More effective social services

The Wise Group's submission to the New Zealand Productivity Commission

wisegroup.

Introduction

This submission is made by the Wise Group in response to the New Zealand Productivity Commission's issues paper – *More effective social services* (2014). It consists of:

1. **key messages and recommendations**
2. **specific responses to the 56 questions posed in the issues paper**
3. **a case study on employment services.**

The Wise Group is one of the largest non-government organisations (NGOs) in New Zealand, with more than twenty five years' experience of dealing with multiple agencies and funding arrangements. It is well placed to comment on commissioning, accountability and outcomes, contestability, service delivery, the private market and how we use information to influence the quality and effectiveness of social services.

The New Zealand Productivity Commission's issues paper – *More effective social services* is a clear signal that there are areas that need to be explored. We expect the Commission will hear compelling evidence that if we are to have a country where all New Zealanders thrive then change is needed and this will require both commitment and courage.

This is a joint submission from the following legal entities and has deliberately been written in plain language to ensure clarity of message and to aid communication of the recommendations.

Wise Management Services interacts daily with multiple government agencies and delivers business infrastructure and development services for the entire Wise Group, specialising in finance, legal and contracting, auditing, information services, human resources, communication and design, and governance. www.wisegroup.co.nz

Pathways operates nationwide and contracts with multiple district health boards (DHBs). It provides a range of specialist through to community-based services to support people with experience of mental illness and/or addiction to live well and flourish in the communities of their choice. These services include peer-led services, alternatives to hospital admission, community based support and a broad range of wellbeing services. www.pathways.co.nz

Te Pou is one of only a few NGOs internationally who holds a commissioning role on behalf of the government to support the delivery of evidence-based workforce development to the mental health, addiction and disability sectors. Funded by the Ministry of Health and Health Workforce New Zealand, Te Pou is a source of resources, support, tools, advice and funding. Te Pou incorporates Disability Workforce Development and Matua Raki (addictions workforce development). www.tepou.co.nz

Workwise provides services national wide and contracts with DHBs, Ministry of Social Development (MSD), Corrections and primary health organisations (PHOs)**.** It works with people who are experiencing personal challenges, and supports them to find and keep work. Workwise believes that having a paid, meaningful job is a key part of helping people live happy, healthy lives. www.workwise.org.nz

Mental Health Solutions is a centralised contract-holding company that provides a single point of entry for any Crown agency to contract and fund a member of the Wise Group. Mental Health Solutions also plays a critical role for the group in sponsoring and supporting the establishment of innovative, transformational services.

Wild Bamboo develops and delivers smart client information systems so non-government community organisations can work smarter and get better results for them and their clients. www.wildbamboo.co.nz

Linkage contracts with multiple government agencies and provides a variety of services to help people navigate their way through the government, health and social service systems to find solutions that best meet their most urgent needs. Linkage provides service navigation and community engagement services, the online Webhealth health and wellbeing provider directory, advisory support for ACC claimants and general practitioner (GP) integration services for people transitioning out of secondary mental health services. www.linkage.co.nz

Blueprint for Learning delivers a diverse range of training at all levels, to a wide range of health, mental health and social sector agencies. Blueprint is a private training enterprise. www.blueprint.co.nz

Keys Social Housing is a social housing provider and ensures safe, healthy, comfortable and affordable homes and practical support are available to people who need homes in Auckland, Hamilton, Whanganui, New Plymouth and Wellington. www.keyshousing.co.nz

Le Va creates opportunities for Pacific families and communities to flourish through embracing Pacific solutions. Le Va's diverse portfolio supports a holistic perspective to wellbeing, encompassing Pacific mental health, addiction, disability, public health, general health, suicide prevention and education. www.leva.co.nz

Key messages and recommendations

Change is needed and this inquiry is timely and welcomed.

Contestability and the costs associated with it currently reside in the area of least investment - in the NGO sector. This is detrimental to the delivery of high quality, effective social services. For example in specialist mental health and addiction services the NGO investment only makes up 28 per cent of total expenditure, with the additional 72 per cent in DHB provider arms which are never retendered.

1. The government should appoint an independent body to explore and determine which government services could be best provided using a different approach.

In addition to getting better value at a lower cost this will also make the non-government social sector sustainable and remove the degree of destructive competitive behaviour. It will also address advocacy issues.

2. There is an urgent need to acknowledge and eliminate instances in social services where there is a lack of funder/provider split.
3. A 'tight, loose, tight' high trust contracting framework should be adopted across the contracting of all social services. Tight in terms of specified resource, population and impact/outcomes. Loose in terms of model of care and service continuum.
4. Longer term contracts of high trust and based on outcomes should be developed. No less than five years and a maximum of ten. Start-up and/or innovation funding should be made available where appropriate.
5. A project should be undertaken to review, standardise, simplify and reduce the volume of reporting for the NGO sector.
6. A thorough review of the international and New Zealand literature on client-directed budgets should be conducted and made available as a resource le to funders and providers.

There is enormous potential to direct private investment toward social outcomes.

7. Trusted mechanisms and investment vehicles which provide a realistic financial return relative to risk need to be established quickly and efficiently. The appropriate sharing of risk between providers, investors and underwriters is a key to success.

As regards information technology and information sharing:

8. There is an urgent need to identify a subset of information about an individual client than can be shared, the development of a protocol about how that information should be managed and the development of a central mechanism to manage the sharing of information.
9. Initiate a programme of work to continue to develop and foster 'information competence' through all levels of the health sector.

Māori and Pasifika national and local organisations play a critical role in effective services for some of our most vulnerable populations. Ethnically disproportionate disparities and outcome inequalities are best addressed by solutions from within those communities.

10. Service specifications should require organisations and services to be culturally responsive and competent.

Employment case study - Mental health conditions are the most prevalent health condition of the working age population. Currently people experiencing these conditions fall out of work unnecessarily and when unemployed don't have access to the evidence-based employment support services which would support a successful return to employment and an improvement in health.

11. A national cross government mental health and employment strategy is needed to guide and support the policy, funding and delivery of more effective employment support services for people with mental health conditions.

We need contracting frameworks which create an operational environment that is flexible, innovative, responsive to need, results focussed and more productive. This environment is what we all want and it is what NGOs can deliver for New Zealanders.

Q1 What are the most important social, economic and demographic trends that will change the social services landscape in New Zealand?

The social, economic and demographic trends are well known and this information is publically available. How we respond to these trends will be greatly affected by what the social services landscape will look like in the coming years. We need to get it right and to do this we need change.

During the past twenty five years New Zealand has experienced exponential growth in the number of non-government social service agencies. Prior to this only a handful of agencies existed and most did not receive government contracted funding. The Wise Group was operational in 1988 and did not receive government contracted funding. Table 1 outlines what we experienced as the key differences between the two environments.

Table 1: The different contracting environments

	Pre government contract funding	**With government contract funding**
Advocacy	Most of the issues clients experienced related to access and service delivery from government agencies. The non-government providers readily challenged the system and individual services and escalated issues quickly for resolution.	Government agencies are now both funders and providers with little or no separation. Providers are now significantly compromised in their advocacy role for clients and unable to raise concerns.
Referrals	People self-referred to services and were easily transitioned to other providers, both government and non-government, with a phone call. There were no formal assessments or paperwork to any great degree and resources were mobilised with ease at a community level.	The government controls most referral points now and providers in many areas are unable to respond directly even if they see someone in extreme need. Many feel like a *'government waiting service';* referral systems are lengthy with multiple silo assessments for housing, income and health treatment.
Competition	In a world of no contracts the whole of the community had to work together to solve daily problems. There was a spirit of cooperation and whatever it takes between all providers to deal with those most in need.	There are too many providers for the amount of contracts available. Providers are pitted against each other in contracting environments and advance their own status with funders in a bid to survive.
Bureaucracy	There was no reporting, no paperwork of any degree, no audits.	Onerous paperwork and systems that don't talk to each other. Providers having to use vital funding for endless bureaucracy. There is waste with multiple audits all auditing the same area.
Funding	Everyone ran off the smell of an oily rag and what staff there were worked extraordinary hours. Piecemeal funding meant there was no guarantee of being able to continue to provide services and the organisations lacked the ability to purchase vital resources including training.	Organisations have been able to grow. Funding however is still piecemeal with most contracts under two years. This not only has a contracting cost but also increases costs with items like the lease of buildings and cars.
Systems	Little resource able to be spent on systems.	Rapid adoption of systems and in many cases now more sophisticated than some government agencies. Frustration at having to keep old technology like fax machines as the only people still using them is government agencies.

The growth of the NGO sector was fuelled by new government funding and a desire by some funders to have wide provider diversity. In deliberately growing this sector the current situation we now have was inevitable.

It is noted that on page 20 of the issues paper that the government is the largest provider of social services. The Better Public Services also noted this and recommended that all services be put out to tender.

However, government agencies have interpreted this as retendering all services, other than their own, that are currently tendered. This is causing increased anxiety with some services provided by non-government agencies being put out to tender every two years. This has serious implications on the organisations willingness to invest and cooperation between agencies. We have highlighted examples in this report.

To change the landscape of New Zealand to be able to respond to the social, economic and demographic trends that are looming we need to do the following.

- An independent body should be appointed to explore and determine which government services could be put out to tender. In addition to getting better value at a lower cost this will also make the NGO social sector sustainable and remove the degree of destructive competitive behaviour. It will also address advocacy issues.
- Eliminate issues in relation to funder/provider conflict, bureaucracy and cost by using other systems and mechanisms to purchase and provide services.
- With providers with a proven track record of success, offer longer term contracts. No less than five years and a maximum of ten years.
- Identify and eliminate waste in regard to referral and assessment processes, paperwork and compliance.

The Wise Group has flourished with government funding over many years but we have lost the freedom to respond to the needs of the community. We need contracting frameworks which create an operational environment that is flexible, innovative, responsive to need, results focussed and more productive.

This environment is what we all want and it is what NGOs can deliver for New Zealanders.

Q2 How important are volunteers to the provision of social services?

Times have changed and we now have a social service sector that deals with more and more complexity. The ability to incorporate volunteers is becoming increasingly difficult. In essence, having a volunteer is the same as having an employee. They need to be security checked, they need to be inducted, they need to comply with extensive health and safety requirements, they need to be trained and they need to be supervised.

Volunteers should never replace funded front line staff and we should ensure as country that our most vulnerable people are receiving services from our most skilled people who have a mandate and ability to advocate and link to other government and non-government services.

Q3 What role do iwi play in the funding and provision of social services and what further role could they play?

The role of iwi varies hugely across the country with some innovative and effective social services that may serve as exemplar to be shared and up scaled.

Indigenous Pasifika populations need to be acknowledged. Pasifika have been part of our New Zealand identity for more than 100 years, with government to government treaties, agreements, obligations and

legal commitments. Cook Islands, Tokelau, and Niue are administered under New Zealand, are New Zealand citizens, and utilise New Zealand social services.

A further role for Iwi and Pasifika organisations is working nationally in an integrated way across sectors and in collaboration with other key organisations; addressing critical issues of poverty and disparities together, with a shared vision, but different ways of doing this.

For example, Le Va's focus is to achieve consistent mental health and addiction outcomes for all New Zealanders by enhancing the quality of services for Pasifika peoples and their families.
Le Va brings solutions to Pasifika issues by working nationally in an integrated way across sectors – holding national portfolios delivering on mental health, addiction, disability support services, public health, and suicide prevention. Le Va has a track record of working in collaboration with key organisations – co-designing Pasifika mental health workforce development programmes with Te Pou, Pasifika addiction programmes with Matua Raki, and New Zealand's first Pasifika suicide prevention programme with Te Rau Matatini. Le Va thrives on working together for the best outcomes possible for Pasifika communities, and has extensive cross-sector relationships, such as a memorandum of understanding (MOU) with the Ministry of Education and is currently developing an MOU with the Mental Health Commission.

Q4 What contribution do social enterprises make to providing social services and improving social outcomes in New Zealand?

The issues paper raises the confusion regarding the definition of what is a social enterprise. The Wise Group regards itself as a social enterprise as it has a social mission and reinvests surpluses in the fulfilment of this mission.

We do wish to raise a word of caution in regard to social enterprise business being developed with the aim of meeting the employment needs of populations who face multiple challenges to returning to work. This is the other widely used definition of a social enterprise. Around ten years ago we developed a range of manufacturing and retail businesses for the sole purpose of assisting people who experience mental illness to gain employment. Around this time research emerged that effective supported employment programmes (individualised employment support) can support 60 per cent of people who experience a mental illness into mainstream competitive employment and that many people preferred this as an outcome. These employment support programmes are three times more effective at supporting people into work than traditional vocational programmes, like social enterprises. Furthermore, these employment programmes help people get jobs for more hours, higher wages and people stay longer in the jobs (Bond et al, 2008).

Our own experience supported this research and we sold these businesses and reinvested this funding into employment support services (more detail is provided in the employment case study on page 36).

Evidence shows us that the effort and funding used to establish social enterprise businesses to provide employment for vulnerable populations is better directed to employment support services alongside incentives to assist mainstream businesses to thrive and support the health and wellbeing of a diverse workforce.

Q5 What are the opportunities for, or barriers to, social-services partnerships between private business, not-for-profit social service providers and government?

Cross sector social services partnerships targeting strategic outcomes are a relatively new concept for New Zealand. Traditionally social services have been provided more or less independently through

existing government departmental structures, not for profit service entities and private business. There have been obvious limitations in providing coordinated services focussed on the needs of individuals and communities. Entrenched structures and patterns of behaviour, together with inadequate communication appear to have been the main obstacles.

Partnerships provide the opportunity to bring together a range of expertise and experience to focus on very specific problem resolution and strategic objectives.

The most significant challenges in achieving this are the lack of appropriate vehicles to support cooperative delivery and changing the entrenched and often inflexible structures. Well intentioned independent strategic objectives within the sectors and individual organisations will need to increasingly incorporate cross sector strategic objectives. The lack of experience and competence in managing cooperative mechanisms, combined with the tendency to preserve existing process and practice is a significant obstacle to progress.

Effective cross sector delivery requires focussed goals supported by appropriate joint venture structures to bridge the inherent communication and operational gaps. Mutually accepted and consistent definition and measurement of delivery and outcomes is an essential ingredient for success. Flexible funding mechanisms which facilitate the targeting of cross sector priorities are necessary to support the targeted initiatives.

Huge opportunity exists for coordinated cross sector problem resolution with the right mechanisms in place. A prime example is the potential for an emerging social bonds market to enable the focus of multi-disciplined teams to address complex cross-sector problems, supported by social investment from a wide range of investors. This places power in the hands of those most equipped to deliver results and provides an avenue for innovative solutions and targeted financial support.

Q6 What scope is there for increased private investment to fund social services? What approaches would encourage more private investment?

There is enormous potential to direct private investment toward social outcomes. The growing desire and expectation for commercial and other organisations to demonstrate a 'social conscience' provides an opportunity to tap into the already existing private investment funds. This is increasingly seen by progressive organisations as essential to long term sustainability.

This will require the establishment of trusted mechanisms and investment vehicles which provide a realistic financial return relative to risk. The appropriate sharing of risk between providers, investors and underwriters is a key to success. The ability to establish these vehicles quickly and efficiently is a key enabler for this to happen.

The challenge of defining outcomes as the basis for attracting and underwriting social investment returns is significant. However, the potential rewards for addressing this challenge are certainly attractive.

The prospect of an investment market providing attractive financial returns, combined with investors being associated directly with sustainable social outcomes for the betterment of society is both profound and extremely exciting. This is potentially a significant win/win opportunity. It also provides the potential to increase and recycle philanthropic investment.

Q7 What capabilities and services are Māori providers better able to provide?

Māori and Pasifika national and local organisations play a critical role in effective services for some of our most vulnerable populations. Ethnically disproportionate disparities and outcome inequalities are best addressed by solutions from within those communities.

Ethnic and linguistic diversity among services is associated with better access to and quality of care for disadvantaged populations[1]. Pasifika services have connections with Pasifika communities, personal understanding of Pasifika issues, and Pasifika cultural and language skills.

Māori and Pasifika services are best placed to strengthen cultural competency

Ultimately, Māori and Pacific cultural competency is recognised as an essential means of reducing ethnic disparities in access, quality and outcomes in services. Health economics also shows better value for money when services meet ethnically diverse population needs. Le Va provides national cultural competency training and resources based on solid science, endorsed by Harvard Medical School and the Human Rights Commission, so that workers better engage with Pasifika peoples. Le Va developed and implements Real Skills Plus Seitapu cultural competency framework and training (part of the Ministry's *Let's get real* competency framework). Le Va has also designed and delivered an innovative blended learning programme, Engaging Pasifika consisting of online modules (including ethnic specific approaches), face-to-face workshops, and online follow-up forums. More than 1,500 people have completed the programme and results that show 95 per cent of participants rate it as excellent overall.

Providing national leadership and coordination for Pasifika social issues

This role includes facilitating national platforms for integrated solutions like GPS: Growing Pasifika Solutions conferences, and a Pasifika voice nationally to lead vulnerable communities, such as through the Drua Pasifika addictions network. Leading the implementation of FLO: Pasifika for Life as part of Waka Hourua, our national Māori and Pasifika suicide prevention programme (Ministry of Health suicide prevention action plan), as well as the Ministry's Faiva Ora: National Pasifika Disability Action Plan, and Taeao o Taaiui: Pacific public health workforce development action plan means Le Va can play a key role in coordinating Pasifika issues across these inter-related sectors.

Q8 Why are private for-profit providers significantly involved in providing some types of social services and not others?

Return on investment must surely feature as the most significant compelling factor coupled with the potential size of the market, both now and in the future. Aged care would be a good example.

Other factors are the perceived/real complexity of the populations needs and the risks associated with meeting them coupled with contracting arrangements and conditions which significantly impact on the returns available.

Q9 How successful have recent government initiatives been in improving commissioning and purchasing of social services? What have been the drivers of success, or the barriers to success, of these initiatives?

The Wise Group was one of six NGOs invited to participate in the Ministry of Business, Innovation and Employment's (MBIE) 2012 Streamlined Contracting Pilot.

1 Ministry of Health. 2014. 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018. Wellington: Ministry of Health.

We would assess the pilot as successful from the perspective that it sent out a positive signal that the government, through MBIE, is committed to improving the way the Crown commissions services from the NGO sector.

Limitations of the pilot were:

- district health boards were not included in the pilot and this is where significant variance in commissioning practices occur
- only one of the group's multiple contracts with multiple Crown funding agencies was mapped from its old form to the new Results Based Accountability form
- no improvements occurred under the one contract that was mapped to the new streamlined agreement in terms of reporting and monitoring. In fact both increased.
- no improvements occurred for the group in the area of audit.

The group continues to have multiple, individual contracts in place with multiple funding agencies, spends significant time and resource in activity based reporting and experiences significant cost and duplication in terms of auditing. We have estimated that each year we spend 30 per cent of senior management time involved in either contract negotiations or audits (Appendix A, Wise Group's Results document, 2012).

Q10 Are there other innovations in commissioning and contracting in New Zealand that the Commission should explore? What lessons could the Commission draw from these innovations?

Effective commissioning and contracting

Critical success factors for effective commissioning and contracting are easy to describe but hard to achieve. They include:

- good functional relationships between the funder and provider based on trust and respect, with regular reporting and feedback mechanisms
- long-term relationships and contracts as social service delivery is inevitably ongoing – with built-in flexibility to adapt to service environments which change over time
- funder and provider both having a good understanding of the service area and both participating in service development
- transparency with both parties taking a 'no surprises' approach.

Having both parties acting in an effective partnership is arguably more important than innovation as such – but is perhaps rare enough to be considered an innovation when it occurs.

Case study - Partnerships in contracting a service

Te Pou has found value through strategic procurement to establish sub-contracting arrangements with key stakeholders operating within its policy and practice context. This can be particularly effective when translating government policy into practice within regional and local settings. For example Te Pou was required to provide, as a contractual outcome with the Ministry of Health, improvements in workforce planning and regional engagement across the mental health sector. It contracted four regional workforce planning lead roles based in a lead agency in each of the four traditional health service regions, rather than Te Pou employing staff to undertake this. These lead agencies all had well established relationships with NGOs and DHBs in their own region. Te Pou contracted them to develop regional workforce plans and to support workforce information uptake.

Te Pou provided the evidence brief, literature review, methodology for work along with materials for the regional leads to use when implementing their workforce plans and contributing to a national workforce stocktake (by assisting with communications and data collection). Because

Te Pou had an operational partnership with region shared services agencies, the sub-contracted workforce planning leads were able to personally engage with services in each region thereby building considerable local support for the national workforce stocktake. This was evident in very high response rates to survey questionnaires.

This is an example of a contracting relationship where both parties get positive outcomes – Te Pou mentor and support the roles and provide evidence, the four sub-contracted regional representatives undertake planning and engagement at a local level to embed the planning in day-to-day practice.

Case study - Skills Matter programmes
Post entry clinical training programmes for the mental health and addiction sector had been performing poorly for a number of years when managed by the Clinical Training Agency, a business unit within the Ministry of Health. The Ministry undertook a review of programmes and held a request for proposal (RFP) process to seek another provider to manage these programmes in 2008. Problems identified by the Ministry were:

- under subscription of places for nursing and allied health
- inconsistent contracting processes for providers of programmes
- problematic sub-contracting arrangements
- high incompletion rate
- poor pastoral care of students
- inconsistent pricing for programmes.

Te Pou won the tender to manage these programmes and has now successfully managed the programme for six years. During the first three years, Te Pou scoped requirements for post entry clinical training for the sector with expert advisory groups, managed an RFP to engage new providers and refresh current programmes, disestablished poor performing programmes, improved pastoral care and supervision arrangements, engaged employers and training providers in better relationship management.

This is a role that goes beyond managing funds. Te Pou is supporting recruitment into the workforce with improved student completion rates and better engagement with employers. Because of Te Pou's other work in research and evaluation, outcomes measurement and workforce development, contracts for programmes with fresh curriculum can be quickly updated. This enables a faster 'knowledge to practice' learning that could otherwise take many years through a government agency or Ministry. Te Pou now has a lot of evidence and experience of how to manage contracts, programmes, change management and relationships. Te Pou also has a great deal of data that can be used to look at trends for this workforce.

Case study – Wairarapa adult mental health and addiction services
See response to Question 13 on page 13 for more information on this case study example.

Q11 What other international examples of innovative approaches to social service commissioning and provision are worth examining to draw lessons for New Zealand?

In many respects commissioning in New Zealand is undertaken by capable professionals and results in very cost effective results. For example, Te Pou has been entrusted with strategic commissioning and contract management responsibilities (including Vote Health Non-Departmental Operating Appropriations on behalf of the Ministry of Health) for approximately eight years (for mental health and disability workforce development innovations).

One of the most influential and tangible workforce programmes Te Pou manages is Skills Matter (see Question 10 on page 10). There are six programmes which support new entrants in nursing and allied health and extend the specialist skills of senior practitioners in high priority workforce development areas (child and youth, addictions, psychological therapies, clinical leadership).

Te Pou works with programme providers, employers and clinical leaders to ensure the programme aligns with best practice and policy direction (including a strong focus on knowledge, skills, values and attitudes in *Let's get real*.) The role bridges clinical and academic boundaries, ensuring programme development keeps pace with best and emerging practice.

While this has worked incredibly well, these services might have delivered even more social value (impact) if they had been initially designed and then piloted by a central government agency with robust economic analysis capability, before being transferred to Te Pou for management. Such analysis, early in the policy development phase, would have enabled decision makers within the Ministry of Health to better anticipate the consequences, expected and unexpected, of their initial commissioning decisions.

Such a process would require additional economic analysis capacity within the health and social care system and ideally in central government agencies alongside, or within, policy and national service development teams. Without this, NGO providers like Te Pou can inadvertently inherit the management of very complex scenarios (via successful bids) that are best managed by those who have a mandate to create standards and policies to regulated human service industries.

The Australian Federal Government took such an approach before beginning consultation on its relatively new National Disability Insurance Scheme. It was apparent from its initial economic analysis that a strategic approach, built on sound economic principles (presented in the form of a social value framework), would deliver more a more sustainable solution than maintaining less effective lower cost services.

However, the challenge for the Australian Federal Government is now less about declaring why it should happen and more about how to implement a national change management programme on a vast scale (approximately $20 billion per year). This example suggests that the business case and the implementation plan are equally important and that both aspects need careful consideration and strong bipartisan support.

Q12 What are the barriers to learning from international experience in social services commissioning? What are the barriers and risks in applying the lessons in New Zealand?

Successful implementation of new programmes or tools requires purposeful and active steps. Two areas of significant risk for the New Zealand social services context exist.

Firstly, there is a lack of skills for the appropriate translation of internationally-developed programmes or tools into the New Zealand context. Secondly, active and purposeful implementation requires specific skills understanding the complex implementation process and the ability to anticipate and respond to barriers at each stage of the process. Implementing tools or programmes without considering the New Zealand context or in the absence of specific implementation skills is a significant financial risk to the sector.

The capacity and capability of the workforce undertaking commissioning on behalf of central or local government is variable and workforce churn for such roles is particularly high (resulting in many services providers commenting that they don't know who is managing their contract on behalf of the

commissioning agency). On some occasions this has resulted in NGOs dealing with junior administrators as interim contract relationship managers for extended periods with contracts valued in millions of dollars per annum. For periods of a few weeks this practice is possibly unavoidable, but it is concerning if the interim contract manager becomes the incumbent without any experience of dealing with the complexities of service provision in very diverse and dynamic health and social care settings. Te Pou has experience of developing resources and providing assist to funders and planners and the recently published Peer Competencies are supported by implementation guides for employers and, separately for funders and planners. This approach is promising. Such resources are ideally supported by follow up support and mentoring where this is possible and appropriate.

Reducing seclusion and restraint using international evidence and partnerships

Te Pou is a member of the International Initiative for Mental Health Leadership (IIMHL). This has enabled the sector to work with international agencies and use their experience to translate learning to the New Zealand environment. Through IIMHL Te Pou has made an impact on decreasing the use of seclusion and restraint for mental health consumers who use inpatient services in New Zealand. Te Pou worked with the National Association of State Mental Health Program Directors (NASMHPD) in the US who had eliminated this practice in a number of states. Te Pou used NASMHPD's materials for working with staff in DHBs to use alternative practice for the New Zealand context eg adding working with Māori and use of consumer leaders. It was important to use the US evidence-base but translate this for local practice. The New Zealand experience has now been shared with partners in Australia.

Q13 Where and when have attempts to integrate services been successful or unsuccessful? Why?

The group was awarded a three year contract to provide an integrated mental health and addiction service in the Wairarapa, including provision for housing and employment services. As might be expected the first year was developmental and extremely challenging. The second year heavily focused on service evaluation and rapid service improvement. It was not until the third year we saw more significant gains just as the contract term was ceasing. The group then had to engage in a lengthy re-negotiation process over some months to be awarded a further two year term. It illustrates the need for longer term contracts, five years minimum, particularly when establishing new and complex service models. The service remains the first of its kind in New Zealand.

Integrated employment support

We take a 'whole of person' approach to providing successful employment services for people facing personal or health challenges. At the Wise Group, we believe in responding to the needs of everyone we touch with every resource we have. This means when an organisation contracts with one entity in the group they get the full resources of the group contributing to the success of the service, and to outcomes for people.

Within our employment services (Workwise) we extend this further by being highly integrated with other health and welfare providers (currently integrated with 60 different clinical and NGO services around the country).

Where clients are receiving treatment or support from teams not directly attached to Workwise it proactively links with these providers on a person-by-person basis to ensure that employment support plans and treatment and wellness plans are well aligned. This enables an early intervention approach and promotes better employment outcomes, so it is also where the best return on investment lies. We believe that real opportunities for New Zealand lie in linking health and employment services at a policy, funding and service level.

Good levels of flexibility and trust during initial establishment phases and the acknowledgment by all parties that good things take time has supported this level of integration. An undisputable international evidence-base highlighting that employment support and clinical management should be integrated, not separated, has also enabled all parties to be on board and work towards successful integration.

These evidence-based services are not however routinely available across New Zealand for numerous reasons including the lack of integrated contracting arrangements between Ministries, contracts that impede the delivery of evidence-based practices and/or a lack of knowledge from commissioners of this evidence-base.

Evidence based supported employment is effective because it integrates employment and health services

Integration is most successful when it occurs at policy, funding and clinical levels. Individual placement and support (IPS), also known as evidence-based supported employment (EBSE), is effective because employment support services are integrated with health treatment teams. Research shows that as the employment consultant becomes part of the clinical team, they increase health professionals' awareness of the importance of employment for recovery and improved wellbeing. Integrating employment consultants:

- facilitates an earlier referral to the employment services
- encourages joint planning of treatment and vocational goals
- can lead to health professionals initiating more conversations about employment directly with patients/service users.

This coordination of care is crucial to ensure that the patient/service user doesn't have to navigate two service systems. IPS has been integrated into teams at six New Zealand DHBs and two primary care environments.

The integration that is achieved in high performing IPS programmes is much more than the collaboration usually found between health services and community support services. It is a formal collaboration in which the two organisations come together to offer one integrated service around the individual. It is this high level of integration, coupled with the intensity of the support provided, which drives effective performance.

Examples of evidence for successful integration

Integration that works: applying IPS supported employment in primary care

Employment support agency Workwise partnered with Midlands Health Network, Waikato Work and Income, Compass Health and Wellington Work and Income to establish an integrated employment support programme in a number of general practitioner practices during 2012. The programme was the first application of IPS principles in New Zealand primary care. The evaluation of the programme showed that it was successful in increasing access to effective employment support for people with mental health conditions who are currently unemployed.

Please visit the Te Pou website for the evaluation of this programme.

WorkFirst: Integration of IPS into a secondary mental health team

An evidence-based supported employment service, fully integrated within some of Capital and Coast District Health Board's community mental health teams, aims to address the employment and educational needs of people with moderate to serious mental illnesses in secondary mental health services. The programme actively supports service users to fulfil their employment or study goals.

Please visit the Te Pou website for the evaluation of this programme.

The merger of two workforce programmes

Over the last three years Te Pou and Matua Raki have merged. Both these programmes were contracted separately under the Ministry of Health, Te Pou to lead on mental health and disability, Matua Raki to lead on non-addictions. The senior leaders from both organisations worked together to carefully plan how both entities would merge and gain benefits from each other's experience as well as how to communicate this to stakeholders.

The planning for the merger took approximately six months with many meetings and clarifying unique points of difference and commonalities. It was important to keep individual identities but find things that could be blended so one strong organisation with two unique programmes would result. A further advantage, particularly from the Ministry's point of view, was the much needed focus on people who have co-existing mental health and addictions disorders. Working on a few big national projects together really cemented the relationship in the early stages of the merger.

There were several decisions that helped make the merger successful, including:

- the appointment of an addiction leader to the Te Pou board
- the appointment of several addiction leaders to Te Pou's clinical reference group
- the appointment of a new national manager role for Matua Raki (who was a member of the team and supported the outgoing Director)
- ensuring employment conditions for staff were well managed in the transition
- on-going communication of any changes
- visibility of working together
- this merger was instigated by the leaders of our programmes, not the funder, and this helped make the transition smoother.

Q14 What needs to happen for further attempts at service integration to be credible with providers?

At a macro level service integration is often thwarted before it even has a chance to get off the ground from a service provision perspective when the funding sources come from different crown funding agencies. It becomes evident that policy shifts need to occur at the centre to allow for this in the absence of leadership or devolved authority to act. The Better Public Services framework is welcomed, but translation of this into whole of government policy and contracting has not taken effect.

The motivation for service integration at times is also questionable, particularly when it becomes evident through the process it is a cost saving mechanism and not a means to improve service outcomes for people.

Service integration and working collaboratively is also complex. In the example we provided in response to Question 13 on page 13 this integrated service model (mental health, addiction services, housing, employment) involved three NGOs. There was little appreciation at the commissioning end for how difficult the task at hand was and the time that would be required to achieve sustainable gains.

To effectively integrate services also requires skilled project management and therefore investment. Resourcing of this type is generally not made available and providers are expected to manage this from the service budget. It is unrealistic given the complexity of the task.

Finally we would suggest that the adoption of a 'tight, loose, tight' high trust contracting framework always be applied to service integration initiatives. Tight in terms of specified resource, population and

impact/outcomes. Loose in terms of model of care and service continuum. What generally occurs is 'tight, tight, tight', suffocating service innovation and flexibility at the very time it's required most.

Q15 Which social services are best suited to client-directed budgets? What would be the benefit of client-directed budgets over existing models of service delivery? What steps would move the service in this direction?

Individualised funding programmes have been implemented in the United States, Canada, Australia and the United Kingdom from as early as the 1980s to fund health, personal and social care. Many of the programmes in these countries are available for older people and people experiencing mental health conditions, as well as people with disabilities.

In general, outcomes for people and their families accessing individualised funding are positive. Recipients have reported better psychological wellbeing and greater motivation and confidence than those receiving usual care (Davidson et al., 2012; Forder et al., 2012). However, individualised funding models require significant administrative investment, particularly upfront. In both Australia and New Zealand the costs associated with individualised funding were underestimated; forcing host agencies to work to unrealistic schedules (Fisher et al., 2010; Laragy & Ottmann, 2011; Synergia, 2011).

Evaluations of individualised funding programmes have revealed a number of programme features that support successful implementation. Key components to successful implementation include: provision of good information; active outreach to marginalised or at risk groups; transparent decision making regarding resource allocation; availability of ongoing third party support to assist with the management of finances and employment relations; supportive staff attitudes and the willingness to pass control to the person using services; adequate funding including costs of related administration; and careful policy development and planned implementation.

An international evaluation study of individual funding reported resistance and aversion to risk among teams working with mental health service users or with older people (Glendinning et al., 2008). However, in the last decade New Zealand has invested in developing recovery competencies as well as developing and implementing the *Let's get real* framework of knowledge, skills, values and attitudes[2] needed to support a service user-centred New Zealand mental health and addiction workforce. So although New Zealand is behind other countries with respect to the use of individualised funding approaches in mental health, it is possible that the workforce is better equipped to implement self-direction mechanisms compared to other jurisdictions.

Q16 Which social services do not lend themselves to client-directed budgets? What risks do client-directed budgets create? How could these risks be managed?

Client directed budgets have applicability for all services, within boundaries of capacity. The move to client centred budgets sends a message of someone managing their own health and wellbeing needs, regardless of circumstance. Risk can be managed by establishing clear parameters and goals between the funder and the consumer with partnership monitoring. Empowering a consumer with making decisions on the services they may wish to purchase will assist with less reduced dependence on an expensive system of care.

[2] See here for information about *Let's get real*: http://www.tepou.co.nz/supporting-workforce/lets-get-real

We would encourage the Productivity Commission to instigate a thorough review of the international and New Zealand literature on client-directed budgets as a resource that is available to funders and providers.

Q17 What examples are there of contract specifications that make culturally appropriate delivery easy or more difficult?

Over specified, standardised contract specifications do not lend themselves to culturally appropriate delivery. When service specifications require organisations and services to be culturally responsive and competent to Māori and Pasifika culturally needs, it prompts services to ensure quality services are provided consistently to all New Zealanders.

Q18 How could the views of clients and their families be better included in the design and delivery of social services?

The group supports a co-design approach generally described as "a product, service, or organisation development process where design professionals empower, encourage, and guide users to develop solutions for themselves. Co-design encourages the blurring of the role between user and designer, focusing on the process by which the design objective is created" (Sanders and Stappers, 2008).

We recognise this takes time, resource and a skilled facilitator which is why the process often used in social services is to select a pre-prepared service specification from a mandated government framework, tender for a provider and then have people fit the service. The group's experience has been that innovative responses to fit people's needs under these types of contracts are seen by contract auditors (sent annually by funders) as 'non-compliant'.

In mental health and addiction services reasonable attempts are generally made by funders to include service users and families in the design of services. However this tends to be limited to workshops that the silent majority can't attend. Technology is one means to create more ways for people to have their say.

Q19 Are there examples of service delivery decisions that are best made locally? Or centrally? What are the consequences of not making decisions at the appropriate level?

As the issues paper highlights, there are trade-offs between centralised and devolved systems of decision making (New Zealand Productivity Commission, 2014, p45). Given the absence of good evidence on the effectiveness and/or unintended consequences of centralised versus devolved decision making, it is imperative that better data is captured on the effectiveness or otherwise of these different approaches so future recommendations can be made as to the appropriate level of decision making needed.

In the absence of good evidence, we are reliant on opinion based approaches to decision making which generally favour the status quo and all too often aren't focused on the individuals most affected by the decision.

Q20 Are there examples where government contracts restrict the ability of social service providers to innovate? Or where contracts that are too specific result in poor outcomes for clients?

Support hours contracts from DHBs have tight funding, which means paying staff fairly is very difficult and increases turnover. Time is spent on excessive recruitment rather than innovation.

Activity based contracts such as these which require excess of 75 per cent service user related time evidenced to National Health Index's creates an unhealthy pressure to focus on the immediate service delivery via contact hours at the expense of workforce development, community development, quality improvement and a focus on outcomes which demonstrate a higher value than being busy. These contracts set services up to 'hit a target, but miss the point'.

Bed night contracts have replaced full time equivalent contracts for housing and recovery services (supported accommodation) and for crisis respite services. This means smaller services which provide a quiet homelike environment – which is often required to meet service user need - are not financial viable because of economies of scale. The contract therefore forces providers into larger bed numbers per site.

Entry criteria within health contracts can often be so specific that services are prevented from working with people in primary care who would benefit from short term use of service to avoid more costly admissions to hospital and other specialist services later on. We should be looking at innovative ways of 'turning off the tap'. Moreover, service contracts can reinforce a culture where services are so wary of duplicating services rather than responding to people in need - any door should be the right door. In New Zealand we have got a long way to go with this.

Q21 How can the benefits of flexible service delivery be achieved without undermining government accountability?

A well designed results based accountability framework has the ability to shift the focus from activities to results, from how a programme operates to the good it accomplishes. It must however:

- define clear performance expectations and measures
- provide incentives for performance
- have great strategic and program logic
- include provisions for flexibility, including identifying any changes in external factors that will impact performance and the adjustments required
- include transition or establishment period 'hold harmless' clauses.

In our experience contracts that come closest to adopting a 'tight, loose, tight' high trust contracting framework gain the benefits of flexible service delivery and maintain government accountability. Tight in terms of specified resource, population and impact/outcomes. Loose in terms of model of care and service continuum. Unfortunately what generally occurs is 'tight, tight, tight', suffocating service innovation and flexibility.

Q22 What is the experience of providers and purchasing agencies with high-trust contracts? Under what circumstances are more relational contracts most likely to be successful or unsuccessful? Why?

From the early 2000s the Wise Group entered in to a high trust contract with the Ministry of Health. As part of this contract the Wise Group was required to not only experiment but report to the Ministry on innovation. This marked the most significant period of service transformation the group has experienced.

At the time the Health Funding Authority was being wound up and district health boards established. As a large national provider the group's contracts were passed back to the Ministry of Health to allow time for DHBs to develop planning and funding capability.

The initial contract was for a three year period and then extended for a further five years. The basic format of the contract was 'tight, loose, tight'. Tight in terms of specified resource, population and impact. Loose in terms of model of care and service continuum.

Over the period of the agreement the group was able to substantially disinvest in high cost, low service volume bed based services and reinvest in mobile support services that enabled people to live well in their own home. Service access increased markedly over this period. Initially there was a perceived loss of 'beds' from some quarters of the sector however the reality was more 'beds' were created. They just happened to be people's own bed in their own home, a much preferable and lower cost outcome.

As people became increasingly independent and their aspirations improved the group was then able to direct resource to employment services. Given people had complex mental health histories the notion of people entering into paid employment on the open job market was seen as revolutionary at the time. This highly successful service, now nationwide, would not have been possible under a traditional, highly prescriptive contract.

To date this one-off high trust contract is the only one the group has experienced over the last twenty five years. When it was carved up and devolved back to individual DHBs all high trust elements of the contract were removed.

In summary our experience of working to a high trust contract is limited which is disappointing. However given the contract operated over successive years we understand the hallmarks of success to be a high degree of trust between the parties, made easier by significant competency at the commissioning end matched with significant capability at the provider end.

Q23 Do Crown entities and non-government commissioning agencies have more flexibility to design and manage contracts that work better for all parties? Are there examples of where devolved commissioning has led to better outcomes?

An example of devolved commissioning is the request by the Ministry of Health to Te Pou to manage the Māori mental health research. Te Pou commissioned research from a university provider that showed very high rates of Māori were being secluded in mental health inpatient units compared to non-Māori. In response to this issue, Te Pou was able to proactively support further work to identify solutions and support service leaders to implement solutions. DHBs were prioritised using the national seclusion statistics to identify DHBs with the highest rates of Māori seclusion. This resulted in a rapid reduction of Māori seclusion in acute mental health units.

Te Pou was able to integrate commissioning research, service and workforce development, use of national outcomes information to support better outcomes for Māori service users. The example shows how devolved commissioning supports an integrated approach to addressing a complex issue. One of the success factors in managing contracts is the structure for contracting, reporting and monitoring as well as provider relationships.

Other examples of NGO-led innovation made possible by NGO commissioning

- The Equally Well collaborative, instigated by Te Pou and Platform, demonstrates the need for services to respond collectively and at different levels to address dramatic physical health inequities for people who experience mental illness and/or addiction. Equally Well is an example of NGO-led innovation made possible by NGO commissioning which has public sector services in the collaboration alongside NGO providers, service users, academics and the medical colleges, all with the shared goal of improving the physical health of people who experience mental illness and/or addiction.

- New roles and career pathways are also appearing such as developments in the peer and consumer workforce and the self-managed workforce (individualised funding) in the disability sector. These developments have potential to enable professionals to spend more time working at the top of their scopes of practice. Such developments demonstrate the need for a workforce

strategy that acknowledges challenges such as the economic value of unpaid work (eg informal carers and volunteer roles in the NGO sector), an ageing workforce, and low pay rates.

- Individualised funding is one promising possibility as funders and planners consider new service models. Many of the programmes in countries similar to New Zealand are available for older people and people experiencing mental health conditions, as well as people with disabilities. Recipients have reported better psychological wellbeing, motivation and confidence than those receiving usual care.

- In the last decade New Zealand has invested in developing recovery competencies as well as developing and implementing the *Let's get real* framework of knowledge, skills, values and attitudes[3] needed to support a person-centred workforce. The *Let's get real* framework can play a vital role in strengthening the workforce.

- Ensure the NGO workforce is prioritised for the next review of mental health and addiction post-entry clinical training (Skills Matter). This review will need to incorporate forecast modelling and consider future career pathways to extend the programmes' reach beyond DHB services.

Q24 Are there examples of where government agencies are too dependent on particular providers? Are there examples of providers being too dependent on government funding? Does this dependency cause problems? What measures could reduce dependency?

The commentary in the issues paper relates to the non-government sector and it is noted that providers can easily start to emulate government agency structures. One of the prime reasons that this occurs is that despite the non-government sector often disagreeing with the bureaucracy requirements of the government sector the dual conflicting roles that the government holds as both provider and funder results in little ability to disagree without compromising the relationship. Many of the systems and processes are wasteful and would be abolished by the non-government sector overnight if permitted.

Additionally it is argued that the government is by far the largest provider of social services. It is government agencies that are too dependent on government funding to meet the costs of their infrastructure. This has resulted in government departments continuing to provide services that could be better delivered by the NGO sector at better value and resulting in better outcomes for the people of New Zealand.

Q25 What are the opportunities for and barriers to using information technology and data to improve the efficiency and effectiveness of social service delivery?

Clear policy narratives like Rising to the Challenge (Ministry of Health, 2012) explore key themes required in order to address need, measure progress and to shape system wide responsiveness. This provides a very strong emphasis on the need to collect and measure information.

The Wise Group has invested in, and is involved in, the development and implementation of systems, infrastructure and workforce development to improve data collection, management, analysis and utility. As a result of investing in information technology (IT) and data management systems and processes we are now able to manage and utilise data with greater sophistication.

[3] See here for information about *Let's get real*: http://www.tepou.co.nz/supporting-workforce/lets-get-real

We have a robust system that can deliver on funder reporting requirements. In addition, we have strengthened our internal ability to measure and understand what we are achieving and how we can improve service and service user outcomes.

We have taken a broad approach to information systems and process management. This includes data collection (workforce development and competence), data capture and management (Recordbase and systems), analysis and reporting and information utility to understand and improve the effectiveness of our services.

It is our experience that, in general, the health sector is slow to embrace technology and, technology change well out-paces the sector. The workforce is great with people, but has low tech resilience, and there is also little to no access to information experts or analysts.

We anticipate an increasingly mobile workforce and fewer bricks-and-mortar services. With the cost of mobile data services reducing, there is an increased potential to leverage highly capable and mobile technologies, for example, smartphones can do what many full spec computers can.

The tech sector is increasingly focused on big data and cloud-based services. Many cloud-based, information services are more affordable but are out of reach because of data governance issues.

We understand that there is not a singular IT solution, system, or process to manage the information life cycle. We know that managing multiple data reports, using multiple and different systems presents real challenges when trying to build a national picture. This challenge has been well known to the sector and remains a point of contention.

The ability to get multiple data sets and systems to talk to each other has been a focus, influencing decisions on our system, reporting development and enhancements.

Small NGOs can't leverage economies of scale like larger NGOs with technology often priced out of reach. There is often no room in funding for provision of new technology which means NGOs push the limits of older technology, limiting access to new approaches. As a knock on affect, it then becomes more difficult for NGOs to understand how to apply and benefit from new technology.

The burden of contract and audit reporting requirements is increasing and reporting templates and processes are outdated. There are efficiency opportunities lost in the failure of funders and agencies to embrace new technologies that can dramatically decrease time and waste in reporting. For example, there are multiple and different reporting approaches across DHBs.

A project to review, standardise, simplify and reduce the volume of reporting would be valuable.

There is an appetite for information sharing but an uncertainty about what information can and should be shared, and what utility it might have. There is a need to:

- identify a subset of information about a client than can be shared
- develop a protocol about how that information should be managed
- develop a central mechanism to manage the information sharing.

There is a need to establish, as much as possible, information system architecture and governance which seeks to standardise data production.

Given the pace of change in IT development, information hubs (or a single national hub) could be established to support social services to better utilise data. This needn't be an expensive endeavour, if existing resources like Te Pou and Wild Bamboo were leveraged.

Q26 What factors should determine whether the government provides a service directly or uses non-government providers? What existing services might be better provided by adopting a different approach?

There are times when it may be more appropriate to manage the provision of services centrally due to statutory requirements often related to risk and capability requirements eg child protection services, forensic or compulsory care services. However, there have been a number of opportunities to strengthen even the mandatory services that government provides by effectively using non-crown agencies.

If there is not good 'on the ground ' knowledge of day-to-day provision of service from the government services, it may not be helpful for the government to manage such a service. There seem more opportunities to develop partnership contracts that support better outcomes for these services.

The Wise Group recommends the government identifies an independent body to explore and determine which government services could be better provided by adopting a different approach and contracting out the services.

Q27 Which social services have improved as a result of contestability?

There has been substantive and quantifiable improvement across mental health and addiction services, sector workforce development services and employment services for people with mental health conditions as a result of increased contracting of the NGO sector.

The Wise Groups employment case study, provided as part of this submission on page 36, provides more in depth evidence of that.

From a mental health and addiction service perspective we have seen the NGO sector thrive and grow during the mid-1990s to mid-2000s, enabling more people than ever before to leave institutions and long stay hospital run rehabilitation wards, and access services in the community. Contestability not only saw a sharp increase in service quality but also the capability of NGO's back room functions, including technological innovations.

This developmental trajectory of driving resource to the community end of the spectrum has effectively now flat-lined.

As an example in 2004/2005 the level of investment in NGO mental health and addiction services compared to DHB provider arm services was 30 per cent/70 per cent respectively. In a recent Ministry of Health report published in 2014 the percentage split is 28 per cent/72 per cent. What changed over this period was commissioning functions passing from the Health Funding Authority to DHBs. This would suggest a correlation between the lack of growth in the NGO sector and the removal of the provider/funder split.

Q28 What are the characteristics of social services where contestability is most beneficial or detrimental to service provision?

While we have seen significant improvement in service quality in the NGO mental health and addiction sector the gains that could be made are limited given that only equates to 28 per cent of the governments total investment in specialist mental health and addiction services.

Seventy two per cent of the total investment is locked in to service provision by the DHB's provider arm services and they are never re-tendered. This investment has stayed at 70-72 per cent for a decade.

It is detrimental that contestability and the costs associated with it occur in the area of least investment.

Q29 For which services in which parts of New Zealand is the scope for contestability limited by low population density?

Contestability can be limited not only due to low population density but also remoteness. Examples would be the East Cape and the far north.

Our experience in smaller communities has been the preparedness of funders to dispense with high cost tender processes and engage in collaborative planning with providers, selecting the provider or providers on the basis of known capabilities coupled with the staffing capacity to respond.

Q30 Is there evidence that contestability is leading to worse outcomes by working against cooperation?

Yes. Some of the group's contracts have been re-tendered every two years. This includes highly specialised services where the group has built up significant intellectual property that would be hard to replicate easily or quickly by a new provider. On each occasion the group has re-secured the contract however the practice has sometimes been described to the group as necessary because of the governments 'procurement rules'.

Given the outcome each time it is hard to justify the cost to the Crown, to the group and to other organisations who participate in the open tender.

Contestable processes have also been used to bring about reasonably benign changes to service models where a less costly and disruptive approach would be to discuss and agree the changes and then simply vary the contract.

Q31 What measures would reduce the cost to service providers of participating in contestable processes?

There is little or no adoption of technology that would streamline procurement processes. At its most basic this could be a standardised, secure, online proposal site that respondents populated. In the absence of this most government agencies operate paper based systems.

Additionally most contracts tendered are short-term, never greater than three years and for many now one year agreements; this despite their definition being for essential services. This is certainly the case in specialist mental health and addiction services where in one DHB area all of the group's contracts are for one year. Longer term agreements, five years minimum, would reduce the cost of contestability.

A similar example is year on year contracts which are continuously re-issued. For example, in one DHB area we have had 12 one year contracts over 12 years!

A further measure would be to adopt a preferred provider process, thereby preserving the positive elements of competition but reducing the number of possible service providers.

Additionally designing and adopting a contracting matrix that offered guidance on when to enter into high trust, longer term contract would reduce contestability costs. MBIE's analysis of contract type for the 2012 streamlined contracting pilot evidenced that few contracts are high trust.

Q32 What additional information could tender processes use that would improve the quality of government purchasing decisions?

While we accept tender processes are a robust mechanism to purchase new services, at times our experience has been that it is used as the default position to bring about changes to existing services, rather than negotiating sensible changes to current contracts to match evolving client needs and aspirations. This seems a costly, disruptive and unnecessary process.

Additionally there seems to be wide variance in the different funding agencies interpretation of the governments procurement rules about knowing when to tender, when to re-tender and when to consider an alternative mechanism.

In terms of how tender processes could be improved we would suggest tenders be fewer (based on our experience that alternative processes would be more appropriate and support this reduction), that they be more in depth and result in high trust, long term contracting arrangements.

Specifically they should include provider/site visits for shortlisted applicants and speaking with relevant stakeholders and referees. This mitigates the risk of what providers say they do in written proposals compared to what they actually do and how well they do it based on the experience of informed parties.

Q33 What changes to commissioning and contracting could encourage improved services and outcomes where contestability is not currently delivering such improvements?

The government is the largest provider of social services in New Zealand and contestability has therefore been limited. Contestability has not been applied to most government services even where it has been recommended. On page 66 of the New Zealand Productivity Commission's *More effective social services* issues paper the problem is illustrated.

The Welfare Working Group recommended that employment services be based on contestable, outcomes–based contracts. These recommendations were only partially adopted….. For the majority of its clients, Work and Income chose to adopt an investment approach …. Together with strengthening the case management capabilities of its front line workers.

So here an independent body recommends all services are contestable but because the government service provider is also the funder they are conflicted. They have total power to decide whether to accept this advice or not. To make the services contestable means downsizing its own organisation and that's hard ask. We have to find mechanisms to remove this conflict. It's not about tinkering with the current system.

We reiterate that the following needs to happen.

- An independent body should be appointed to explore and determine which government services could be put out to tender. In addition to getting better value at a lower cost this will also make the non-government social sector sustainable and remove the degree of destructive competitive behaviour. It will also address advocacy issues.
- Eliminate issues in relation to funder/provider conflict, bureaucracy and cost by using other systems to purchase services such as social bonds.
- Have longer term contracts. No less than five years and a maximum of ten years.

- Identify and eliminate waste in regard to referral and assessment processes, paperwork and compliance.

Q34 For what services is it most important to provide a relatively seamless transition for clients between providers?

We cannot think of one instance where it is not critical to provide an absolutely seamless transition for clients between providers.

Q35 Are there examples where the transition to a new provider was not well handled? What were the main factors that contributed to the poor handover?

We have been involved in multiple transitions. Below are the factors that need to be addressed.

- Leadership – at Board and CE level there must be agreement and commitment. There needs to be the expertise within the organisation to lead the transition. Funders need to be in support.
- Communication – a strategy and importantly key messages needs to be signed and agreed.
- People - if there are changes for staff, customers or stakeholders then key people need to be freed up to be fully available.
- Planning – a detailed project plan needs to be developed and agreed by both parties.
- Financial information – needs to be openly available and transition costs identified and agreed.
- Risks – need to be identified and openly discussed.

Q36 What are the most important benefits of provider diversity? For which services is provider diversity greatest or most limited? What are the implications for the quality and effectiveness of services?

Clients need choice. They need to be able to choose between providers based on culture, the services they deliver and whether it best meets their unique needs. Where and who a client receives services from is usually decided by a government agency and client choice is not readily supported.

However funding hundreds of small non-government agencies to achieve provider diversity costs not only in terms of contract management and auditing but is compromising the sustainability of the entire system. It is also driving unhelpful behaviour of competition, a lack of cooperation and sharing of information and resources as organisations seek to survive.

Q37 How well do government agencies take account of the decision-making processes of different cultures when working with providers?

In general, agencies are not inclusive enough in decision making processes for Māori and Pasifika populations and services.

Q38 Do government agencies engage with the appropriate people when they are commissioning a service?

Generally speaking yes in terms of potential service providers being invited to provide a perspective into planning processes, however this is variable across the country.

This type of engagement almost never includes authentically working to co-design principles as it's often perceived by funders as a risk that those providers who participate may have an advantage if a service is then tendered for.

Robust commissioning takes time and in a high volume, low trust, transactional contracting environment there tends not to be time to authentically do this.

Important voices, particularly that of vulnerable populations, are often silent as they don't neatly fit into a tight planning processes, processes that are often held at funders premises and are almost always during the day.

Q39 Are commissioning agencies making the best choices between working with providers specialising in services to particular groups, or specifying cultural competence as a general contractual requirement?

No. Cultural competence for Māori and Pasifika (particularly for urban populations) should be a general contractual requirement but is not included and on the rare occasion that it is, is inconsistent or vague.

Organisational cultural competency requires whole organisations' systems and structures to be responsive to the needs of Pasifika communities. If whole organisations' and systems are connecting culture and care for Pacific people, we would see better access and service utilisation rates, earlier access of services, a reduction in 'did not attend' rates, more satisfaction with services and, ultimately, better outcomes.

Commissioning agencies are not making the best choices for Pasifika providers, because they are not broadening the net and widening the market to new, more innovation Pasifika providers that are emerging.

Q40 How well do commissioning processes take account of the Treaty of Waitangi? Are there examples of agencies doing this well (or not so well)?

It is hard to determine if they are accommodating within the intent of the Treaty as it's still about contractual protocols and preference.

Q41 Which types of services have outcomes that are practical to observe and can be reliably attributed to the service?

Mental health employment services

During the last five years (2008-2013), Workwise employment programmes have engaged 5,174 people to improve their employment prospects. 3,020 people, many of whom were the furthest from the labour market, have secured employment during this time. These results are in line with 16 large-scale controlled research trials from across the world that demonstrate that on average, high performing employment services successfully place 60 per cent of people in contact with mental health services into employment. High performance services are those that align well to the evidence-base, assist more people into jobs, and support people to work longer hours, earn better wages and sustain employment for longer. Our experience and the evidence-base show that programme characteristics are key in better employment outcomes (as outlined below).

Evidence based supported employment – a proven method

Competitive employment is a measurable outcome which can be directly attributed to the assistance of an employment service. Individual placement and support (IPS), also known as evidence-based supported employment (EBSE), is the most researched approach to supported employment for people in contact with mental health services and the current gold standard of vocational rehabilitation services. It is three times more effective and supports clients to stay in a job longer than traditional vocational

rehabilitation services (Bond, Becker, & Drake, 2011). Services implementing IPS with high fidelity according to the validated IPS fidelity scale produce better outcomes (Becker, Smith, Tanzman, Drake, & Tremblay, 2001). IPS has been successfully implemented in New Zealand in both secondary mental health care and primary care settings.

National and international evidence supports a generally positive relationship between employment and health, particularly mental health and identifies the harmful effects of unemployment (Waddell & Burton, 2006). Many people with mental health issues want to work and view employment as a core part of recovery (Mental Health Commission, 1999). Contrary to many widely held beliefs, returning to employment, with the support of an effective employment support service, does not exacerbate symptoms (Burns et al., 2007).

Developing outcome measures in mental health and addictions services

Te Pou has worked to support district health boards and NGOs to implement outcome measures for people who use mental health and addiction services in New Zealand. All DHBs now have to collect outcome measures for people who access their services. Te Pou developed measures on behalf of the Ministry of Health to ensure that services are measuring progress for people who use services. Te Pou encourages all services to see outcome measures and collection as a way of using information to improve the quality of the services they provide.

Outcome measures are also being used to help consumers see where they can make improvements in their mental health and wellbeing. Whilst outcome measurement at a clinical level is not attached to funding for service, it could be used to help rate service quality.

Te Pou's role has been to establish the national outcome measures, train staff in doing measurement and then help the Ministry of Health collate the outcomes data so it can be fed back to services. Services can then use the information for benchmarking purposes. Outcome measures can be used at a service or team level to view population trends eg acuity, use of alcohol and other drugs etc. This in turn can help a service consider their workforce needs and skill mix in order to be responsive to their populations. Te Pou is an enabler to meet a government target and support services to use information to improve quality.

Q42 Are there examples of outcome-based contracts? How successful have these been?

A number of Workwise's employment support contracts are outcome based – where it is paid for each of the milestones the client achieves. These milestones can include enrolment, employment plan, job start, and job retention at three, six and twelve months. Contracts differ in the number, conditions, and money attached to milestones. The aim is to incentivise providers to engage in behaviours that lead to the desired outcomes.

A key driver for Workwise is to deliver on all contracts and it works hard to do this. Realising revenue for these outcomes is contingent on receiving adequate referrals and achieving contracted outcomes. It has been Workwise's experience with some government contracts, that while services are being established, service volumes and the resulting revenue streams can be slow to reach peak levels. There is often a lower rate of referrals than projected.

Providers carry the risk of having to staff up to provide services. Referral flows being patchy and slow has been an on-going issue via Work and Income and other government agencies. It has significant ramifications in regards to outcomes and so to revenue and sustainability for providers.

An opportunity for change is to increase flexibility within contracting arrangements to be able to make referrals (that meet criteria) directly to providers. This will mean that people with mental health issues

who want employment support are able to access it when they want it. Making the service available to more people keen to work will have a powerful effect upon engagement and results. It will also increase the rate of referral to meet service capacity available and more fairly share risk.

Access into services is also a crucial contributing factor to programme effectiveness. The provider needs to share this role with the purchaser, but in many cases contracts specify that the purchaser controls the referral pathway which severely restricts the outcomes that can be achieved and in payment by results contracts this also has a significant impact on the finances available within the contract for the provider as discussed above

More detail on the advantages and disadvantages of outcomes based contracts in this area of social services is provided in the employment services case study provided on page 36.

Q43 What is the best way to specify, measure and manage the performance of services where outcomes are not easy to observe or to attribute?

The Wise Group favours the adoption of a partnership approach between funder and provider and broadly speaking then working to a Results Based Accountability framework. This requires a level of expertise often not evident in the contracting environment.

Our experience is that most funders place far greater emphasis on defining a highly prescribed service and the adoption of significant reporting requirements that really only answers two questions "How much did we do and to who?"

Very little emphasis is placed on identifying measures that would help answer the more important questions of "How well did we do it?" and "Was anyone better off?"

In summary most of the group's contracts are input/activity based contracts with little or no attention paid to determining agreed outcomes. Additionally the process of review is annual and transactional, centred on the insertion of new clauses and increased activity based reporting that we receive via written notification.

We would welcome a move to outcomes based contracts with the provision of start-up funding where appropriate.

Q44 Do government agencies and service providers collect the data required to make informed judgements about the effectiveness of programmes? How could data collection and analysis be improved?

The drivers for information collection, reporting and use have changed overtime. Historically, data collection and reporting may have been viewed as just a transactional part of contract monitoring and accountability to a Ministry or funder.

Beyond a governance role that respective Ministries have assumed with information collection and reporting back, providers should be expected to be 'information competent' in their data management, analysis and use.

The Wise Group now view data collection and use as a core tool in our quality management. Regular use of data to monitor performance of services and health outcomes is a key strategy for the continuous improvement of data quality and ultimately service effectiveness. By analysing and interpreting data – gaps and improvement opportunities for data collection can be identified. This provides opportunity to strengthen future data collection, future proofing improvements to enhance quality.

We are reasonably confident that the range of data collected through various mechanisms can provide a depth of knowledge if data is mined effectively. We are data rich and information poor. We still struggle to turn the data into information that is accessible to the majority.

A significant challenge to providers is funding and building skillsets to:

- ensure data quality and analysis
- develop an 'information competent' workforce to understand and use information
- develop leadership
- use information to measure impact for end users.

There is a need to increase accountability in this area. Discussion of the issues and resulting implications with those responsible for data collection will pro-actively encourage improved data quality. A key focus on developing a culture of enquiry at all levels of provider services will build momentum in applying information to practice, and impact on programme effectiveness.

Ministries are sitting on large data sources which could be better tapped to yield information and evaluation of both non-government and government services performance. Strategies to report back to providers and NGOs annually on their performance could be developed.

Q45 What have been the benefits of government initiatives to streamline purchasing processes across agencies? Where could government make further improvements?

As detailed in response to Question 9, the Wise Group has not experienced the benefits yet of government initiatives to streamline purchasing processes across agencies, nor streamlined reporting or auditing.

A considerable number of the group's contracts are with district health boards and as could be expected in a decentralised health system with decentralised planning and funding functions, it is here where we see the opportunity for the greatest improvement.

In an unprecedented move the Wise Group, at its own cost, has engaged a former DHB general manager planner, now an independent contract, in a further attempt to engage with DHBs at the most senior levels to streamline the group's contracts.

Q46 Is there sufficient learning within the social services system? Is the information gathered reliable and correctly interpreted? Are the resulting changes timely and appropriate?

Whilst agencies and providers have focussed on the collection, capture and some reporting of data, the quality – correctness, completeness and analysis – of data requires greater scrutiny and improvement.

A piecemeal approach where focus is on one part of the information life cycle will be limiting.
We recommend a commitment to a national culture of information utility with skillsets and competencies matched to the specific and respective contexts.

Key success factors that support information informed service delivery requires good models of leadership that encourage information sharing feedback loops. The use of information needs to be hardwired into service delivery.

An information quality project to establish and test/audit data quality framework and protocols – to assist providers to correct and improve data quality would be valuable.

We recommend that a programme of work should continue to develop and foster 'information competence' through all levels of the health sector. It is too early in our information journey to expect organisations and providers to address the information skillset deficit on their own.

Q47 Does the commissioning and purchasing system encourage bottom-up experimentation? Does the system reinforce successful approaches and encourage reform of less successful ones?

We have the embarrassing situation that innovation occurs in New Zealand in spite of the commissioning and purchasing system. We need to change this and in future innovation should occur because of the system. It should be a natural by-product of the system.

Innovation currently is often viewed as non-compliance against the contract and on occasions when proudly displaying to funders innovations that have occurred we have been censured. In some areas risk adverse funders are holding the system back by insisting on service delivery models that are not needed and are costly.

The Wall Street Journal recently ranked Gary Hamel as the world's most influential business thinker, and Fortune magazine has called him "the world's leading expert on business strategy. Currently, Hamel is leading a pioneering effort to reinvent management by harnessing the power of open innovation.

The most profound challenge facing 21st-century leaders can be simply stated: How to reap the blessings of bureaucracy—control, consistency and predictability—while at the same time killing it. Bureaucracy, both architecturally and ideologically, is incompatible with the demands of the 21st century.

All of the following are examples of bottom up experimentation. Two are examples of the Wise Group funding innovation and one is an example of the government demanding innovation and funding it as part of the contract.

Workwise

From the early 2000s the Wise Group held a five year national contract for services with the Ministry of Health. As part of this contract the Wise Group was required to not only experiment but to report to the Ministry on innovation. This proved to be one of the most innovative periods in the history of the Wise Group.

As a direct result the first evidence-based employment services in New Zealand were developed and six social enterprise businesses. As outlined in Question 4 we soon found that the social enterprise business didn't deliver the employment outcomes we sought but the employment consultancy service exceeded our expectations. This led to the group continuing to grow and invest in these services which subsequently have now become mainstream and are now funded by MSD, Corrections and the Ministry of Health.

The group however continues to invest in innovation placing the first employment positions ever alongside primary care teams.

The People's Project

This project is at the fringes and we know that's where you go to get change.

We have a problem with homelessness in New Zealand and it is an increasing population. The international evidence is clear. Either decide to manage homelessness or end it. There's no in between. To date, New Zealand has chosen to manage the situation however we believe that in most areas of New Zealand we can end homelessness and we are starting in Hamilton with
The People's Project.

This is a start-up for the Wise Group and one thing we have learned is the importance of putting your very best people into start-ups. Internal sabbaticals are used within the group and one of the groups CEs has been freed up to lead this project.

We will eliminate homelessness in Hamilton by 2016. We are not sure quite how we will do it but we do know we need to bring a whole range of people and agencies together to achieve change. That's the journey we are on. All major players, local government, the business community, central agencies, and NGOs have willingly come together and decided to tackle this big social issue together. Everyone is putting in resource and everyone is deeply committed. What has been identified already is that a major contributor to homelessness is the lack of any joined up thinking between agencies and sectors. This project is pulling these walls down and creating a new way of operating.

The Monastery

Nearly ten years ago the Wise Group opened a facility called The Monastery to challenge the current system and operated it as a private trauma retreat. When the Christchurch earthquake hit the Wise Group was severely affected. Staff asked for help and asked to attend The Monastery. What quickly became apparent was The Monastery was able to help people recover quickly and return to Christchurch to help others. This led to the Wise Group opening The Monastery for the people of Christchurch. .

For the 700 people who have used The Monastery, every single one of them has said it is what they have needed to be able to stay in Christchurch. This intervention has meant for many that they have been able to come off prescription medications, repair their relationships and their lives. Six month, twelve month and two year follow up has shown that these affects are lasting.

We have been lucky that the workforce support needs were recognised early and that
The Monastery stepped in to meet this need. We know these 700 people have together impacted an estimated 14,000 others and we would be in a very different state if these front line workers, from all sorts of professions, had not had this resource available. We also know
The Monastery is recognised as the only experienced, specialist residential trauma service in the country.

We all know The Monastery service has been built over time and it is not a service you can build overnight or in response to a particular event. We also know in a country like New Zealand that sits on earthquake fault lines and volcanoes as well as societal risk, events that result in trauma will continue to occur.

Everyone in both the government and philanthropic funding worlds agree this is a service that delivers and is needed. But here's the problem. It doesn't fit into any neat funding box. And so it will probably close and in the years to come when the next disaster strikes everyone will say 'isn't it such a shame The Monastery closed'.

And that is often the price of innovation. They are services before their time and often beyond the thinking or the funding structures of the current system.

Q48 Would an investment approach to social services spending lead to a better allocation of resources and better social outcomes? What are the current data gaps in taking such an approach? How might these be addressed?

An investment approach to social services would certainly lead to a better allocation of resources and better social outcomes. The concept of maximising long term social return would provide the focus required to support the delivery of tangible and definable outcomes which make a real and lasting difference to society. Any investment mechanism will need to align both the social and financial return to risk in order to attract the investment and deliver social return in the areas providing the greatest benefit to society.

Gaps currently exist in both the definition and capture of data to support the measurement of social returns on investment. Outcomes are often inherently difficult to define. However an investment approach would focus the need to address these definitions and stimulate innovative techniques for measurement. Often surrogate and associative measures can provide a pragmatic avenue for assessing the effective delivery of outcomes.

New investment which generates positive social returns may well be funded through reduced levels of social support funding in the longer term. This is likely to be easier to achieve than attempts to redirect existing social support funding in the short term.

Q49 How can data be more effectively used in the development of social service programmes? What types of services would benefit most?

Te Pou published the first set of Programme for the Integration of Mental Health Data (PRIMHD) reports in 2009. Since then the collection of outcomes data has become part of clinical practice and DHBs continue to improve the ways they use their data to better understand the services they provide.

We continue to work with the Ministry of Health and the sector to enhance the current reports to ensure they are understandable, usable and useful.

Accurate outcomes information can be used to assess service effectiveness at DHB, NGO and national levels by:

- clinicians to support their decision-making in day-to-day practice, monitor change, improve their understanding of client needs and evaluate the effectiveness of different interventions
- service and general managers can use outcomes data to inform service provision and identify workforce development and community needs
- planners and funders can use outcomes data to assess population needs for mental health services and assist with allocation of resources
- policy and mental health strategy developers can use outcomes data to develop policy based on nationally aggregated data (Te Pou, 2012, Outcome measures).

We recommend that a programme of work should continue to develop and foster 'information competence' through all levels of the sector. It is too early in our information journey to expect organisations and providers to address the information skillset deficit on their own.

Q50 What are the benefits, costs and risks associated with using data to inform the development of social service programmes? How could the risks be managed?

The Wise Group has been involved in The KPI (Key Performance Indicator) Project to promote and support the use of service user's information to support recovery, ensure that services are responsive and to improve services at a clinical, service and national level.

Te Pou has also led work to develop casemix adjusted outcomes. This enables analysis and comparison of outcomes achieved by different mental health services for benchmarking and quality improvement purposes.

The ability to compare outcomes at a national level using data collected routinely in PRIMHD was identified as a priority. In 2013 the PRIMHD casemix grouper development was completed based on the New Zealand mental health classification (NZ-CAOS). The grouper enables outcomes for service users with similar characteristics, and patterns of service use, to be analysed in a comparable way against a national average irrespective of service provider.

This work was intended to inform service effectiveness, improvement and benchmarking initiatives but was put on hold in late 2013 pending further analysis. In the absence of an alternative, outcome data reported back to providers is on an aggregate individual collection basis rather than outcomes of services provided.

Although not intended for funding purposes, with a validation process using current cost data, the existing classification could be used in the future to attribute cost weights.

Further analysis of the methodology may include minor changes such as the modification of the existing report suite to better explain outcomes in community settings; medium-term projects such as the examination of the system's utility for cost weight analysis; or longer-term such as a revision of the underpinning classification methodology itself.

Q51 How do the organisational culture and leadership of government agencies affect the adoption of improved ways of commissioning and contracting? In what service areas is the impact of culture and leadership most evident?

In the group's experience, leadership and organisational culture play a significant part in the adoption of improved ways of commission and contracting.

Given the long standing and complex contracting relationship the group has with multiple government funding agencies we see this played out first hand. What is also evident is the variance in experience of funders and any training they may have had to prepare them for the role and its correlation to the adoption of high trust contracting principles.

Unsurprisingly there is a correlation between the competence and confidence of the funder and how prescribed the contract is.

Specifically in mental health we have seen a trend of former clinicians of DHB provider services move into planning and funding roles. While this can offer an obvious strength it has its limitations if the appointee is not offered training in commissioning based on a whole of system perspective.

An added complication is the perception/reality that there is no provider/funder separation.

Finally the average length of employment for mental health and addiction planner/funders is diminishing and in some cases the group has had three to four new funders in a single year. This has resulted in a

total loss of institutional knowledge of the contract, the service provided and indeed the group as a provider.

Q52 How do the organisational culture and leadership of providers affect the adoption of improved ways of supplying services? In what service areas is the impact of culture and leadership most evident?

It is accepted that culture and leadership are the foundations of any great organisation. For us at the Wise Group we know leadership now needs to be vested in many. We don't have a traditional hierarchical organisation. We have multiple chief executives all leading different parts of the business, we share infrastructure services but when it comes to service delivery we think and act as one.

We monitor staff engagement like a hawk, we rotate people through the organisation, to projects and to leadership roles. We invest heavily in leadership development at all levels. We make our leaders available to mentor others and we release people on sabbatical to work at the fringes.

An example of this is one of our chief executives who is on sabbatical within the group. She has chosen to work on the street to eliminate homelessness within two years. With her skills and networks she has already managed to bring the leaders of all government departments to the table, local government, the business community and the non-government sector. She has identified the enormous frustration of clients, the system change that is needed and is challenging the silo systems we have created.

The Wise Group has placed a small amount of resource with what is now known as
The People's Project, to enable this to act in essence as a start-up company. This work also serves to refresh the Wise Group's own work by challenging how we ourselves are delivering services.

Gary Hamel is regarded by one of the as the world's most influential business thinkers. This is what he has to say in regard to leadership.

We live in a world where never before has leadership been so necessary but where so often leaders seem to come up short.

Our sense is that this is not really a problem of individuals; this is a problem of organizational structures—those traditional pyramidal structures that demand too much of too few and not enough of everyone else.

So here we are in a world of amazing complexity and complex organizations that just require too much from those few people up top. They don't have the intellectual diversity, the bandwidth, the time to really make all these critical decisions. There's a reason that, so often in organizations, change is belated, it is infrequent, it is convulsive.

Because, typically, in those traditional structures, by the time a small team at the top realizes there's a need for fundamental change, by the time a problem is big enough or an opportunity clear enough that it prompts action, that it breaks through all the levels, commands the attention of these extraordinarily busy people up top—it's too late. So if we want to build truly adaptable organizations, we have to syndicate the work of leadership more broadly.

Q53 What institutional arrangements or organisational features help or hinder the uptake and success of innovative approaches to service delivery?

Unfortunately most of the current institutional arrangements hinder the uptake and success of innovative approaches to service delivery.

- Failure to recognise innovation - an innovative idea is often radical and beyond what is currently delivered. Funders often struggle to appreciate the change or see its potential.
- No culture of innovation – in most areas innovation is not encouraged with a strong central message that we will decide what we want to buy and then go to the market.
- No incentive to innovate – at times providers have developed a break through solution, invested heavily in the development only to be told their idea/product will now be put out to tender.
- Risk adverse public service – inherent in innovation is risk. The Public Service wants innovation but its tolerance for failure is low. That's because they receive two messages from Ministers – make it innovative but if it fails we will look to apportion blame.
- Status quo rather than change – the current system is vested in the status quo particularly in relation to services delivered by government.
- Current RFP arrangements are tightly prescribed and innovation is not encouraged. We have now stopped putting into RFPs ways in which the service could be delivered differently.

The institutional arrangements however that help the uptake and success of innovative approaches to service delivery are individuals. Passionate driven 'mavericks' within both government and NGOs who are committed to change.

Q54 Have recent amendments to the Public Finance Act 1989 made it easier to coordinate across government agencies? Are there any examples where they have helped to deliver better social services? What further measures could be effective?

The amendments to the Public Finance Act are understood but at the moment are experienced as Wellington centric with government official's regularly meeting with each other and collaborating. This is not being felt in the regions however where control and resource is tightly held by the relevant agencies.

Q55 Are there important issues for the effective commissioning and contracting of social services that will be missed as a result of the Commission's selection of case studies?

Yes. Additional case studies should include:

- examples of NGO mergers which have resulted in more effective social services, as outlined in the example provided with Matua Raki and Te Pou.
- an in depth examination of service and financial auditing for an NGO service.

We attach for your interest as Appendix B a report by PricewaterhouseCoopers, commissioned by the Wise Group in 2012 that outlines in any one year the 'current state' of service/financial auditing experienced by the group. It evidences significant duplication that comes at an avoidable cost to the Crown and the group as a provider.

Importantly the report also identifies the ease with which an integrated audit could be developed and adopted, creating significant savings in both time and money.

The Wise Group tabled this report during the MBIE streamlined contracting pilot but has gained no traction in streamlining its audit programme with government funding agencies.

Q56 Are you willing to meet with the Commission? Can you suggest other interested parties with whom the Commission should consult?

The Wise Group welcomes the opportunity to meet with the Commission.

Employment case study: supporting people with mental health conditions to return to and stay in work

Combining evidence with innovation to deliver results

The Workwise experience www.workwise.org.nz

> *"An effective employment service can overcome all the disadvantages and work restrictions at an individual level" (Waghorn, 2012)*

A vision for the future – the opportunities for change

- Employers and work colleagues pick up the early signs of mental distress and know how to respond appropriately to people, where to go for additional help, and receive this support quickly.
- People who are struggling at work feel able to come forward and talk about their mental health with their employer and colleagues, and support is readily available to assist them and their employer.
- Primary care teams discuss employment status routinely with patients, and have specialist employment support services available to help people stay at work, or to return to work.
- On admission to specialist mental health care, people are asked if they have a job. If they have, employment advice and support is available for them, the clinicians and their employer.
- All health professionals see employment support as integral to mental health treatment and provide work-focused health care to support people to enter and remain in the workforce.

What we need to be able to achieve this

- Integrated health and welfare funding frameworks, based on outcomes achieved and the best available evidence.
- Increased access to integrated health care and employment support for people with mental health conditions - this is an approach which we know works. This means enabling health and employment services to work together locally, using evidenced approaches such as Individual Placement and Support as the basis for employment programmes.
- Flexibility of contracting arrangements to be able to take referrals directly from employers, GPs and other health professionals, taking an 'any door is the right door' approach.
- A national cross government mental health and employment strategy (similar to those developed in the UK and Australia).

Introduction

For 14 years, Workwise has supported people with complex histories and multiple barriers to employment to find – and keep – jobs. And we've done it well. Our evidence-based approach sets us apart, and it's one of the reasons we get results. We know having a paid, good quality job brings health and wellbeing, financial security, an increased sense of citizenship and reduces offending and other negative social impacts.

Workwise has taken a 'whole of person' approach to providing successful employment services for people facing personal or health challenges. At the Wise Group, we believe in responding to the needs of everyone we touch with every resource we have. This means when an organisation contracts with one entity in our group – like Workwise – they get the full resources of the group contributing to the success of the service.

At Workwise we extend this further by being highly integrated with other health and welfare providers (currently 60 different clinical and NGO services around the country). We work this way because the usual approach of collaboration between mental health and other community services does not always assist people with mental health conditions to secure and maintain employment. This is because in the early stages of a job, performance at work is supported through a combination of mental health treatment, care and vocational support. Integration not only delivers more effective services, it also enables much earlier intervention and this is where the best return on investment lies (refer to briefing paper, Appendix 1).

Our experience, combined with research evidence, tells us that integrating health and employment services in a more effective way at a policy, funding and service delivery level is where real opportunities for New Zealand lie.

During the last five years (2008-2013), our programmes have engaged 5,174 people to improve their employment prospects. More than 3,000 people, many of whom were the furthest from the labour market, have secured employment during this time. These results are in line with large-scale controlled research trials from across the world of high performing employment services. High performance services are those that align well to the evidence base, assist more people into jobs, and support people to work longer hours, earn better wages and sustain employment for longer.

Workwise operates in several New Zealand regions and through the diversity of our contracts (refer to Appendix 2), we have been able to take referrals from a wide range of sources, including Work and Income, health professionals and from individuals themselves. We have worked successfully with people with different health and personal challenges, including:

- serious mental health conditions
- common mental health conditions
- a range of active psychological symptoms
- past histories of offending behaviours

- co-existing problems (including substance dependence or abuse and long-term physical health conditions).

We see people of all ages, from those who may have just lost their job, to people who have been out of work for years or who have never worked. We are committed to creating work connections to support people finding and living their dreams.

Our staff are dedicated specialists experienced in employment and mental wellbeing. They have collaborative and enduring relationships with Work and Income, Corrections, Community Mental Health, other NGOs, primary care providers and employers.

The importance of employment support services for people with mental health issues

Mental health is the most prevalent health condition in the working age population. The incidence rate is much higher than other physical illnesses, such as cancers, musculoskeletal or neurological disorders in this group of the population. Furthermore the age of onset for most common mental health conditions is before the age of 21.

However, employment rates for people with mental health conditions lie well below the general population rates and for people with bi-polar and schizophrenia, employment rates are less than 20 per cent. People also fall out of the workplace at twice the rate of people without such conditions. It is logical therefore that mental health is the main reason people are in receipt of a welfare benefit, with this group making up 40 per cent of new and existing benefit claims.

Yet despite these high levels of unemployment, this group of our population have a high 'want to work' rate, with 60-80 per cent wishing to return to employment.

In the absence of evidence on individual characteristics – which determine success in obtaining employment – research has focused on methods of supported employment which are most effective at helping people get and keep competitive jobs. There are now more than 20 randomised controlled trials, internationally, which have established a proven method of supporting people who have mental health conditions to secure employment. It is called Individual Placement and Support (IPS) also known as evidence-based supported employment (EBSE). Meta-analysis of these trials have shown that programmes which implement IPS are more than three times more effective at securing job outcomes and supporting people to sustain employment. On average, 60 per cent of people referred to an IPS programme are supported into jobs (Bond et al, 2012).

IPS is a well-defined, rigorously tested service model to support people with mental health conditions to secure and sustain employment (Lockett and Bensemann, 2013; Appendix 3).

IPS programmes are also cost effective. A recent return on investment evaluation conducted by Price Waterhouse Coopers on a cohort of 1400 people with mental health conditions identified savings to the Crown of 2 to 1 in the first year ie. for every dollar spent on the programme, a dollar would return to health and a dollar to welfare within the first year alone. Overseas research has found similar returns based on savings through welfare benefits, tax payments and reduced stays in mental health treatment services (Hoffman et al, 2014).

In New Zealand, IPS programmes have been effectively established in some secondary and primary care environments, although coverage is based on local contracting arrangements

and therefore these evidence-based programmes are not routinely available across the country.

In 2012, the Ministry of Health published *Rising to the Challenge* the five year mental health and employment strategy. This builds on Health Workforce New Zealand's earlier strategic document, *Towards the Next Wave of Mental Health & Addiction Services and Capability*, and the Mental Health Commission's *Blueprint II*. All these policy documents support the need to increase access to evidence-based approaches to employment support services for people with mental health conditions. These, combined with the recommendations from the Welfare Working Group report (2011), mean that we now have a health and welfare policy context aligned with the evidence-base.

The evidence on what works to support people to retain their employment is less well developed. A logical extension of supported employment services is to provide employment support services to assist individuals and their employers avoid people losing their jobs. Although these 'stay at work' programmes are available for people who are covered by ACC, they are not currently available for people who are at risk of losing their job as a result of a mental or physical health condition.

At the leading edge of evidence-based supported employment

In the last decade, the Wise Group has built extensive experience and knowledge in the provision of IPS. To deliver effective services, programmes consist of intensive, individualised support and focus on immediate job search, followed by placement in paid competitive employment. Time-unlimited support for both employee and employer is provided and support is integrated with health care. Workwise uses these principles to guide its practice and achieve the best possible outcomes for individuals.

We actively monitor the quality for our employment services against the evidence base to ensure we continually improve what we do and the results we achieve. We do this in the following ways.

- Working with the very best academics in the field, continually exchanging knowledge on new developments. We have established long term relationships with the Queensland Centre for Mental Health Research, the University of Melbourne, the Centre for Mental Health (UK) and Dartmouth College (USA).These four centres together represent the leading international thinkers and researchers on supporting people with mental health conditions to return to and stay in employment.
- Training staff in the evidence based model of practice.
- Routine evaluation of outcomes to ensure service effectiveness.
- Utilising a Fidelity Scale to ensure continuous service improvement

Commitment to innovative practice

Since our inception, we have been engaged in enabling, developing and delivering a range of initiatives to help people find and sustain employment. We have self-funded experiments in new areas including the following.

- *Primary health:* Workwise has successfully initiated the first mental health employment support services in primary care in New Zealand, in partnership with Midlands Health Network PHO in Hamilton; and with Compass Health PHO in Wellington. Evaluations have been conducted on both, to inform on-going service improvement and assist with wider roll-out.
- *Employment and Mental Health Option Grid*: the Wise group led the development of the Employment and Mental Health Option Grid, a decision support tool which helps people accessing services and their health providers discuss the evidence for different treatment options.

Commissioning

A national mental health and employment strategy

IPS programmes are effective because they integrate health and employment services. Yet the current policy, planning and funding frameworks in New Zealand actually work to separate employment and health services.

To improve productivity and value for money what is needed is a national mental health and employment strategy, similar to ones developed in the UK and some of the Australian states. This would provide an integrated purchasing and contracting framework including shared performance indicators for both health and social development, applied at a regional level and across secondary and primary health services.

This would help to lever the changes required at operational levels - from the promotion of good mental health at work, to early intervention at a primary health level to stop people falling out of work – and include evidence-based supported employment to ensure access to employment support for people who require it.

Workwise contracts

Over our history Workwise have held a wide variety of contract types involving different terms and conditions. Currently our contracts fall into two main types.

1. *Results based accountability* contracts – we are paid for each of the milestones the client achieves. These milestones can include enrolment, employment plan, job start, and job retention at three, six and twelve months. Contracts differ in the number, conditions, and money attached to milestones. The aim is to incentivise providers to engage in behaviours that lead to the desired outcomes.

2. *Activity based funding* contracts – are paid on the amount of time spent with clients (FTE employed to provide service) and have traditionally been light on outcomes frameworks, although Workwise has worked with DHBs to put outcomes guidelines into contracts.

An overview of these contract arrangements is below. Payments possible (on average) range from $1,000 - $6,000 per client dependent on contract type and milestone configurations.

Overview of different contract types

Results based accountability

Purchasers	Eligible client groups include:	Access routes include	Payment milestones and criteria include
MSD	People with common mental health issues Job seeker support beneficiaries	• Centralised data driven referrals • Identified by the provider and endorsed by the funder • Community networks and endorsed by the funder • Self-referral and endorsed by the funder • Work and Income case managers	Payments made on: • client enrolment • job placement • job retention (3 months) • job retention (6 months) • job retention (12 months). Occasionally upfront administration fees on contract signing. Higher payments for greater service intensity on some contracts.
Corrections	Long serving prisoners Community Probation Service clients	• Prison case mangers • Probation officers	Minimum of 5-15 hours per week employment secured before payment made. Six months to work with person.

Activity based funding

Purchasers	Eligible client groups include include	Access routes include	Payment milestones and criteria include
District Health Boards	People using secondary mental health services	Referral from Community Mental Health Teams.	Monthly payment made for agreed FTE (employment consultants) in place. Monthly reporting on general service health statistics and FTE hours delivered. Expected range of outcomes (referrals made and jobs secured) reviewed as part of regular contract review. No minimum employment hours required. No minimum length of time to work with clients.

Contract design

While delivery of programmes aligned to the principles of IPS achieve good employment outcomes, recent research suggests that a large contributing factor for the variability in the performance of IPS programmes is the contract terms and conditions.

Researchers have examined the effects of specific types of contracts, particularly activity based versus results based contracts on provider performance. Although this is not a well-researched area it is generally acknowledged that all funding mechanisms have advantages and disadvantages.

In relation to supported employment programmes for people with mental health conditions, there are two distinct government funding streams available in New Zealand: funding from the Ministry of Health via the 20 District Health Boards (DHB), and from the Ministry of Social Development (MSD).

DHB funding is activity based and usually allows for time unlimited employment support for people in contact with secondary mental health services (5 per cent of the population) but targets are very low (often along with low expectations). Reporting is based on inputs ie. full time equivalent staff employed and not outcomes. Although current health policy stipulates DHBs need to increase access to evidence-based employment programmes, there is no current requirement on DHBs to purchase employment programmes and therefore their availability is reliant on local planners and funders and service providers.

In contrast, MSD contracts for supported employment focus on outcomes. The advantage is that providers are incentivised to deliver effective employment programmes, however these contracts often have restrictions which limit their application to people with more complex barriers to returning to work. For example:

- limitations on how long a provider can work with an individual if a job outcome has not been secured
- limiting the provision of on-going support once a person is in work
- limiting it to people only on welfare benefits (therefore excluding many young people with mental health conditions who are living at home and not yet claiming benefits).

MSD Mental health and employment pilots

One of the most recent evolutions of contracting in the mental health and employment space are the MSD mental health and employment pilots. Workwise is one of the providers of these three year pilots (running to June 2016) in Auckland, Waikato and Canterbury.

The aim of the mental health employment service is to provide employment support that enables people with common mental health conditions to return to work and achieve sustainable employment. This service provides wrap around support, employment placement and employer support, for up to 12 months. Work and Income remains responsible for the income support administration of the client.

Participants are referred, or have their referrals endorsed, by Work and Income because they are limited in their capacity to look for or be available to work full-time due to common mental health issues – such as anxiety, stress and depression – that can be effectively treated in the primary care setting through low-intensity community-based services.

Clients have a service intensity categorisation of medium, high or very high representing the support required. This categorisation is informed through a combination of the current internal

Work and Income LLTBR (Likelihood of Long term Benefit Receipt) tool, and other assessment tools.

Clients are exited from service if an employment placement is not achieved within six months.

The outcome target is for the client to achieve sustainable employment that is aligned to their work test obligations. Providers are expected to achieve 50 per cent employment placement outcomes, with 80 per cent of those placed being in on-going employment after 12 months.

Results based accountability

The current focus on more effective delivery through outcomes-based contracting is to be welcomed particularly the emphasis on expanding contracts with local communities and NGOs to achieve this. There are clear recommendations about the need to 'harness the innovation and effectiveness of non-government providers' in the Welfare Working Group reports.

A well designed results-based accountability framework has the ability to shift the focus from activities to results, from how a programme operates to the good it accomplishes. It must however:

- define clear performance expectations and measures
- provide incentives for performance
- have great strategic and programme logic
- include provisions for flexibility, including identifying any changes in external factors that will impact performance and the adjustments required
- include transition or establishment period "hold harmless" clauses.

In our experience contracts that come closest to adopting a 'tight, loose, tight' high trust contracting framework gain the benefits of flexible service delivery and maintain government accountability. *Tight* in terms of specified resource, population and impact/outcomes; *Loose* in terms of how the provider is monitored to apply the model of care (assuming a foundation of evidence-based best practice),*Tight* in regards to evaluation and improvement.

The balance between flexibility and accountability needs to be reviewed regularly and adjusted - with requirements being added or removed based on insights from evaluations.

As the model within employment support services matures, we would expect to see a gradual relaxation of compliance requirements due to a greater understanding of what works at the provider level.

Achieving outcomes based revenue targets

A key driver for Workwise is to deliver on all contracts. Outcomes based contracts are considered high revenue risk. Realising revenue for these outcomes is contingent on receiving adequate referrals and achieving contracted outcomes. It has been our experience with some government contracts, that while services are being established, service volumes and the resulting revenue streams can be slow to reach peak levels. There is often a lower rate of referrals than projected.

Providers carry the risk of having to staff up to provide services. Referral flows being patchy and slow has been an on-going issue via Work and Income and other government agencies. It has significant ramifications in regards to outcomes and so to revenue and sustainability for providers.

Access into services is a crucial contributing factor to programme effectiveness. The provider needs to share this role with the purchaser, but in many cases contracts specify that the purchaser controls the referral pathway. As mentioned above, this severely restricts the outcomes that can be achieved, and also has a significant impact on the finances available within the contract for the provider

An opportunity for change is look to increase flexibility within contracting arrangements to be able to make referrals (that meet criteria) directly to providers. This will mean that people with mental health issues who want employment support are able to access it when they want it. Making the service available to more people keen to work will have a powerful effect upon engagement and results. It will also increase the rate of referral to meet service capacity available and more fairly shares risk.