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Community sector reform council consultation – alcohol and other drug and mental health community support services recommissioning processes

29 August 2014

Background

The Victorian Healthcare Association (VHA) is the peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health service, aged care facilities and Medicare Locals. Established in 1938, the VHA promotes the improvement of health outcomes for all Victorians, from the perspective of its members.

The Hon Mary Wooldridge MP, Minister for Mental Health, Community Services, and Disability Services and Reform has asked the Community Sector Reform Council (Reform Council) to reflect on the recommissioning processes undertaken in mental health community support (MHCSS) and alcohol and other drug (AOD) services and to provide advice that will help refine and inform future approaches.

The Reform Council has released a discussion paper outlining the endorsed principles for reform, a background to both recommissioning processes and issues for consideration.

The VHA welcomes the opportunity to provide input to the consultation, and notes that while the information contained in this submission is based on member feedback, the VHA's submission does not supersede any made by its member agencies.

VHA Response

Recommendations

1. That an independent analysis be completed in no longer than 12 months from implementation, reviewing the impact of the recommissioning on consumers and service providers
2. That future recommissioning approaches be supported by a stronger emphasis on consumer engagement and co-design
3. That future recommissioning approaches ensure realistic transition arrangements are in place, including adequate timelines, active hand-overs and are completed in a way that supports commercial business processes

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4. That successful tenders articulate detailed and realistic implementation plans as soon as they are publically confirmed as service providers
5. That future recommissioning approaches are evidence based and informed by appropriate trials and pilots in Victoria prior to a state-wide implementation
6. That regional variability, population health need and existing service provision profiles are taken into account when designing system reform
7. That the Department of Health ensures consumers are engaged and informed through the entire process, particularly during any transition of services.

Engagement and system design

Engagement between the Department of Health (the Department), peak bodies and service providers was hindered during the probity period. The 'Q&A' service provided by the Department aimed to address queries and issues transparently, but delays in responses meant that issues were at times unaddressed, leaving both the Department and sector unaware of developments and concerns.

By extending the timeline for tender completion, the Department added a layer of complication that potentially disadvantaged providers who submitted their bids by the initial date, and indicated internal issues with the Department's readiness and ability to manage consecutive reforms of this scale. There are examples of organisations that tendered across a number of catchments being able to attend an interview for each, effectively allowing them the opportunity to rehearse their methodology. This should be noted as a risk for future approaches.

The Department's publishing of draft design papers and discussion papers facilitated a consistent engagement on system design; however feedback indicates that efforts to engage service users and carers could have been strengthened. Relying on consumer representatives may allow streamlined engagement processes, but system design and transition planning would have been improved with more frequent and transparent engagement with consumers. The Department should undertake to assertively engage with consumers and integrate their priorities into future reforms.

Future reforms must continue to be supported by a robust engagement of all key stakeholders, including consumers, service providers, carers, peaks, Department of Health regional offices and Department of Health program managers; and a strong focus on co-design, with both consumers and service providers closely engaged and contributing to the reform's design and implementation. Probity processes must be adhered to,

and the regular update of prospective providers must continue to be supported by timely and transparent responses.

Transition

Timelines for transition and hand-over were wholly inadequate and have resulted in avoidable confusion and breaks in continuity of care. This has potentially impacted the readiness of new service providers to be accepting consumers from the implementation dates of 1 August and 1 September.

Sector feedback has highlighted concerns with the timing and structure of the transition process. The short transition has placed significant pressure on all providers. Business processes, particularly for providers expanding into existing or new catchments, require a longer lead-in time than has been made available. Examples of business processes that required a longer transition period include:

- Securing new leases on properties;
- Conducting an industrial process of making staff redundant or relocating them to new areas;
- Recruiting new or additional staff;
- Finalising aspects of the new service models and implementing these, including training/retraining staff;
- Communicating changes to consumers, carers/families and stakeholders; and
- Transferring large numbers of consumers from one provider to another.

Some service providers undertook these exercises without first executing any formal contractual agreement with the Department, save for the announcement of being an approved provider. This meant undertaking major business and industrial decisions on the basis of an announcement, rather than a signed contract. The lack of swift contract execution and tight timelines meant that some service providers were forced to accept unnecessary and avoidable levels of risk.

Given the expectations that the community sector would need to tender in a competitive commercial environment, it is reasonable to expect that the Department ensures its timelines and processes are also commercially appropriate and do not result in service providers accepting unnecessary and avoidable risk.

Regarding the readiness of the AOD system, sector feedback indicates that key stakeholders – including general practitioners, pharmacies, community service organisations, Victoria Police, child protection services, family violence services, schools and other organisations that make referrals to AOD providers – were advised of the change of intake and assessment functions to the new provider less than two weeks prior to 1 September. That this situation existed so close to the implementation date is worrying, particularly given the number of new relationships that the intake and assessment provider must develop state-wide. This is partly a result of the

ambitious timelines set for the sector to undertake and complete the task of transitioning all arrangements to new and continuing providers.

Future commissioning approaches should include as a precondition that all successful organisations new to a catchment provide detailed and realistic implementation plans to local stakeholders. This, combined with a reasonable transition and hand-over period, would reduce confusion and disorganised communication.

Alignment of funding model and policy intent

Elements of the AOD funding model are not adequately aligned to the stated policy intent. The model does not discriminate between the funding of an individual consumer counselling session and a group counselling session, and is inconsistent with an activity-based funding model. The activities are different, have different therapeutic intent and rationale, have different resource implications, and require different weightings. Structured this way, the new funding formula misses an opportunity to address weaknesses in the use of episodes of care, one of which was noted by the sector to be the opportunity to 'game' by over-using group work.

The funding model should be refined to include differential weighting for group work and individual counselling, and quarterly adjustments of payments and DTAU allocation based on the previous quarter's actuals. This will build a capacity for real consumer choice, which is artificial if not supported by resource re-allocation.

Consumer choice

The VHA notes that the rhetoric of expanded consumer choice has underpinned both reforms, yet the resulting arrangement of service providers and the service model does not consistently support this. There are examples of single service providers in catchments; and in other catchments, particularly small rural communities, new consortia have been introduced to a 'market' where the previous provider was able to offer a holistic wrap-around service, integrating health and social programs relating to AOD consumers within the one health service.

There is no capacity to adjust the proportion of activity allocated to any particular provider in response to consumer choice; a consumer will not have the opportunity to choose a popular provider if they have already achieved their proportionate allocation, making choice available only to those consumers who require assistance earlier in the financial year. While the concept of 'choice' as an underpinning priority is important, the VHA queries whether expanded choice exists and if it outweighs the importance of integrated person-centered care.

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Impact on rural communities

The VHA is concerned about the impact on rural Victoria, particularly reductions to consumer access to care and support. Discussions between the VHA and service provider consortia across regional Victoria have identified that new providers largely intend to operate from regional centres, often leaving large areas without accessible services – or a reduced level of service provided by a partially funded existing rural provider. Many areas have very limited access to public transport and consumers are often without private transport. This is a disadvantage that presents a significant barrier to treatment.

The capacity for face-to-face early intervention and walk in assessment has been severely reduced and is now dependent on 'in-reach' to smaller communities. Contacts need to be planned; the capacity to respond to an individual spontaneously seeking help has been withdrawn, unless an existing agency provides unfunded responses beyond the new framework. The VHA is concerned that some consumers will be lost to the system as a result.

There is great value in the relationships and links between local stakeholders, particularly their ability to wrap services around their consumers and link them to broader supports important for recovery. The lack of physical presence in smaller rural communities places this at risk.

Consumer guidance

The transition of consumers to new providers was hindered by a lack of consumer-friendly information for those whose service provider was either ceasing operation completely or ceasing particular elements of service. Providers were keen to ensure the correct information was available to consumers, but found this challenging without Department-sanctioned, consumer-friendly information. The Department must prioritise the needs of consumers in this process and ensure that they are fully informed and engaged throughout future transitions.

Independent analysis of outcomes

The VHA calls for a robust and independent impact analysis of the recommissioning to be completed no longer than 12 months from the implementation date. This analysis needs to consider consumer, community and provider impacts, and should include a consideration of the potential impact and opportunities offered by Services Connect and the future establishment of Primary Health Networks.

The process must be transparent and inclusive, with the terms of reference developed in consultation with service providers and sector representatives.

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A review of the funding model may be necessary following this analysis to ensure alignment with any findings, including consideration of appropriate funding for servicing small rural communities.

Further information

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