic and social participation for people with disability cannot be achieved if the service programs they and civil society more generally utlise, are excluded from the work of Australia's disability funding agency.

Unfortunately, the NDIS and the Australian Government have not progressed interface arrangements with other service systems as they needed to since 2016.

This has not only contributed to the spiralling costs of the Scheme and the level of disputation with participants and health systems. It has also contributed to the problem of NDIS participants who become long stay hospital patients, while collaborative management of concurrent health system and NDIS supports remains largely unresolved.

As well as demonstrably improving the economic and social participation of service users, the embrace of collaborative commissioning across systems to achieve better health and dignity of people with disability, would be a welcome move.

Collaborative commissioning in practice

Individuals with disability the Alliance represents and works with, commonly require multisystem service responses. These responses require negotiation with programs provided by different government agencies and service sectors; and collaboration and negotiation with colleagues from these other sectors to create the integrated service responses needed. To achieve these outcomes, and as part of our work to resolve the young people in residential aged care issue, the Alliance works collaboratively across systems.

As well as working with the NDIS and the broader disability services system, we work with and across whatever service systems and sectors are needed to deliver the desired outcome, such as health, mental health, aged care, housing and justice programs. We collaborate with colleagues in these systems to achieve the outcomes individuals with disability we are representing require.

To do this, the Alliance has developed a successful cross sector, collaborative commissioning practice called, 'systems wrangling'.

This type of cross sector service negotiation occurs vertically and horizontally at policy, service system, and individual levels and delivers the following benefits to individuals, service providers and service sectors/systems.

Outcomes at different levels	
Person	▪ greater well-being ▪ higher levels of community participation ▪ better social outcomes ▪ sustainability of informal care arrangements ▪ greater understanding of and choice about services ▪ better communication with service providers ▪ reduced time in hospital ▪ enhanced ability to remain in the community, and ▪ a greater sense of control.
Service providers	▪ greater understanding of people's needs ▪ improved linkage and communication with other services to meet these needs. ▪ better understanding of local population. ▪ overall service quality is enhanced.
Policy, systems	Positive outcomes can include: ▪ streamlining and avoidance of duplication ▪ reduced hospital stays ▪ prevention of admissions to residential care ▪ reductions in health expenditure.

While this model has been highly effective, clear mandates to undertake this type of negotiated engagement must be in place as inherent parts of government agency operations and contracting.

Without such mandates, the collaborative commissioning the Productivity Commission envisages will fail.

Key components of effective systems wrangling at each level

Working with individuals

- A single point of contact
- Being properly informed (accurate, practical and honest information)
- A relationship of understanding and trust with the coordinator
- Support to exercise choice and control in line with their own goals and priorities
- Timely access to services and supports
- Confidence that future needs will be met
- Engages service providers with the necessary knowledge and expertise
- Consistent information provided to service providers

Working with government and policymakers

- Cross-sector formal commitment to service coordination
- Shared accountability supported by structures and mechanisms, e.g., KPIs
- High level 'permission' to encourage flexibility at meso level to overcome system blockages
- Funding of coordination across sectors, including linkage or focal points in sectors such as health, housing and education
- Cross-sector efforts to build mutual understanding (e.g., agreement on common language and terminology; regular and purposive communication including meetings)
- Workforce training and skilling to work collaboratively across sectors
- Systems for shared data and information to build an evidence base (including a focus on cost-effectiveness and beneficial outcomes for people)

Working with service delivery

Elements of the service coordination role:

- Advocating to enable the person to access services and supports—a 'systems wrangler' works to overcome system blockages
- Using and having access to a 'contingency fund' to broker solutions where a person's needs cannot otherwise be met.
- Providing a single point of linkage—liaising within and across systems, information sharing, developing and maintaining cross-sector networks
- Respecting and enabling the person
- Partnering with people, families and community supports
- Actively developing and maintaining cross- sector networks
- Supporting the implementation and monitoring of a plan (e.g., NDIS) including
  a. facilitating choice of providers
  b. monitoring and reviewing the person's needs
- Advising on service provider education and training needs

Skills and qualities of wranglers:

- Knowledge and understanding of the person, e.g. disability, health conditions, goals, needs, rights
- 'Can-do' capabilities to work around barriers
- Able to build trust and relationships
- Thorough knowledge and understanding of relevant service systems
- Liaison skills, e.g., building collaboration

Structures and processes

- Communication and information sharing mechanisms
- Formal cross-sector arrangements that enable the coordinator to secure access to services: mandate
- Points of contact in relevant sectors, to facilitate linkage between disability and mainstream services
- Mechanisms for training and skilling service providers in different organisations and sectors
- Mechanisms to ensure access to expertise (e.g., advisory groups with specialist and cross-sectoral membership)

Benefit to all sectors

While we provide in principle support for collaborative commissioning to increase care service integration and the co-operation and partnership between those programs and sectors that it depends on, we strongly believe collaborative commissioning should not be limited only to the health sector as Draft Recommendation 2.1 would suggest.

Instead, we recommend that collaborative commissioning not only be available to health sector actors, but also the NDIS and other relevant programs such as housing, aged care, mental health, education, and justice et al.

Support for such an approach is scattered throughout the NDIS Review's *Final Report*.

Here, the terms 'collaboration' and 'joint commissioning' are used to describe improved safeguarding processes developed in conjunction with the states and territories; state and territory collaboration to reduce restrictive practices; and the need for greater collaboration with service users to develop the integrated and other services required.

The Review says

> *Coordination and consistency across all parts and levels of government must be underpinned by both legislative and policy architecture — as well as culture — across the system that sets clear objectives, roles and responsibilities, drives collaboration and information sharing, and harmonises laws and regulations to reduce complexity*[4]

The Review also declares that improved collaboration and shared commissioning with other programs could deliver fiscal and other benefits to the parties involved. The Review's Recommendation 4 refers to joint commissioning as the methodology that will assist people with disability to navigate mainstream, foundational and NDIS supports and urges the NDIA to

> *…adopt a joint commissioning approach to deliver local navigation support within a nationally consistent framework developed in partnership with other relevant Australian government and state and territory government agencies.*[5]

Those who undertake joint or shared commissioning or collaborate to solve the wicked problems that currently bedevil the human services system, have the opportunity to test new ways of interacting and provide feedback regarding shared policy and practice imperatives. In this way, collaborative commissioning has a unique opportunity to provide real time feedback on the activities and outcomes of the work that has been jointly commissioned so its next collaboratively commissioned iteration can incorporate these learnings.

[4] Commonwealth of Australia, Department of the Prime Minister and Cabinet *Working together to deliver the NDIS - Independent Review into the National Disability Insurance Scheme: Final Report*, Canberra, 2023: 231.

[5] Op.Cit: 7.

Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure: Response to Draft recommendation 3.1

As it stands, Draft Recommendation 3.1 relies entirely on government – both federal and state and territory jurisdictions – to successfully engineer a National Prevention Investment Framework that seeks best value for money opportunities to reduce demand for future acute care services.

While government is clearly a key stakeholder in such a Framework, so are the citizens, sectors and programs that the Framework seeks to assist.

A co designed approach that involves all actors is essential if such a Framework is to be effective and the mutual benefits that come from its work realised.

As well as intergovernmental agreements between federal, state and territory governments that describe their respective roles and responsibilities, such agreements should be extended to include agencies such as the NDIS and the National Injury Insurance Scheme. The continued fiscal well being of both social insurance schemes depends on successful collaborative commissioning of services.

As social insurance schemes, both these agencies have a vested interest in minimising their current and future care and support expenditure. The NDIS already takes a codesigned approach to development of its navigator program where NDIS participants with disability work with agency representatives and other members of the disability sector to ensure that collaboratively commissioned work is fit for purpose and effective.

We strongly recommend that Draft Recommendation 3.1 be extended to include all relevant actors, take a codesigned approach that includes consumers who will benefit from this Framework and collaborate with relevant programs to deliver the Framework.

Finally …

As we have indicated in this submission, the Alliance provides in principle support for the implementation of Draft Recommendations 1.1, 2.1 and 3.1 with the following caveats.

1. Work to reform quality and safety regulations must be codesigned with all actors including service users with disability
2. Work to reform quality and safety regulations must include other service programs and systems in addition to health. These include the NDIS and disability services, mental health, education, aged care, justice et al
3. Undertaking collaboration and negotiation with other programs/systems is a direct challenge to the siloed systems that currently predominate. Support to work differently, more collaboratively and to negotiate genuinely shared outcomes must be available and delivered by independent intermediaries until networks and trust are established

4. The critical importance of the practice and quality standards is evidenced by a supporting statutory duty of care that applies to all workers and service providers and incorporates significant civil and criminal penalties for breaches of the standards
5. Collaborative commissioning must not be limited to use by health services only but should be available to all programs and systems
6. Collaborative commissioning must be supported practically by independent intermediaries who can guide preliminary interactions until actors' familiarity with and trust in each other is established
7. Actors engaged in collaborative commissioning should have a good understanding of the other service programs/systems they are collaborating/negotiating with including
    a. the other service systems' capacity to make monetary or in kind contributions to resolve the identified issue;
    b. their inability to deliver their share of the negotiated solution; and
    c. where their authority comes from.