A REVIEW OF DISABILITY SERVICES DELIVERED BY TASMANIAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Prepared for the Department of Health and Human Services Tasmania
September 2016
Disclaimer

This report has been prepared in response to a contract between KP Health and the Department of Health and Human Services and the specific outputs required therein. The report is not for wider consideration or use without the prior written consent of KP Health.

The findings in this report have been formed on the basis of information provided by the Department of Health and Human Services and their nominated stakeholders, cited references and the methods described in the report. KP Health has relied on that information being accurate and up to date.

Reported results from stakeholders consulted reflect a perception of the approved representative sample of stakeholders. Any projection to the wider stakeholder group is subject to a level of bias in the method of sample selection.

The services provided by KP Health are advisory and not subject to standards issued by any regulatory body.
### Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Administration</td>
<td>For the purpose of this report it is used in its broadest sense. It incorporates executive support officers, program support officers, administrative support officers, administrative assistants, and executive assistants.</td>
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<tr>
<td>Client</td>
<td>A generic term for an individual or group of individuals that is the recipient of a service or support activity. The focus of this report is clients who have a disability. This term is used interchangeably with consumers, service users, service recipients, people or patients.</td>
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<tr>
<td>Complex support needs</td>
<td>These occur “at the intersection between an individual and their environment,…may span multiple domains and/or involve high levels of need in one or more areas…[and] may include the presence of multiple disabilities, severe/profound intellectual disability, coexisting mental health issues, significant health conditions, behaviours of harm, alcohol and/or drug misuse, and experiences of trauma or neglect”[1]</td>
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<tr>
<td>Consultant</td>
<td>Disability Consultant – Gateway.</td>
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<tr>
<td>CPT</td>
<td>Community Partnerships Team</td>
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<tr>
<td>CSO</td>
<td>Community Sector Organisation that receives DHHS funding to deliver services.</td>
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<tr>
<td>Cross-sector</td>
<td>Denotes collaboration across the private, not-for-profit, and government sector.</td>
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<tr>
<td>Cross-sector collaboration</td>
<td>This denotes collaboration between the private, not-for-profit and government sector and implies that government has a key role in coordinating that collaboration. It is distinguished from collaboration between the government and not-for-profit sector only. It is salient as private providers and not-for-profit providers will be involved in the transition to NDIS and the government has a role to play in improving its relationships with both sectors to improve the likelihood of effective transfers of care for disability clients.</td>
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<tr>
<td>DCS</td>
<td>Disability and Community Services</td>
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<td>DAAT</td>
<td>Disability Assessment and Advisory Team</td>
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<tr>
<td>DHHS</td>
<td>Tasmanian Department of Health and Human Services. Also referred to as “the Department”.</td>
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<thead>
<tr>
<th>DSP&amp;P</th>
<th>Disability Services Policy and Programs</th>
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<tr>
<td>Dual disability</td>
<td>Client who has concurrent mental illness and disability (intellectual or physical) and complex support needs.</td>
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<td>Dual diagnosis</td>
<td>For the purpose of this report it is used to refer to clients who have developmental disability along with co-occurring mental illness and behavioural difficulties.</td>
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<tr>
<td>FTE</td>
<td>Full Time Equivalent.</td>
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<td>KPH</td>
<td>KP Health</td>
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<td>Incident</td>
<td>An event or circumstance lead to harm, loss and / or damage resulting from, or impacting upon, service provision to clients.</td>
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<tr>
<td>Inter-agency</td>
<td>Working across agencies, typically government departments such as the Department of Education, Department of Premier and Cabinet and Department of Health and Human Services.</td>
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<tr>
<td>Interprofessional teamwork</td>
<td>For the purpose of this report, it refers to clinicians from different professions (usually allied health professionals) working together to provide client support. Support can be multidisciplinary, transdisciplinary, or interdisciplinary.</td>
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<tr>
<td>LACs</td>
<td>Local Area Coordinators</td>
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<td>ISS</td>
<td>Intensive Support Service</td>
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<td>NDIA</td>
<td>National Disability Insurance Agency</td>
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<td>NDIS</td>
<td>National Disability Insurance Scheme. Also referred to as “the Scheme”.</td>
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<td>NDS</td>
<td>National Disability Services</td>
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<tr>
<td>NFP</td>
<td>Not-For-Profit organisation</td>
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<tr>
<td>Our consultants</td>
<td>KP Health consultants</td>
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<tr>
<td>Person-centred</td>
<td>Policies, programs, services and systems are designed to respond to individual needs. Can be used interchangeably with consumer-directed.</td>
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<tr>
<td>PSO</td>
<td>Project Support Officer</td>
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<tr>
<td>SP</td>
<td>Senior Practitioner</td>
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<tr>
<td>THS</td>
<td>Tasmanian Health Service</td>
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<tr>
<td>Transition period</td>
<td>Period between now and when the NDIS is fully implemented.</td>
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<tr>
<td>WDU</td>
<td>DCS Workforce Development Unit</td>
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Executive Summary

The Tasmanian Department of Health and Human Services (DHHS) currently provides a broad range of specialist disability services and functions to over 6,500 Tasmanians with disability.

In June 2016 the DHHS engaged KP Health to review its specialist disability services and determine which functions should remain and which should cease to be provided in a full scheme National Disability Insurance Scheme (NDIS).

The NDIS is a national reform agenda designed to increase choice and control for people with disability by transitioning from block-funded support to a self-directed funding model. It is anticipated that by July 2019, all states and territories will have transitioned to a full scheme NDIS. For eligible Tasmanians with disability, the NDIS represents an opportunity for more choice and control and, ideally, increased access to better quality services and supports.

A key finding of the review was that the NDIS changes the role and focus of the DHHS in relation to its specialist disability services and programs. Under the NDIS, the ongoing role of the State Government will be limited to strategic policy and purchasing, regulation, monitoring data and finance, and facilitating collaboration between the private, not-for-profit and government sectors. There will also be a time-limited role between now and June 2019 for transition support and effective change management. Most of the existing specialist disability services provided by Disability and Community Services (DCS) will cease to be provided in a full scheme NDIS and many will need to be halved by June 2018 when it is projected that 45% of the eligible participants will have transitioned to the NDIS.

This represents a substantial change and the DHHS will need to invest in effective support for the transition as a result. In particular, all affected clients and DHHS staff will need to be fully informed of the relevant changes and their future options as soon as possible.

Overall, the impact of the NDIS on the sector is likely to be positive, particularly for clients who are eligible for the scheme. That said, the NDIS is not as yet equipped to respond to clients with complex and specific support needs. For this reason, DHHS will need to pay particular attention to ensuring these clients are not adversely affected by the transition.

In conjunction with the National Disability Insurance Agency (NDIA), the DHHS will also need to improve and clarify its transitional governance arrangements; improve the capability and capacity of mainstream to respond to and support people with disability; and support capacity building amongst Tasmanians with disability to make informed choices about their support requirements.
## Recommendations

The National Disability Insurance Scheme (NDIS) is a national reform agenda which involves a market-based system of delivery of disability services. All recommendations are predicated on current projections by the NDIA that the NDIS will be fully implemented by July 2019. The following recommendations relate to the DHHS’s ongoing role in specialist disability services in a full scheme NDIS:

1. That good public policy mandates that the DHHS seek to commission, rather than directly deliver, disability services wherever possible.

2. That the DHHS consolidates its ongoing disability functions to strategic policy and purchasing, regulation, monitoring NDIS data and finance, and coordinating collaboration between the private, not-for-profit and government sectors.

Current estimates suggest that by June 2018, 45% of participants will have transitioned to the NDIS, which means that demand for DHHS services will decrease during the transition period, but the final 12 months will require intense activity as the remaining clients transfer to the NDIS. The following recommendations relate to how the transition to full scheme NDIS affects current specialist disability functions in the DHHS:

3. That with respect to the disability specific component of the Community Partnerships Team (CPT) function, the DHHS ceases half of it by the end of June 2018 and ceases the remainder of it by the end of June 2019.

4. That the DHHS ceases half of its Disability Assessment and Advisory Team (DAAT) function by the end of June 2018 and ceases the remainder of it by the end of June 2019. This will require ensuring there are effective referral pathways and continuity of care arrangements for existing clients.

5. That the DHHS ensures its DAAT clinicians accurately account for the actual hours of service provision involved in supporting NDIS clients, particularly those with complex support needs.

6. That the DHHS ceases half of the Disability Gateway Consultant function by or before June 2018 and ceases the remainder of it by June 2019.

7. That the DHHS ceases half of the existing management and administration functions consistent with the reduction of other DCS functions by June 2018, and ceases the remainder of these functions by June 2019.

8. That the DHHS ceases the Intensive Support Services (ISS) function by or before June 2019 and ensures there are effective referral pathways and continuity of care arrangements for existing clients.

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9. That the DHHS ceases half of the current Individual Funding Unit (IFU) function by the end of June 2018 and ceases the remainder of it by June 2019.

10. That the DHHS ceases its disability services Workforce Development Unit (WDU) function by or before June 2019.

One of the risks with the transition to full scheme NDIS is that clients may be adversely affected, particularly those with complex and specific support needs. The following recommendations relate to DHHS’s role in effectively and safely managing clients during the transition:

11. That the DHHS comprehensively describe and mitigate the strategic, tactical and operational risks relating to the transition to full scheme NDIS, prior to transitioning clients.

12. That the Tasmanian government works with key stakeholders including the NDIA, Tasmanian Health Service and Primary Health Tasmania to ensure clients with complex and/or specific support needs are not adversely affected by the transition, and to improve the capacity and capability of mainstream services to support them.

13. That the DHHS puts strategies in place to improve collaboration across the private, not-for-profit and public sectors to: ensure clients with complex and specific support needs can access appropriate services; identify service gaps; and increase the likelihood of effective system responses to service gaps.

14. That the DHHS specifically strengthens its regulatory approaches in relation to clients with a dual diagnosis, in recognition that amendments to Tasmanian disability legislation will not negate the Department’s obligations under other legislation.

15. That the DHHS considers reviewing its interim quality and safety processes and makes an assessment as to whether the office of the Senior Practitioner requires additional support until such time as the National Quality and Safeguards Framework is finalised.

16. That the DHHS works with key stakeholders to optimise its responsiveness to individual client needs, and supports building capability amongst Tasmanian consumers to undertake self-direction and make informed choices about their support requirements.

The final recommendation relates to the need for DHHS to recognise the significant impact of the recommendations on its specialist disability workforce.

17. That during the transition period the DHHS ensures effective change management and transition support for all affected DHHS staff. This will need to include clear communication, timeframes, and timely information about career pathways and options.
Background

The National Disability Insurance Scheme (NDIS) commenced as a trial in July 2013. The overall objective of the NDIS is to move from block-funded support to an individualised funding package, which will afford people living with disability greater choice and control to select which agencies provide their support.

Since 2013, approximately 1,100 young people in Tasmania (aged 15-24) have been supported by the NDIS as part of a trial stage of the scheme. Over the next three years, all remaining eligible Tasmanians with disability will transition to NDIS supported services, with full scheme transition being achieved by 2019.

Many services have already been transitioned to private and NFP providers in Tasmania, with selected specialised services still being delivered by Disability and Community Services (DCS). Currently, more than 6,500 Tasmanians living with disability receive supports and services from one or more of around 80 community-based organisations, or directly from DCS.

Key services still provided by DCS, under the Disability Services Program and include:

1. Disability Policy and Planning;
2. NDIS State Implementation Team;
3. Senior Practitioner;
4. Workforce Development Unit;
5. Individual Funding Unit;
6. Tasmanian Autism Diagnostic Service;
7. Intensive Support Service; and
8. Disability Services Area Teams, made up of:
   a. Community Partnership Teams;
   b. Disability Assessment and Advisory Team;
   c. Disability Consultants – Gateway;
   d. Business Advisor / Project Support Officers; and
   e. Administration Teams.

This Project

The objective of this project is to identify which of the above specialist disability functions will need to be retained in a full scheme NDIS, and which not. The project explores the current scale and scope of practice of each business unit listed and seeks to understand the market capacity to deliver the services under the NDIS. The Tasmanian Autism Diagnostic Service, Community Services, State Implementation Team and Senior Practitioner functions are out of scope for this project. That said, approximately 30% of the work undertaken by The Community Partnership Teams (CPT) relates to community services rather than disability services. While that has been taken into consideration in
evaluating the CPT function in a full scheme NDIS, none of the recommendations here relate to Community Services, TADS, or SIT. Further, the need for community services policy and planning is likely to be ongoing.

Project methods

In order to establish the most effective model for service delivery in Tasmania, the following project methodology has been undertaken.

- A review of services currently being delivered by DCS to establish which functions need to be retained by the DHHS in a full scheme NDIS, which need to cease, and which could be delivered by the private or not-for-profit sector. The review explored the financial implications of transitioning services, whether transitioning services will have an effect on outcomes for clients, and whether there is capacity in the current market to be able to deliver services without increasing delays to the clients.

- A comprehensive stakeholder consultation phase sought advice on the appropriateness of transitioning services, and the impacts on clients, carers and the community of reducing or ceasing the current DCS functions. In total, 109 stakeholders were consulted either face-to-face or via telephone, and 40 stakeholders completed an anonymous online survey. Those consulted included clinical staff (social workers, psychologists, specialists, occupational therapists, registered nurses, speech pathologists); executives, management and administrative staff; and representatives from not-for-profit organisations, unions, advocacy organisations, peak bodies, mental health services, other jurisdictions, the NDIA and the NDIS. Although the findings in this report are informed by feedback from stakeholders, every effort has been made to ensure it is not identifiable.

- A review of governance arrangements including current legislation to ensure the continuity of service provision should services be transitioned, and to ensure that all state legislative responsibilities are discharged appropriately until such time as state legislation is repealed or replaced by the *NDIS Act*.

Findings from the activities above formed the basis for this report and recommendations.
The Disability Service System in Tasmania

Tasmania has a higher population of people living with disability than the rest of Australia, with 22.7% compared to 18.5% nationally. Services in Tasmania are provided to people with intellectual, psychiatric, sensory or physical impairments, as well as individuals with cognitive impairments. This includes people whose disabilities:

- are permanent or likely to be permanent;
- result in substantially reduced capacity of the person for communication, learning or mobility;
- require continuing support services; and
- may or may not be of a chronic nature.

Guiding principles

Provision of services to people with disability is guided by the principles agreed in the United Nations Convention on the Rights of Persons with Disabilities which are reflected in the Tasmanian Disability Services Act 2011, namely:

- respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons;
- non-discrimination;
- meaningful participation and active inclusion in society;
- respect for difference and acceptance of persons with disability as part of human diversity and humanity;
- equality of opportunity;
- accessibility;
- gender equality; and
- respect for the evolving capabilities of children with disability and respect for the rights of children with disability to preserve their identities.

In a high quality disability service system, service provision should:

- promote and uphold the rights, needs and best interests of people with disability;
- meaningfully engage people with disability in shaping policy, program development and legislation;
- recognise that a whole of community effort is required to support the inclusion of people with disability in the life of their communities;
- ensure that the service system for people with disability is easy to understand and navigate;
- recognise that people living with disability are the natural authorities over their own lives and can make choices about their care and support;

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3 Australian Bureau of Statistics; 4446.0 Disability, Australia 2009.
   http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4446.0main+features42009

• ensure products, services, environments and communities are accessible and usable by all people to the greatest extent possible without the need for specialised modification;
• operate with a life course approach such that a person’s likely needs and aspirations over their lifetime are taken into account, paying particular attention to times of significant change;
• be person centred – policies, programs and services for people with disability are designed to respond to the needs and wishes of each individual;
• promote independent living – services and equipment enable people with disability to be independent; and
• involve collaboration – governments work together to ensure that policies and programs work well together.

Eligibility for services

Under Tasmanian legislation, services are provided to anyone who is a permanent resident of Tasmania, who has a disability as defined in the Disability Services Act 2011 that manifests before the person is 65 years of age. Under the Act, disability in relation to a person is described as:

A disability of the person which:

a) is attributable to a cognitive, intellectual, psychiatric, sensory or physical impairment or a combination of those impairments; and
b) is permanent or likely to be permanent; and
c) results in:
   i. a substantial restriction in the capacity of the person to carry on a profession, business or occupation, or to participate in social or cultural life; and
   ii. the need for continuing significant support services; and

d) may or may not be of a chronic episodic nature.
The role of the Tasmanian Government in specialist disability service delivery

The Tasmanian Government currently supports a wide range of specialist disability services including but not limited to community access and support, specialist clinical services, and respite services. The Tasmanian Government’s vision for these services is to provide outstanding and effective services to the Tasmanian community and to be recognised as a service that is responsive, has a holistic focus on individual needs and demonstrates quality through its people, use of resources and collaborative approaches.\(^5\)

The Tasmanian Government has been transitioning out of the direct delivery of disability services for years. Representative here is supported accommodation and group home service delivery, which were transitioned to non-government service providers.\(^6\) Since then, many other services and functions have effectively been transitioned to the non-government sector. DCS currently funds approximately 80 community sector organisations (CSOs) to provide support to Tasmanians with disability.

Services directly delivered by DCS

Not all specialist disability services have been transitioned to the community sector by the DCS. At the time of preparation of this report the specialist disability functions provided by DCS include:

- Disability Area Teams, made up of:
  - Community Partnership Teams (CPT);
  - Disability Assessment and Advisory Team (DAAT);
  - Disability Consultants – Gateway; and
  - Administration Teams;
- Intensive Support Service (ISS); and
- Individual Funding Unit (IFU).

Supporting the delivery of disability services in Tasmania are:

- Workforce Development Unit (WDU);
- Disability Services Policy and Planning (DSP&P);
- Office of the Senior Practitioner (SP); and
- NDIS State Implementation Team (SIT).

These are described in detail below.

**Community Partnership Teams (CPTs)**

The CPTs are the formal point of contact between DCS and funded Community Sector Organisations (CSOs). There are three CPTs, one in each region. The Southern team has 7 FTE, which includes two Managers and 5 Community Liaison Advisors. The North

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\(^6\) This included a Human Resource Strategy for affected DHHS staff whereby permanent staff could express interest in a voluntary separation program and other suitable alternative employment opportunities.
has 4 FTE made up of 1 FTE Manager and 3 FTE Community Liaison Advisors, and the North West has 1 FTE Manager and approximately 2.5 FTE Community Liaison Advisors.

The core functions of the CPT include:

- building and managing effective relationships between the sector and DCS;
- negotiating and managing funding arrangements and contracts, in consultation with relevant stakeholders;
- monitoring service and performance standards schedule in funding agreements, including supporting stakeholders to understand reporting requirements and interpret data;
- providing the first point of contact for quality and safety issues and enquiries, including:
  - provision of information and resources on continuous improvement and the requirements of DHHS Quality and Safety Standards Framework;
  - investigation of serious consumer related incidents
  - liaison with CSOs to discuss quality and safety issues;
  - monitoring CSO’s implementation of required activities that have been identified through reviews undertaken through quality and safety processes; and
- processing complaints and managing risks including responding to service issues, disputes and identified issues.

The CPTs manage approximately 55 CSOs and provide a range of ad hoc advice and support. The CPT are also responsible for due diligence processes for new providers registering with the NDIS, and ensuring registered providers comply with state regulations regarding employment screening, police checks, and National and State guidelines and standards regarding restrictive interventions. Approximately 30% of the work performed by the CPT is not related to specialist disability services and focuses on community services such as neighbourhood houses, gambling support, and other community services policy and programs. The transition to full scheme NDIS does not affect these functions and they are likely to need to continue to be provided by the DHHS.

Disability Assessment and Advisory Teams (DAATs)

There are four DAATs, with one each located in the North, North West, South East, and South West regions. The DAATs work in partnership with people with disability and their support networks to promote choice, quality of life, active participation and community membership. The teams are made up of allied health and nursing professionals who collectively have extensive specialist skills and knowledge in the disability sector. The allied health professionals include speech pathologists, occupational therapists, clinical psychologists, social workers and a dietitian.

The Northern DAAT has 8.68 FTE, the North West 7.93 FTE and the combined Southern DAATs have a total of approximately 15 FTE (7 in SE, 8 in SW). There are clinical nurse

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specialists in the northern teams but not in the southern teams, and at present none of the teams have a physiotherapist. DAAT services include, but are not limited to:

- coordination of supports;
- behaviour support;
- specialised assessment of skills, abilities and needs;
- therapeutic supports;
- support with assistive technology; and
- supporting the service system though education, training, and service coordination.

There is a DAAT Practice Framework 2015 which articulates a person-centred approach, focus on individual outcomes, commitment to responsive and accountable service provision, focus on increasing choice and control, and promotion of least restrictive interventions (Figure 1).

Key functions of the team are to assess referrals and deliver single focus, complex and behavioural support services, as well as to work with the sector to build capacity. Services may be delivered by single clinicians, or by a multidisciplinary or transdisciplinary team approach (for complex and behavioural services).

Figure 1: DAAT Service Model

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9 Ibid.
Disability Consultant – Gateway Services (Consultants)

Disability Consultants – Gateway Services (Consultants) assess the eligibility of people seeking support through DHHS and community providers. The Gateways are managed by Mission Australian and Baptcare in Tasmania. Although the nature of the role differs slightly from region to region, in general terms the Consultants are a conduit for information between the DHHS, client, Gateway Services, and mainstream systems. There are 2 FTE Consultants in the south: one is the key contact for Baptcare and the other for Mission. The North and North West team each have a 1 FTE consultant.

They provide advice and support to people who have complex support needs and face service delivery issues. They also support the overall operations of DCS by drafting Ministerial responses, representing DCS at meetings and working with other business units such as the CPT, DAAT, IFU, and ISS. Further, the Consultants provide support to the NDIS Local Area Coordinators (LACs) as required. For example, by providing background information about clients and support navigating the system.

The Consultants provide a gatekeeping and a liaison function by assessing referrals for the DAATs and liaising between the acute and community sector. They assist with transfers of care and help with advocacy of behalf of clients, thereby mitigating the risk of clients being prematurely referred to residential aged care facilities. The Consultants also support the operation of the Community Equipment Scheme. Each Consultant works somewhat differently and according to their experience, professional strengths, and the region they operate in.

Administration

For the purposes of this report, the term administration is used in its broadest sense. It incorporates an executive support officer (1 FTE), program support officers (2 FTE), administrative support officers (3 FTE), administrative assistants (2.8 FTE), and an executive assistant (1 FTE). There is also a 1 FTE program support officer (PSO) position tied to the SIT team that is currently vacant.

The administrative staff range in skills and abilities and have different roles and functions across the state. There is 1 FTE administration in the North and 2 FTE in the North West. These positions are responsible for a range of tasks to support the broader team. Functions include: maintaining databases, filing, responding to calls, taking minutes, secretariat support, project support, sending information to the NDIS and supporting DAAT members with NDIS processes. They are the main interface with clients and stakeholders and need to have a good working knowledge of the sector in order to effectively support the DAAT, CPT, consultants, and Area Managers.

At present the Southern area team has: 1 FTE executive assistant, and 1 FTE executive support officer, 2 FTE project support officers, 2 FTE administrative support officers, and 0.8 FTE administrative assistant. They range in employment category from a Band 1 to a Band 4. The Band 1 positions provide reception, phone and administrative support to the whole DCS South Team.

The Band 2 position provides back up reception and phone, as well as basic finance and business support tasks across the whole DCS South Team. The Band 4 Executive Support Officer position provides direct support to the Area Manager role, as well as
supervision to the Band 2, and Band 1 administrative positions (at present the Band 1 and 2 are taking on higher duties as the executive position is vacant).

One of the PSOs currently has a focus on project support in areas such as supported accommodation (transition to NDIS), unit pricing review and other stand-alone projects. The other PSO has acted as a proxy for the Consultants, and provides high level project support for them and the DAATs. This includes: assisting stakeholders with navigating the health system, assisting with referrals, project work and navigating a range of databases and files to source key historical information about clients for Ministerial briefings and reports.

**Intensive Support Service (ISS)**

The Intensive Support Service is a 1 FTE tertiary behaviour intervention service for people who have complex and exceptional needs. ISS clients typically display severe behaviour that places themselves or others at risk of harm. Such clients require intensive support and cannot readily be managed within existing resources and services. The service provides resources to enable the development and implementation of a comprehensive behaviour support plan, in the person’s normal environment or at a transitional unit. Interventions are intended to be short to medium term to stabilise the behaviour and assess future support needs. The ISS also provides ad hoc clinical support for the broader DCS service system.

**Individual Funding Unit (IFU)**

The Individual Funding Unit (IFU) manages a range of individual funding agreements. The IFU team is currently 4 FTE made up of three consultants and a coordinator based in the south of the state. The primary IFU functions include, but are not limited to, managing the:

- Individual Support Program – this includes managing Individual Support Packages to assist with everyday living tasks such as personal support and/or respite, support with activities of daily living in the home or community, one off support, and equipment;
- Community Access Program – this funds community access services (including recreation, leisure, social activities and skills development) in various settings; and
- Younger People in Residential Aged Care (YPIRAC) – this program enhances the delivery of specialist disability services to younger people with disability who choose to remain in residential aged care, or for whom residential aged care is the most suitable option.

**Workforce Development Unit (WDU)**

The Workforce Development Unit includes a 1 FTE Workforce Development Coordinator position and 1 FTE Workforce Development Officer. Although these positions are not based in the north, they report to the Northern Area Manager, and have a state wide focus. The WDU has been consolidated as part of a former restructure. As such, the primary focus of the unit is internal workforce development.
According to stakeholders consulted for this review, the WDU supports the work of DHHS by providing strategic leadership and progressive workforce planning for the disability and community services sector, and also supports DCS staff with professional development.

The WDU functions include: work health and safety; managing and monitoring the learning and development webpage; maintaining the DCS induction manual and staff learning and development database; monitoring the learning and development activities of DCS staff; supporting DCS staff and students undertaking placements at DCS; helping to ensure DCS staff have current working with children checks; and developing and supporting the development of policies, procedures and guidelines related to workforce development.

**Disability Services Policy and Planning (DSP&P)**

Disability Services Policy and Planning (DSP&P) is responsible for a number of centralised activities that support the strategic direction for disability services in Tasmania. The team is currently made up of 1 FTE Manager and 2 FTE Senior Policy Officers.

The team is responsible for policy development at a state level and participates in policymaking at a national level. Although the main focus of the unit is on policy, the team are also responsible for implementing programs and projects at the Minister’s discretion. In particular, DSP&P is responsible for the development and implementation of documents that align with national and state disability reform strategies. Areas of policy advice and development include: quality and safeguarding practices; restrictive interventions; translation and implementation of NDIS, including:

- Disability Services Medication Management Framework (2016);
- Eligibility Access to Specialist Disability Services;
- Restrictive Interventions for people in services with a disability; and
- Preventing and Responding to Abuse in Services.

The DSP&P is a delegate of the Secretary and as such contributes to the development of the Tasmanian DCS Strategic and Operational Plans and informs the state based quality and safeguarding frameworks. The team mainly provides advice and support to the Community Partnership Team (CPT), Senior Practitioner and State Implementation Team (SIT), though they also play a role in supporting community sector organisations.

**NDIS State Implementation Team (SIT)**

The State Implementation Team works with state and federal governments to support the transition to the full scheme NDIS. It is the conduit between the NDIA, the DHHS and the regional areas, and is responsible for ensuring the deliverables in the 2016 Tasmanian


Operational Plan for NDIS Transition\textsuperscript{12} are achieved. At the time of preparing this report, the team included 1 FTE Project Manager, 1 FTE Business Analyst, and 2 FTE Project Officers, though the DCS is currently investigating options to recruit additional support for the transition period. The SIT works closely with the DSP&P, particularly in translating NDIS policies, guidelines and practices to the Tasmanian context; monitoring in-kind expenditure and funding arrangements between the state government and NDIS; and monitoring service activity and provider registration.

Management of disability services provided by DCS

There are three 1 FTE Area Managers in the North, North West and South who have broad oversight of the area teams. There are also four CPT Managers, one in the North and North West and two in the South, although the Southern CPT Managers have different portfolios. Further, there are four DAAT managers: one in the North, one in the North West, and two in the South. There is a Project Manager who oversees the SIT and a Manager who oversees the DSP&P. There is also a manager / senior psychologist position in the DCS. The DCS unit is overseen by a Director and the Senior Practitioner is in the directorate as well.

The role of the Senior Practitioner

The role of the Senior Practitioner (SP) is to protect the rights of people with disability, particularly in relation to restrictive interventions. The role was established under the Disability Services Act 2011 to ensure that appropriate standards and requirements are met and that any restrictive interventions are compliant with the Act. Regulations regarding restrictive interventions under the Act include:\textsuperscript{13}

- environmental restriction, which includes modifying the environment and / or an object to enable behavioural control of a person with disability; and
- personal restriction, which involves a restrictive intervention that includes (partial or otherwise) physical contact to enable the behavioural control of a person with disability, and / or restricting their freedom of movement.

All restrictive interventions must be signed off by the Minister.

The SP may delegate some of their duties to other, nominated Tasmanian Government employees. Currently, the Secretary is nominated as a responsible person under the Act, along with the three DCS Area Managers who take part in the investigation of complaints and gather information on behalf of the SP.

The DSP&P assists the SP with the development of policies and guidelines that relate to restrictive interventions. The team also helps to distribute knowledge and information on behalf of the SP. The CPTs are responsible for monitoring and maintaining quality and safety in the provision of services.

\textsuperscript{12} NDIS. 2016. Operational Plan Commitment between the National Disability Insurance Agency (NDIA), Tasmanian Government and Commonwealth Government for Transition to the National Disability Insurance Scheme (NDIS).

\textsuperscript{13} DHHS. 2014. Restrictive Interventions in Services for People with Disability Guidelines, © State of Tasmania
The NDIS changes the role of the DCS in service delivery

The NDIS aspires to provide more equitable access to higher quality supports for people with disability. A key mechanism by which this is achieved is through providing self-managed funding to people with disability, allowing them to choose and purchase their own supports.

Through an NDIS-agreed funding package, the person purchasing services stimulates service providers to be more responsive to their individual care needs. This is an important concept underpinning the success of the transition to the full NDIS scheme. The success or otherwise of the NDIS will rest on the ability of the market to grow and adapt to provide a functioning competitive market for disability services.¹⁴

Consumer-directed plans constitute a fundamental change in the manner in which disability care has traditionally functioned by placing the focus on consumers and their caregivers. Consumer-directed plans enable consumers and their caregivers to treat their disability expenses in a price-sensitive way, making choices about the types and amounts of supports they receive based on the quality, timeliness and cost of those services. Studies have found that, with proper supports and reliable information, people treat their service choices in the same way they do other expenditures, by searching out the best service at the best price.¹⁵

Not all people with disability receive the same amount of support. The NDIS is a tiered system. The top tier (Tier 3) is the core of the NDIS. Anyone under the age of 65 who has significant disability that is permanent, or likely to become permanent, is eligible for specific supports according to an individualised plan and agreed resource allocation under the NDIS, as long as they are a citizen or hold a permanent residency visa. The second tier, Information Linkages and Capacity Building (ILC), provides broader support to people with a disability and to the sector. The ILC Policy Framework provides more information. The third tier aims to create awareness about the issues faced by people with disability and promote inclusion and opportunities for them across Australia.¹⁶

The role of governments in a market-based disability service system

The role of governments changes in market-based service systems. Government retains the roles of funder, regulator and policymaker, but generally does not operate as a direct service provider within the service system. This concept, as it relates to the transition to the NDIS, is presented in Figure 2.¹⁷

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Government competing with the private sector in direct service provision may distort the market, undermining growth and adaptation of the private service system to meet the needs of consumers.\textsuperscript{19}

**Recommendation**

1. That good public policy mandates that the DHHS seek to commission, rather than directly deliver, disability services wherever possible.

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**The role of governments in funding and monitoring performance**

Governments in Australia co-fund the NDIS. Funding for the NDIS is provided by the Commonwealth (40\% of the funding) and the states and territories (60\% of the funding).\textsuperscript{20}

Underpinning the system is national data collection and outcome measurement to monitor the performance of the system.\textsuperscript{21} This information will be used to progressively update the schedule of fees that is paid to service providers as remuneration for specific services they render to or on behalf of clients (Figure 3).

**Figure 3: The role of benchmarking in market development** \textsuperscript{22}

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\textsuperscript{18} Beckett, C. 2016. *National Disability Insurance Scheme: Implementing the NDIS in Tasmania* excerpt from power point presentation at NDIS Essential Briefing 18\textsuperscript{th} July 2016.


\textsuperscript{22} Beckett, C. 2016. *National Disability Insurance Scheme: Implementing the NDIS in Tasmania* excerpt from power point presentation at NDIS Essential Briefing. 18\textsuperscript{th} July 2016.
The role of governments as a ‘provider of last resort’

Although the NDIS will improve access to supports for a significant majority of people with disabilities, it could present access barriers for a high-need minority. Clients with complex support needs who cannot self-advocate may be worse off under the NDIS.

For the purpose of this report, complex support needs “arise at the intersection between an individual and his or her environment,…may span multiple domains and / or involve high levels of need in one or more areas…[and] may include the presence of multiple disabilities, severe / profound intellectual disability, coexisting mental health issues, significant health conditions, behaviours of harm, alcohol and / or drug misuse, and experiences of trauma or neglect”.23

Having complex support needs is not itself an issue. Rather, the issue is when the system fails to respond to those needs effectively due to fragmentation or poor cross-sector collaboration.

There are two pressing concerns regarding consumer-directed service delivery for clients with complex support needs. First, consumer-directed systems may be less well-equipped to respond to such clients. Second, people with complex support needs may be less well equipped to access supports under self-directed systems, particularly if they cannot self-advocate and / or lack people to advocate on their behalf. However, the current system may not be any more effective in meeting the needs of people with complex support needs as block funding of services promotes fragmentation of services and silos between different departments and sectors.

In a full scheme NDIS, the needs of people with intellectual disability may be missed “due to the ‘hidden’ nature of some issues, or due to the difficulties for some people to articulate their needs under a choice and control approach”. By implication, service planners need to be highly skilled to determine what constitutes a “reasonable and necessary scope and level of service” for each person, and to mitigate the risks associated with planning supports for someone “who has no carer or advocate, is disengaged or suspicious of governments and service providers, or has little idea of what potential support options may exist.”

The complex support needs of specific groups may also be poorly addressed where the market lacks depth, for example this may include people with early onset dementia, Aboriginal and Torres Strait Islanders with disabilities, and people from Culturally and Linguistically Diverse backgrounds. The range of client groups who have complex support needs include those:

- who are profoundly disabled;
- who have dual diagnoses such as a mental illness and concurrent disability;
- who need intensive one-on-one support 24 hours a day;
- who are aged 50-65 in residential aged care and may not be eligible for NDIS;
- with mild autism;
- who have degenerative conditions such as Huntington's Disease and Motor Neurone Disease;
- whose needs intersect with other systems such as the Department of Education, Child Protection, and the justice system;
- who require specialist equipment (e.g. paediatric rehabilitation) that involves out-of-pocket expenses;
- who have injuries, present in the acute sector, get misdiagnosed and their brain injuries are overlooked;
- with behaviours of concerns who pose a risk to others and themselves; and
- who are in an environment with intergenerational trauma and disabilities but only certain family members are eligible for support under the NDIS.

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A risk inherent in market-based mechanisms of disability support is that organisations may “cherry-pick” more profitable clients “irrespective of need.”29 The underlying assumption is that the NDIS may not adequately incentivise clients with complex support needs and/or behaviours of concern. We return to a discussion of clients with complex support needs in the forthcoming discussion about governance considerations relating to NDIS transition.

The NDIS roll-out in Tasmania

The Bilateral Agreement between the Commonwealth and Tasmania (the Agreement) describes how and when the NDIS will be rolled out across Tasmania from July 2016.\(^{30}\) The 2016 Tasmanian Operational Plan for NDIS Transition\(^{31}\) provides an overview of how the NDIS will be operationalised in Tasmania. Table 1 describes the key dates in the transition.

Table 1: Key dates for NDIS transition, Tasmania

<table>
<thead>
<tr>
<th>Date</th>
<th>Age group for transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 July 2016</td>
<td>12-14 years old</td>
</tr>
<tr>
<td>1 January 2017</td>
<td>25-28 years old</td>
</tr>
<tr>
<td>1 July 2017</td>
<td>4-11 years old</td>
</tr>
<tr>
<td>1 January 2018</td>
<td>29-34 years old</td>
</tr>
<tr>
<td>1 July 2018</td>
<td>0-3 and 35-49 years old</td>
</tr>
<tr>
<td>1 January 2019</td>
<td>50-64 years old</td>
</tr>
</tbody>
</table>

Under the Agreement, the NDIA is responsible for implementing the NDIS.\(^{32}\) Current estimates suggest that by June 2018, 45% of participants will have transitioned to the NDIS,\(^{33}\) which means the final 12 months of the transition will require intense activity as the remaining 55% of clients transfer to the new arrangements.

During the trial phase of the NDIS, Tasmania has committed $22.1 million in financial and in-kind support. Full scheme implementation will see that commitment rise to $232 million in financial and in-kind contributions. The NDIS Market Position Statement – Tasmania released in July 2016 demonstrates that the number of registered providers have already doubled in a two-year period, and is expected to double again in the next three years. The scheme is also expected to generate 1750 new full-time positions, and increase demand for disability supports from $220 million to $480 million by 2019.\(^{34}\)

The disability service market in Tasmania is already growing and adapting to meet the needs of clients with disability.


\(^{31}\) NDIS. 2016. Operational Plan Commitment between the National Disability Insurance Agency (NDIA), Tasmanian Government and Commonwealth Government for Transition to the National Disability Insurance Scheme (NDIS).

\(^{32}\) See www.ndis.gov.au for general information about the NDIS.


Roles and functions the DHHS will retain with full transition to the NDIS

The DHHS Review of Disability Services 2008 recommended that the roles and responsibilities of the DHHS need to include: building the capacity of the non-government sector; strategic policy and service system development, purchasing, funding; and regulation. The main strategy identified to achieve this was devolving all responsibility for direct service delivery to the non-government sector by 2011, however these recommendations were not implemented.

The transition to full scheme NDIS affords the Tasmanian government another opportunity to exit from direct service delivery.

Findings from this review demonstrate that services currently provided by the DCS are highly variable in form and quality. While individual service providers can be effective and provide high-quality services, overall services are insufficiently responsive, and at times inappropriate for the client and inefficiently provided. As such, they are not consistent with the DCS vision for service provision in the Disability Services Strategic Plan 2015-18 (Strategic Plan). Further, it is not appropriate for government to continue to act as a provider in the emerging disability market as it is difficult for it to ensure competitive neutrality, which is likely to lead to anti-competitive behaviour. This in turn threatens to undermine the principles on which the success of the NDIS is predicated.

In short, the role of the state government in a full scheme NDIS will need to be very different to the current role of the DCS. The role of the DHHS does and will continue to involve regulation, monitoring NDIS-related data and finances, as well as strategic policy and service system development. There may also be a role for strategic purchasing and funding services, although the scope of that function will diminish significantly as self-directed funding through the NDIS increases and becomes the norm rather than the exception.

The DHHS may need to continue to provide block funded services in exceptional circumstances to ensure clients ineligible for the NDIS are still able to access services they need. This may apply, for example, to clients with severe, complex behavioural problems and dual diagnosis. There are divergent views as to the appropriateness of this approach, with concerns that whilst “both government agencies and contracted community providers may find it financially more secure and administratively more convenient to agree on an inflexible block grant approach to service delivery (it) does not mean it is in the best interests of the recipient. Collaboration between the public

35 KPMG. 2016. DHHS Tasmania: Review of Tasmanian Disability Services
37 The ACT Government sees the role of the territory government is to support the NDIS, where doing so requires stepping out for specialist disability service provision so that the market and sector can have an opportunity to respond. http://www.communityservices.act.gov.au/disability_act/national_disability_insurance_scheme/role-of-government-national-disability-insurance-scheme/questions-and-answers
contractor and the private/community provider should not become an excuse for mutual self-interest. The driving principles must be choice and contestability.”

In the transition to full scheme NDIS, the DHHS will have to develop and expand the relational dimension of their role. Although the Strategic Plan identifies working in partnership as a key strategy, the transition to NDIS represents an opportunity not only to collaborate with the community sector, but also with the private sector. In fact, building capacity and facilitating collaboration amongst all three sectors: government, private and not-for-profit, is a challenge for contemporary governments and key to the success of the NDIS. DHHS will be required to support capacity building and meaningful collaboration alongside peak bodies and the NDIA.

**Strategic policy:** The Tasmanian government will continue to have a role to play in developing evidence-based specialist disability policy documents for the Tasmanian system. Shared governance arrangement of the NDIS also means that DHHS policy-makers will need to actively work with other sectors to influence political decisions.

The DHHS will be required to ensure national policies are responsive to local needs, and those not eligible for the NDIS are still able to access required services and supports. They are also likely to have to transition more from policy process to policy outcomes.

Policy makers wanting to safeguard the rights of people most likely to be excluded from the NDIS have a responsibility to understand possible constraints on the service system with the introduction of the NDIS, so that they can ensure viable alternatives are available to protect the rights of people with disability, while maximising people’s level of personal choice.

**Regulator:** the DHHS will continue to play a role in ensuring legislative and statutory requirements are met, performance is monitored, and processes to ensure quality and safeguards are effective. It is likely that the DHHS will need to improve its quality assurance processes in the transition period, and possibly after the national quality and safeguards framework is released.

The DHHS will need to shape the regulatory culture in response to NDIS reforms, and may also have a role in correcting the market through improved regulation and information in response to demonstrated market failure. The NDIS requires a dynamic service system that is financially sustainable and rewards those who provide high-quality

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40 Shergold, 2016.
41 Boyd-Caine. 2016.
42 While outside the scope of this review, the DHHS will also need to retain a policy function focused on community services.
43 Purcal et al. 2014.
44 Seibert, K. Navigating Reform in Contested Spaces: Reflections on not-for-profit sector regulatory reform in Australia, 2010–2013 in Gilchrist et al. (eds.) 2016. pp 131-156
supports. This requires “greater planning, investment and sector development” from government.45

**Cross-sector coordinator:** This denotes the DHHS’s role in coordinating collaboration between the private, not-for-profit and government sectors. Since the DHHS has established relationships with the not-for-profit sector, this component of their role will require developing strategies to effectively engage private sector disability providers, and facilitating improved collaboration between the private sector and the other sectors. Cross-sector collaboration so understood is crucial to identifying risks and issues as they emerge and responding to gaps in the local disability service system in an informed manner.

The DHHS will continue to have the role of facilitating inter-agency and inter-departmental collaboration. As per the preceding discussion, it will also have to develop and improve its role as coordinator of cross-sector collaboration to ensure the NDIS meets the needs of Tasmanian service users and service providers. This forms part of the Government’s role as steward of public resources required to “involve and commission others to help design government policies and to plan the legislative and administrative architecture that frames their implementation.”46

**Strategic purchaser:** the DHHS will continue to have a role as funder during the transition to full scheme that will include monitoring data and finance related to the NDIS. They may also have a limited role in funding for those ineligible for the NDIS after full scheme. The latter will depend on the extent to which the NDIS funding model evolves and is adapted in response to feedback from the sector. As such, the DHHS will need sufficient flexibility to be able to respond to a need to continue as funder in some limited capacity if required.

**Transition support:** Finally, the DHHS has time-limited role to play in effectively driving and managing change in the transition period. The scope of this change is considerable and complex. Findings from the consultation process demonstrate a need for more effective change management, clearer communication with staff, and timely information about which staff will be affected by the transition to full scheme NDIS, when and how, so that they can plan accordingly. There may be merit in contracting change management specialists to facilitate the transition to full scheme NDIS and ensure the DHHS workforce is effectively supported. There may also be merit in developing a function dedicated to clients with complex support needs during the transition.

Ultimately the onus is on the DHHS to operationalise the recommendations and decide on the most appropriate structure and workforce in a full scheme NDIS. Based on the current implementation challenges and complex policy environment of the NDIS, the current complement of 3 FTE policy staff is likely to be required throughout the transition period and ongoing. There may also need to be an additional 1FTE to cover the strategic purchasing, finance and data management related to the NDIS, and 1FTE dedicated to coordinating cross-sector collaboration. There may only need to be 1 FTE Management

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46 Shergold 2016.
position in a full scheme NDIS. It will be important to ensure that the skill mix of the staff matches the requirements of the posts. The following recommendation relates to the role of the DHHS in a full scheme NDIS:

Recommendation

2. That the DHHS consolidates its ongoing disability functions to strategic policy and purchasing, regulation, monitoring NDIS data and finance, and coordinating collaboration between the private, not-for-profit and government sectors.
Roles and functions the DHHS will not retain with full transition to the NDIS

The following functions do not align with the ongoing role of the State Government in the NDIS, namely, strategic policy and purchasing, regulation, monitoring NDIS data and finance, and encouraging effective collaboration between the private, not-for-profit and government sectors. The recommended timeframes for consolidating and ceasing the functions below are predicated on the current projections that 45% of eligible participants will have transitioned to the NDIS by July 2018, whilst the remaining 55% will transition between July 2018 and January 2019, and the NDIS will be fully implemented and operational by July 2019.

Community Partnerships Team (CPT)

The following discussion and subsequent recommendation does not pertain to the community services functions provided by the CPT but is focused on the CPT’s specialist disability functions.

Findings from the review indicate that, while support from the CPT is valued, the system within which the CPT operates (with respect to its disability services functions) is not always efficient or effective. Transitional governance arrangements will need to be strengthened. It is also necessary to ensure building community sector capacity does not create a shared dependency. Findings from the consultation process indicate that the CPT can at times blur the line between being helpful and responsive and inadvertently creating dependency amongst some stakeholders.

The forthcoming national quality and safeguards framework will reduce the role for the CPT as regulatory and quality assurance, oversight of complaints and serious incidents, approach to restrictive intervention, and systems to evaluate the workforce will be managed at a national rather than state level.

Recommendation

3. That with respect to the disability specific component of the CPT function, the DHHS ceases half of it by the end of June 2018 and ceases the remainder of it by the end of June 2019.

Disability Assessment and Advisory Team (DAAT)

Overall findings from the consultation indicate there is support to cease the DAAT functions by full scheme NDIS. DHHS provided data about service utilisation for the first three years of operation of the NDIS in Tasmania. It shows that in relation to DAAT-type services, a large majority of registered providers have yet to provide any of these NDIS services. Analysis of the six highest volume services (individual social skills development, individual therapy with an occupational therapist, speech pathologist and psychologist, and behavioural support management plan) shows that so far only about 44% of

registered providers have billed for these services. Overall, only 66 of 129 (51.2%) providers registered to provide DAAT services had done so by May 2016. This suggests there is significant additional, available capacity currently within the system to manage DAAT clients.

Service quality, responsiveness and appropriateness is contingent on how the individual DAATs function in each region; whether clients can access the professions they need; and which clinicians they are referred to. Findings from the review indicate that the DAAT function could be provided by the private or not-for-profit sector in a full scheme NDIS and there is already evidence of similar services and functions in those sectors. However, the NDIA and Tasmanian Government will need to work closely to ensure the market develops during the transition period.

In order for that to occur, the DAAT function will need to halve during the transition and cease by June 2019. One way to consolidate the functions during the transition period might be to amalgamate the South East and South West DAATs and the North and North West DAATs. Since the market may take longer to develop in the North West, there may be merit in consolidating the DAATs in the South and North earlier than in the North West. Overall, it is necessary to ensure that in ceasing the DAAT function, clients can still access high-quality positive behavioural support plans and interprofessional support, both of which are key components of disability service provision.48 We revisit these issues in the section on market capacity and sector development.

By providing intensive service delivery which at times exceeds the prescribed hours set down by the NDIA, DAATs may have inadvertently masked the actual need for services. During the transition and in the longer-term, the NDIA and DHHS will need to make an accurate assessment and address system gaps, and to quantify the support costs, particularly for complex clients.

**Recommendations**

4. That the DHHS ceases half of its DAAT function by the end of June 2018 and ceases the remainder of it by the end of June 2019.

5. That the DHHS ensures its DAAT clinicians accurately account for the actual hours of service provision involved in supporting NDIS clients, particularly those with complex support needs.

**Disability Gateway Consultants**

The functions of Disability Gateway Consultants of improving transfers of care; mitigating the risk of clients inappropriately being transferred to residential aged care facilities; and liaising between sectors are important, particularly during the transition to full scheme NDIS. However, the function could effectively be located in and provided by the not-for-profit sector now as the Consultants are closely connected to the Gateway services which are based in the not-for-profit sector. As such, while demand for the Consultant

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position will decrease by June 2018 and need to cease by June 2019, there is merit in the DHHS considering devolving the function to the not-for-profit sector earlier.

Recommendation

6. That the DHHS ceases half of the Disability Gateway Consultant function by June 2018 and ceases the remainder of it by June 2019.

Administration and Management

Once the broader regional area teams downsize and start transitioning, the need for administration and management will necessarily decrease and both functions should be consolidated. For example, once the CPT and DAAT functions reduce in response to decreased demand and increased number of eligible clients transitioning to the NDIS, the need for multiple managers and administrators to support those teams will decrease. A finding from the review process was that the ratio of managers to non-managers is high, which can result in micro-management, complex reporting lines, and inconsistent messages between management.

In terms of management, it is important to ensure that the DCS structure does not remain management heavy as the broader functions reduce. A successful transition requires executive and management support, which needs to be characterised by a consistently positive attitude from senior staff. It may be beneficial to contract-in external, expert change-management resources to help with the transition process. If the DHHS decides to cease the Consultant role earlier, the remaining administrative and/or management function could assist with Ministerials.

Recommendation

7. That the DHHS ceases half of the existing management and administration functions consistent with the reduction of other DCS functions by June 2018 and ceases the remainder of these functions by June 2019.

Intensive Support Services (ISS)

The ISS function is an important resource for the small number of clients who have exceptional needs. Nevertheless, there was consensus amongst those consulted that the function could effectively be transitioned to the not-for-profit or private sector. Indeed, there are not-for-profit organisations in Tasmania which already provide ISS. Moreover, the demand for ISS has reduced since some of its main client cohort (people aged 20-25) have transitioned to the NDIS already. As such, while the recommendation regarding the ISS is consistent with the timeframes for ceasing other affected DCS functions, this function could cease as early as December 2017 subject to effective referral pathways for existing clients.
Recommendation

8. That the DHHS ceases the ISS function by or before June 2019 and ensures there are effective referral pathways and continuity of care for existing clients.

Individual Funding Unit (IFU)

Since the number of individual support packages administered by the DHHS will decrease as each age group is transitioned to the NDIS, the demand for the IFU will steadily decrease. As such, it is necessary to consolidate the IFU and start reducing the FTE relative to the diminishing need.

Recommendation

9. That the DHHS ceases half of the current IFU function by the end of June 2018 and ceases the remainder of it by June 2019.

Workforce Development Unit (WDU)

The DHHS is required to provide support to the workforce during the transition, through its existing Human Resources and Workplace Relations functions based in Corporate Policy and Regulatory Services – Human Resources, Management and Strategy. The NDIA, with input from the NDS, is responsible for mapping workforce needs; sector development and capacity building; and liaising between the sector and the tertiary education systems. The Tasmanian government also has a role to play in workforce development and market readiness in response to NDIS.

As such, having an additional WDU separate to those functions in DCS duplicates existing initiatives and centralised workforce development functions. While the recommended timeframe is consistent with the recommendations related to other functions, there is merit in DHHS considering options to devolve this particular function to an area in Government already focused on workforce development and support. As with the ISS function, this could be done as early as December 2017 to integrate and bolster efforts to support the disability workforce.

Recommendation

10. That the DHHS ceases its disability services WDU function by or before June 2019.
Governance considerations relating to NDIS transition

Governance in relation to NDIS transition arrangements refers to the systems by which managing bodies (i.e. the DHHS and NDIA), managers, service providers and other staff share responsibility and accountability for the quality of care, continuously improving, minimizing risks and fostering an environment of excellence in care for consumers.

An effective system of governance at all levels of the disability service system is essential to ensure continuous improvement in the safety and quality of care. Good governance makes certain that there is accountability and creates a ‘just’ culture that is able to embrace reporting and support improvement. Consumers are central to identifying safety and quality issues and the solutions that must be implemented.

This review incorporated a comprehensive analysis of existing and proposed future governance arrangements through the NDIS transition. Since the national quality and safeguards framework, which will articulate the responsibilities of all parties for the safety and quality of services, has not yet been agreed, the governance analysis was necessarily somewhat constrained.

States and Territories have a Schedule as part of their Bilateral Agreement that outlines the transition arrangements for quality and safeguards. Interim quality and safeguards are also a key deliverable in the 2016 Tasmanian Operational Plan for NDIS Transition. During the transition, the DHHS Quality and Safety Standards for CSOs, Disability Services Act 2011, Disability Services Regulations 2015, and other relevant DCS policy documents apply.

Research highlights the complexity of disability support governance in a self-directed funding model like NDIS “given the diversity and complexity of disability systems and the people they service.” Contemporary governance models involve balancing a range of competing elements such as accountability and efficiency, governability and flexibility, cooperation and competition.

Findings from the consultation process suggest that incidents occurring in the sector exceed those formally reported; the Senior Practitioner role is stretched and under resourced; and the interim governance arrangements may not be enough to protect clients with a disability.

There were also more specific concerns raised relating to clients with complex and specific support needs. Representative here is ensuring clients with intellectual disability or dual disability who have been prescribed psychotropic medication are effectively monitored to ensure principles of medication management and least restrictive interventions are being applied. Other concerns raised mirror those discussed earlier in relation to clients with complex and / or specific support needs who may be adversely affected by the transition to a full scheme NDIS.

50 Ibid.
The NDIA arrangements for ensuring least restrictive practices, and how these arrangements will align with existing Senior Practitioner roles within the jurisdictions, have not been formally agreed. The DHHS retains its legislative responsibilities to ensure least restrictive practices are used until such time as the Tasmanian legislation is revoked or amended.

The DHHS has regulatory roles in ensuring the delivery of safe, high quality services to people with disability. These roles are not limited to the functions of the Senior Practitioner. Other legislation is relevant to the care of people with dual disability includes:

- Guardianship and Administration Act 1995;
- Public Trustee Act 1930;
- Anti-Discrimination Act 1998;
- Personal Information Protection Act 2004;
- Ombudsman Act 1978;
- Education Act 1994;
- Guide and Hearing Dogs Act 1967;
- Children, Young Persons and Their Families Act 1997;
- Mental Health Act 1996;
- Motor Accident (Liabilities and Compensation) Act 1973;
- Poisons Act 1971;
- Tasmanian Health Organisations Act 2011;
- State Service Act 2000;
- Health Complaints Act 1995;
- Registration to Work with Vulnerable People Act 2013; and
Recommendations

11. That the DHHS comprehensively describe and mitigate the strategic, tactical and operational risks relating to the transition to full scheme NDIS, prior to transitioning clients.

12. That the Tasmanian Government works with key stakeholders including the NDIA, Tasmanian Health Service and Primary Health Tasmania to ensure clients with complex and/or specific support needs are not adversely affected by the transition, and to improve the capacity and capability of mainstream services to support them.

13. That the DHHS puts strategies in place to improve collaboration across the private, not-for-profit and public sector to: ensure clients with complex and specific support needs can access appropriate services; identify service gaps; and increase the likelihood of effective system responses to service gaps.

14. That the DHHS specifically strengthens its regulatory approaches in relation to clients with a dual diagnosis, in recognition that amendments to Tasmanian disability legislation will not negate the Department’s obligations under other legislation.

15. That the DHHS considers reviewing its interim quality and safety processes and makes an assessment as to whether the office of the Senior Practitioner requires additional support until such time as the National Quality and Safeguards Framework is finalised.
Consumer readiness for the NDIS transition

Although the NDIS’s focus on choice and control are a positive step forwards, in practice these present significant challenges. In particular:

- some people may lack the capacity to manage their funds, “resulting in inappropriate use of their allowance or inadequate services being received”;51
- people eligible for the NDIS may not be interested in self-directed support;
- clients may be vulnerable to “marketing of ineffective products with limited scientific basis”;
- the diversity of individual needs makes it difficult to balance cost and choice;
- low expectations based on previous experiences constrain choice under the NDIS; and
- NDIS nominee provisions for supported decision making.

Self-directed models seem to favour those “with greater capacity to exercise choice,” which may mean some clients are “vulnerable to intended or unintended exploitation.” Nevertheless, research demonstrates that reports of abuse in self-directed support programs are rare.

Examples of client groups who might be adversely affected under the NDIS include those unable to self-advocate; whose expressive language skills do not match their receptive language skills and vice versa; and who lack the required information to choose supports that are all-things-considered best for them. The latter concern has been labelled a ‘new paternalism’ inasmuch as it implies (some) people with disability might not be best positioned to make decisions about their supports. Nevertheless, the challenge for professionals of empowering people “by giving them more control whilst also meeting their duty of care” is well documented.

Another issue is that support needs are contingent on an individual’s personal circumstances, resources, and unique disability trajectory. The latter is rarely, if ever, linear. While the NDIS is a unique example of public policy with an incentive to invest in

51 Crozier et al. 2013.
53 Foster et al. 2016.
57 Crozier et al. 2013.
58 Crozier et al. 2013
59 Crozier et al. 2013.
60 Foster et al. 2016.
early intervention,\textsuperscript{61} it may overestimate the extent to which early intervention mitigates the risk of later complexity, particularly amongst clients with degenerative conditions or intellectual disability.

The above issues are salient, and the state government will play a core role in working with the NDIA in addressing them. Despite this, there is evidence that “satisfaction in service delivery and life domains is generally higher where control or self-direction is maximised.” \textsuperscript{62}

\section*{Recommendation}

\begin{itemize}
\item [16.] That the DHHS works with key stakeholders to optimise its responsiveness to individual client needs and supports building capability amongst Tasmanian consumers to undertake self-direction and make informed choices about their support requirements.
\end{itemize}

\textsuperscript{61} Butcher and Gilchrist. 2016. ‘Conclusion’ in Gilchrist et al. (eds.) 2016.
\textsuperscript{62} Crozier et al. 2013
Market capacity and sector development

There can be a tendency to assume that there is one monolithic market that makes up the disability sector. Rather, the disability sector can be understood in terms of distinct not-for-profit and private businesses that vary significantly in structure and maturity. For example, St Giles is currently a market leader in paediatric disability in Tasmania. Overall, the disability sector “provides support for people with a broad range of impediments including acquired disabilities such as brain injury and spinal cord injury, irreversible physical injuries and children and adults with intellectual and developmental disabilities (from birth) such as cerebral palsy, autism spectrum disorders and Down syndrome.”

There is a risk that the Tasmanian market may not develop sufficiently to meet the needs of NDIS participants. A particular risk is that markets in regional and remote areas may be thin, which may constrain choice for clients in those areas. Another is that specific markets such as access to high-quality positive behavioural support may not increase sufficiently to meet the demand.

In keeping with the former concern, researchers have argued that a demand-driven model like the NDIS may mean people in rural areas are further disadvantaged. Others have argued that the NDIS cannot rely entirely on a market response without explicitly addressing “contextual policy constraints” such as the shortage of service options in regional areas. Rather, “incentives for infrastructure development will be necessary given discrepancies in geographical capacity.” Of interest is that while the NDIA expresses a preference not to interfere with the market unless doing so is required, its recent move to double the funding for housing demonstrates that they are willing to incentivise the market if required.

There is evidence that people who live in rural and remote areas are at risk of “poorer health status, shorter lives, higher rates of accident and injury, greater levels of illness, and lower rates of certain medical treatments.” NDIS policies will need ‘rural-proofing’ to ensure they are “responsive to the needs of service providers and service users in rural and remote areas.” This is underpinned by the view that policy context is important in ensuring rural disability service users and providers are not disadvantaged. Policy

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65 Gallego et al. 2015.

66 Purcal et al. 2014.

67 Foster et al. 2016.


makers need to meaningfully engage with regional and remote communities, and ensure targets and outcomes are appropriate.\textsuperscript{70} Other avenues worth considering include investing in ICT and telemedicine. There is some evidence that even more specialised services such as conducting clinical swallowing evaluations can be done remotely if required.\textsuperscript{71} There is also limited evidence to suggest that people in rural areas see benefit in Information Communication Technologies such as telehealth as a mechanism for accessing clinical support for people with disabilities.\textsuperscript{72}

In a full scheme NDIS, specific market gaps may occur in the following areas:

- access to high-quality behavioural support plans and functional assessments;
- interprofessional specialist disability teams;
- supports for people with dual diagnosis;
- specialised environmental assessments and access to specialised equipment;
- specialist nursing skills;
- support for people with early onset dementia;
- services dedicated to working at the most difficult end of the spectrum; and
- specialised support for degenerative conditions such as Huntington’s Disease.\textsuperscript{73}

Where market gaps intersect with increased remoteness and geographical isolation, access barriers may increase. For example, rates of Huntington’s Disease and early onset dementia are proportionally higher in the North West of the state which has less services than the North and the South. Although building the required market capacity for full scheme NDIS will be complex and take time, there is evidence that the market is already growing and expanding.

The Tasmanian Market Position Statement released by NDIS in July 2016, identified that 228 providers had so far registered to provide services. In particular, it noted that new business types and industries not normally associated with the disability sector, including fitness, builders, financial services and ICT had registered. Opportunities for service providers from outside the usual geographic regions and from adjacent service sectors, such as health and aged care, were also recognised.

Current experience in Tasmania with respect to DAAT-type services indicates that there is a fairly slow, but forwardly progressive trend for registered providers to be contracted for service provision, with 51.2\% of 129 registered providers contracted.

However, of the 32 DAAT service items available through the NDIS, none of the registered providers have been contracted for ten of the items, and less than 20\% had


\textsuperscript{72} Gardener K, Bundy A, Dew A. 2016. ‘Perspective of rural carers on benefits and barriers of receiving occupational therapy via Information and Communication Technologies’ \textit{Australian Occupational Therapy Journal} 63: 2 pp 177-122

\textsuperscript{73} Pridmore, S A. 1990. ‘The Prevalence of Huntington’s Disease in Tasmania’ \textit{Medical Journal of Australia} 153, pp 137-139
been contracted for a further ten services. As such, there is considerable scope in particular specialist areas as well as overall within the registered NFP and private sector to undertake NDIS contracted services.

**Cost modelling**

A cost model using the NDIA efficient price, current DCS regional staff profile (including 20 FTE for management and administration, but excluding executive appointments), current contracted DAAT caseload and various scenarios in relation to face to face client time shows that a base scenario offers a break even position for the not-for-profit and the private sector. In all likelihood the overall complexity of the DCS clients exceeds that factored into the model, but consolidation of administrative and management overhead and recruitment of a workforce with a greater spread of seniority would largely counter-balance these effects.

**Workforce development**

Access to a skilled allied health workforce is crucial to the NDIS. The Tasmanian workforce will need to develop more capacity and capability, particularly in the following areas:

- access to skilled, high-quality support workers;
- workforce with formal disability qualifications;
- workforce diversity;
- workforce opportunities in remote areas;
- cross-sector workforce support in areas such as clinical supervision and continuing professional development and mentoring;
- strategies to mitigate the risk of casualisation of the workforce;
- specialist workforce; and
- access to quality training and professional development for clinicians and carers.

The issues above share similarities with those raised in the literature and in other jurisdictions. Representative here:

- the challenge of facilitating clinical placements in the not-for-profit sector under the NDIS;\(^{74}\)
- poor professional support, limited career pathways, social isolation, and low job satisfaction in rural areas;\(^{75}\)
- need for cultural training and the development of an Indigenous disability workforce;\(^{76}\)
- the shortage of available support workers;\(^{77}\)

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\(^{75}\) Lincoln et al. 2014.

\(^{76}\) Gilroy et al. 2016.

\(^{77}\) Crozier et al. 2013.
nights away from home for work are a barrier for mid-career clinicians with dependents; 78
onerous management and administration systems; inflexible working arrangements; and lack of professional autonomy threaten retention; 79
short-term and casual contracts are a barrier for recruitment and retention; 80

Lincoln et al. 2014 argue that although there is not a shortage of allied health professionals per se, there is a relative shortage in more remote regions, which can present challenges to service delivery when clients are dispersed over larger geographical areas. 81 Research also suggests that there are opportunities for strategic recruitment in rural areas as new graduates can be likely to relocate to rural areas.

The Tasmanian branch of the National Disability Service has recently developed a workforce strategy and action plan. 82 Further, the NDIS plans to map regional supply and analyse sub-markets as part of its ongoing process of developing market position statements for each jurisdiction.

Proposed solutions to the workforce issues outlined above include: clinical placements shared across sectors; strong quality and service compliance framework; flexible recruitment practices to reduce competition between sectors; 83 working with the university sector to get more flexible local delivery of allied health courses; and scholarships in disability that include flexible, distance study options to grow local expertise. The Tasmanian Government will have a role to play in supporting agencies such as the NDIA to identify and respond to workforce shortages and gaps.

78 Gallego et al. 2015.
80 Lincoln et al. 2014.
81 Gallego, G et al. 2015.
83 Lincoln et al. 2014
Supporting the DHHS workforce during the transition

The DCS workforce provided extensive feedback in relation to this review process, as did key stakeholders in the not-for-profit, private, advocacy and government sector. It was very beneficial to our consultants that stakeholders were engaged and forthcoming with their expert opinions. In order to protect the privacy of those consulted and because the Tasmanian disability sector is small, this report does not document that feedback in a way that is identifiable.

Views about whether the DHHS should retain its specialist disability functions in a full scheme NDIS were many and varied. In general terms there was a divide between those who thought the DHHS ought to retain its specialist disability functions in a full scheme NDIS, and those who did not. Overall, more stakeholders consulted supported the DHHS ceasing its specialist disability functions in a full scheme NDIS, subject to strategies to ensure clients are not adversely affected by the transition.

Whilst the NDIS is a national reform agenda, and the recommendations here reflect the current national timeframes for transition, it will have significant implications for the current specialist disability workforce in the DHHS. Many of the affected functions are provided by people who have been working in specialist disability support in the state service for many years, which needs to be recognised when implementing this report’s recommendations. Where possible, efforts need to be made to retain the expertise, knowledge and skill of affected DHHS staff in the sector.

Findings from the review process demonstrate that overall the DCS workforce is fatigued by the uncertainty and change associated with years of disability reform. There is a need for unambiguous and timely information about what the transition to full scheme NDIS means for individual staff members, clients, and CSOs. More specifically, DCS staff need to know the dates of transition and what their career pathway options are.

Affected DCS staff also need to be supported to wind-down work functions and transition to other career pathways. For some staff this will require support preparing to apply for other jobs, training and education support, and one-on-one career option discussions. It will also need active support from management to help individuals reprioritise workloads during the transition to ensure they are manageable.

Clinical staff interested in establishing private practices would benefit from training support in establishing a business, maximising the funded items under the NDIS, and business models that may enable them to provide multidisciplinary or transdisciplinary support to clients. Other staff may be interested in upskilling to assist in finding employment within the state service, or in other sectors.

The redeployment process should ideally start as soon as possible and be staggered during the transition period to mitigate the risk of adversely affecting clients, staff and CSOs when reducing and ceasing DCS functions.

The main risk to the transition is that it does not get implemented in a timely and effective manner. Among other things, this would increase uncertainty and worsen staff morale. The impact of implementing the recommended changes on individual staff members cannot be underestimated. Effective change management will be crucial.
Recommendation

17. That during the transition period the DHHS ensures effective change management and transition support for all affected DHHS staff. This will need to include clear communication, timeframes, and timely information about career pathways and options.
References:


DHHS. 2014. Restrictive Interventions in Services for People with Disability Guidelines, © State of Tasmania


Gardener K, Bundy A, Dew A. 2016. ‘Perspective of rural carers on benefits and barriers of receiving occupational therapy via Information and Communication Technologies’ *Australian Occupational Therapy Journal* 63: 2 pp 177-122


KPMG. 2016. DHHS Tasmania: Review of Tasmanian Disability Services


Maxwell, R. J. 1992 ‘Dimensions of quality revisited: from thought to action’ Quality in Health Care 1: 171-177


NDIA. 2013. ‘Quality Assurance and Safeguards Working Arrangements for the Launch of the NDIS in Tasmania: As agreed between the Department of Health and Human Services (DHHS) and Launch Transition Agency (TASMANIA).


Needham, C. 2016 'The Boundaries of Budgets: Why Should Individuals make spending choices about their health and social care?’ in Gilchrist et al. (eds.) pp 319-334


Olaussen SJ, and Renzaho AM. 2016. ‘Establishing components of cultural competence healthcare models to better cater for the needs of migrants with disability: a systematic review’ Australian Journal of Primary Health 22:2 pp 100-112


Shergold P “Three Sectors: One Public Purpose” in Gilchrist et al. (eds.) 2016.


Shergold P “Three Sectors: One Public Purpose” in Gilchrist et al. (eds.) 2016. p.29-30


Tasmanian Department of Health and Human Services. 2009. Operational Framework for Disability Services ©Department of Health and Human Services


Websites:

- https://www.dhhs.tas.gov.au/about_the_department/business/community_sector_relations_unit/resources,_publications,_and_tools/quality_and_safety_standards


• https://www.stgiles.org.au/therapy-services#fndtn-ui-id-11

