ILC Commissioning Framework - written feedback form

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General comments

In addition to responding to each set of questions in the submission template, MSA has provided some general comments regarding the ILC framework.

- The Policy Framework for ILC is still unclear and it therefore makes it hard to provide detailed comments and responses regarding the Commissioning Framework
- One of the five activity streams, local area co-ordination (LAC), has since been changed and the actual role and function of the LAC is still unclear, with regard to regional differences for example
- The Community awareness and capacity building activity stream should more closely align with the National Disability Strategy principles. Originally the outcomes for the disability support system were based on the National Disability Strategy (see figure 1 on page 4 figure of the Framework document). There now appears to be a disconnect between this premise and Appendix A of the Consultation Draft where the proposed ILC outcomes measures are set out
- Questions and lack of clarity remain regarding the Individual capacity building activity stream, around the use of the term "early intervention" and how this relates to NDIS, particularly how this will fulfil the original intention of the key points of early intervention as set out in Chapter 13 of the Productivity Commission's report. There is still the perception of a 'maze with extra barriers' (as detailed on p164 of the Productivity Commission's report)
- As mentioned in the submissions from National Disability Services, 'A case for Block funding' there is still sector confusion about the sustainability and viability of block funding for especially specialist providers, particularly in creating thin markets
- Transition points for those subject to episodic conditions (such as MS) leaves large grey areas or gaps and the 'whole of life approach' and continuity of care/ intersection with mainstream services seems to have become lost in the commissioning framework i.e. lack of reference to effective coordination/collaboration of sectors
- The National Disability Strategy, policy area 6 Health and Wellbeing, has as its Outcome, that "People with disability attain highest possible health and wellbeing outcomes throughout their lives." In particular, policy direction 2 calls for "timely, comprehensive and effective prevention and early intervention health services for people with disability." For people with MS, timely, specific post diagnosis and early support during transition points is critical to minimising the impact of MS, further illustrating the importance of an effective intersection between the health and disability sectors to improving access and outcomes for people affected by MS.

1. The proposed outcomes for ILC and the best ways to measure them

Questions you might like to consider:

- Do you agree with the nine outcomes outlined in the Consultation Draft? Is there anything else the Agency should consider?
- Do the nine outcomes cover everything you would expect to see in ILC?
- How should we measure each of the nine outcomes?
- How can people with disability, their families and carers and the broader community stay involved in measuring outcomes as ILC rolls out?
- Is there anything we should consider in setting up our data collection processes?
- Is there anything else you would like to tell us?

The nine outcomes should be strengthened to more clearly align with the principles of the Scheme and the National Disability Strategy, to bring these principles to life and to ensure there is less risk that they are viewed as a set of "motherhood" statements.

For example, outcomes could be re-worded to say:

Outcome 1: People with disability **do** have capacity to exercise choice and control.

Outcome 2: Independence and social and economic participation of all is promoted **and achieved/realised**.

Outcome 3: Informal support and care arrangements are **acknowledged, valued, strengthened and maintained.**

Outcome 4: Participants **do** access unfunded supports…

Outcome 7: People with disability, their carers and families, **influence and partner with support and service agencies.**

Outcome 8: Increased community/mainstream awareness of how **to work together** to support people with disability, **their families and carers.**

The outcomes could be expanded to include an outcome regarding successful sector integration such as:

Outcome 10: Sectors including aged care and health are successfully integrated to provide a seamless system of support and services.

There is a danger that the ILC outcomes are too broad and seeking to be too "all encompassing" for the stage the Scheme is at, at present. Further, it seems the outcomes are disconnected from the NDIS principles, and therefore would benefit from being clearly and overtly linked.

The ILC is for every Australian and as per the Productivity Commission's report, sustaining the involvement of families and carers is a preventative and sustainability mechanism for the scheme. The ILC is also about building the capacity of community to be inviting and inclusive of people with disability. While it is possible to build the capacity of the individual, very often this is not sustainable without carer involvement and it seems families, carers and informal supports are less visible, hence the suggestion to add families and carers to outcome 8 above. If capacity and resilience of informal supports can be built, they obviously support the individual with disability. Therefore the provision of relevant information and knowledge (i.e. health literacy) is essential and this is not achieved through a generalist approach. The measures associated with the provision of informal supports needs more work.

People cannot "stay involved" in measuring outcomes if they are not fully aware of the purpose of the ILC in the first place. There is an implied expectation here that people with disability, their families and carers, have had their capacity built and are therefore in a

position to be involved in measuring outcomes. In reality, people with disability are in many cases on their own "learning journey" regarding their own diagnosis and/or disability and may have little or no capacity for involvement in outcome measurement.

Appendix A of the Consultation Draft sets out the proposed ILC outcomes and measures. Outcomes are delineated into outcomes for individuals and outcomes for the whole community. To fulfil the capacity building goal of the ILC it is necessary to get the whole community on board first, for example through initiatives that improve physical and electronic accessibility. This is an important first step, as measuring outcomes for individuals cannot occur before advances are made in building the capacity and awareness of the community as a whole.

It will also be important to ensure that the advocacy function is not lost. People with disability cannot find their way through the maze of advice and service provision alone. The need for effective sector integration and the provision of a seamless web of advice and referral, regardless of sector, must be recognised.

There remains confusion regarding the eligibility for, and sequence of, accessing the components of the ILC. For example, it is difficult to engage with people who themselves are not engaged nor identify with having a disability.

There is also a need to guard against the creation of another hierarchy, further silos and additional bureaucracy in implementing the ILC framework.

2. How to prepare the sector for outcomes-based performance measurement

Questions you might like to consider:

- What are the biggest challenges for organisations moving to outcomes based funding?
- What can the Agency do to help organisations meet those challenges?
- What can people with disability, their families and carers do to help organisations get ready?
- Is there anything else you would like to tell us?

Certainty of funding and an organisation's ability to plan is a big issue, leading to lack of stability and longevity if not guaranteed. Also, the loss of sector expertise and "know-how" and loss of ability for organisations to continue to build the evidence required to maintain good practice and recommend effective interventions is a risk. Whilst these risks are recognised to some extent under the heading "Competitive sourcing" on page 27 of the Consultation Draft, no clear solutions are suggested or interim arrangements proposed. Promoting a transitioning period, piloting some initial proposals and utilising a stepped approach whilst also providing funding security for that period would enable businesses to adapt and strategically respond.

There is lack of clarity regarding the meaning of stage 1 of the competitive sourcing approach and implication for the sector. As stated in the Productivity Commission's report, systemic data on these "Tier 2" services is not available.

Another challenge is that ILC investments will be 'structured to complement the central role of the LACs' (p28 of the Consultation Draft). It is not clear how this is intended to work when the LAC role is still so undefined.

Some organisations that are currently providing specialist expertise, vital to certain cohorts of people, are small, underfunded, often staffed largely by volunteers and may not survive. If these organisations, which have traditionally provided diagnosis-focused information, support and referral, fail, people who have received a chronic illness diagnosis, such as MS, will be left in limbo, attempting to access any information but only in an ad hoc way. The intention of the ILC was to provide information to link people to support and services, but there does not appear to be any mechanisms in place to ensure mainstream sectors are successfully connected. How are those people currently accessing information expected to cope during this transitional period?

There is concern for smaller organisations' ability to develop a competitive tender. Is there an opportunity for different cohorts of participants to be covered and is there capacity for the allied sectors to submit joint competitive tenders? We suggest that during the transition arrangements, the NDIA could consider alternatives, for example, to allow a larger organisation to host smaller funding agreements with smaller organisations but for the larger organisation to provide the reporting and quality assurance requirements.

Five priority areas for ILC investment are set out on page 19 of the Consultation Draft. The outcomes framework and sourcing approach may be onerous for smaller organisations and will make it difficult for smaller providers to compete.

3. How to grow social capital in the sector, particularly volunteering

While there are many different definitions of social capital, in this context social capital means things like volunteering or the relationships that organisations have with others in the community that contribute to the work of the organisation and help people with disability and their families.

Questions you might like to consider:

- The Agency would like to see things like volunteering grow in ILC. What can the Agency do to make sure that happens?
- What barriers might there be to growing social capital?
- What types of activities work well when delivered by volunteers?
- Is there anything else you would like to tell us?

Once again, organisations need certainty and longevity of funding to ensure a robust basis exists for volunteering to flourish.

Volunteers need to feel empowered and feel they are adding value to a wider cause, so secure funding and other organisational supports and encouragement are vital. Volunteering works best when tied to a specific cause or condition and therefore the right level of brand identity is important, especially if the intention is to expand volunteer activities.

Volunteers need to be funded appropriately for community and social inclusion. There is a cost to managing safe guards for volunteers (for example, the vicarious trauma that may be experienced by volunteers working in the neurological or acquired disability field that requires acknowledgement and the right support) and in providing general supervisory support and training.

4. How to prepare the sector for the requirements of the ILC sourcing process

The Agency is moving to a nationally consistent framework for ILC. Funding will be provided to organisations through an open competitive grants process.

Questions you might like to consider:

- What are the biggest challenges for organisations moving to competitive grant funding?
- What can the Agency do to help organisations meet those challenges?
- Is there anything else you would like to tell us?

A big challenge is for organisations to hold or acquire the skill set and tools necessary to complete competitive grant applications and then to deliver on them. Whilst this issue is recognised to some extent in the Outcomes-based sourcing section of the Consultation Draft, it may be necessary to instigate pilot schemes to test the effectiveness of some processes and mitigate against larger scale wastage of time and money.

It will be difficult to measure outcomes when success is dependent on collaboration with other sectors and where no real benchmarks have been established to measure against. Establishing the standard of evidence to measure outcomes is also problematic.

It is necessary to recognise that before an individual has the capacity to be able to exercise choice, there is first the need to establish an integrated system of support.

5. Rural and Remote

The Agency would like to make sure that ILC meets the diverse needs of people with disability across the country.

Questions you might like to consider:

- What does the Agency need to consider when rolling out ILC in rural and remote areas?
- How can we encourage and support growth in ILC type activities in rural and remote areas?
- What things work well in supporting organisations working in rural and remote areas?
- Is there anything else we need to consider?
- Is there anything else you would like to tell us?

Effective processes to ensure sector (health, disability, aged care) integration is vital to the success of ILC in rural and remote areas.

The NDIA must encourage innovative solutions, shared service models and better use of technology.