

**Forum facilitator:** Riley & Riley represented by Kevin Riley and Debbie Sadler

Community Sector Forums were held at the Burnie Civic Centre on Tuesday 4 November 2008 (2 sessions), the Launceston Mercure on Thursday 6 November 2008 (1 session) and the Hobart Mercure on Wednesday 12 November 2008 (2 sessions).

Kevin Riley gave a Powerpoint presentation outlining:

- the draft Principles being considered by Riley& Riley as the basis for the Integrated Financial and Performance Framework; and
- the proposed building blocks of the Framework.

The updated version of the presentation used at the Hobart Forum is attached.

The comments are grouped under the headings provided by the Draft Principles.

## **Principle I: Results Focused**

### **Common views**

Current funding agreement with DHHS are not outcome based. Usually there are only a couple of paragraphs to describe the services to be provided and the activity/ output measures. CSOs would welcome a clearer description of the results/outcomes that DHHS expects. It would fit with other funding organisation requirements.

Defining outcome indicators and performance measures will not be easy. It should be done jointly by DHHS and the CSO when negotiating the funding agreement. The measures need to be both qualitative and quantitative and the CSO may need time to implement.

The Government needs to be clear about its outcomes. From the CSO perspective, outcomes should focus on the individual.

DHHS currently focuses on activity measures. For some CSOs there will be a cost in moving to output measures associated, eg system changes. There should be a timeframe for transition. Other CSOs already have a well-developed strategic planning, budgeting and outputs model.

The evaluation of programs should be done jointly by DHHS, CSOs and clients using a timeframe that allows for all to make a meaningful contribution.

### **Other comments**

The DHHS evaluation process is hit and miss. Some evaluations are very intensive eg based upon MDS and HACC quarterly reports. It would be better to adopt a risk management approach like the ATO.

There is unmet demand, services are not at an optimum. Funding should go where services are needed across the State.

This is all about cost cutting while the government wastes money.

Government priorities change and differ to those of the community sector.

Whole of Government priorities need to be considered.

## **Principle 2: Mutual Regard**

**“get this right and everything else will follow”**

### **Common views**

The roles and responsibilities of the CSO, the OCS and the operational unit need to be clarified and stated in the funding agreement.

DHHS must deliver on its obligations, such as making payments on time. Delays in funding cause unacceptable stress for staff and the CSO itself.

DHHS should negotiate the funding agreement not deliver a “take it or leave it” ultimatum.

DHHS and CSOs should talk more. Funding agreements are sometimes changed without notice.

Does DHHS have the resources to meet the announced timeframes for introducing replacement funding agreements. It is already difficult to find staff to talk to. There are no longer staff in the field available to talk one on one.

DHHS should be prepared to assist CSOs in meeting the new requirements of the department through developing systems, offering training and developing generic policies and procedures for smaller CSOs.

### **Other comments**

DHHS initiates a lot of changes but often don't implement them well because they are not sufficiently staffed and prepared eg Early Support Program. Problems also with Bridging the Gap.

DHHS should provide a separate stream of funding to meet the full cost of developing and implementing reforms that are DHHS requirements. There is significant time lost in consultation, travel, lost service delivery. Small CSOs can't cope. Larger CSOs are better placed because they have admin staff.

DHHS is not clear itself on what the reforms will achieve. Consultation should be genuine and its cost recognized. CSO staff and clients are experiencing the stress of reform overload leading to concern about the future.

There should be recognition of the impacts of the difference in wage rates between the government and community sectors.

CSOs need to be more honest with DHHS about their service demand and strategic directions.

There is a need for cultural change within both DHHS and CSOs.

## **Principle 3: Transparency, Accountability and Sustainability**

### **Common views**

Increased transparency of the funding decision making process is a good thing.

There needs to be a cost /benefit analysis of information collected, KPIs and other measures from both a CSO and DHHS perspective. The minimum of information should be collected and it should meld with other information requirements eg MDS. There should be consistency in the information collected across all units of DHHS.

The acquittal process should be reviewed and a risk management approach adopted. Separate audits of all acquittal statements is very expensive and is not required by the Commonwealth.

DHHS should advise CSOs what the information collected is to be used for. There should be meaningful financial analysis of the data provided. The performance-reporting and re-alignment of funding should not introduce another layer of reporting.

DHHS should develop tools to enable CSOs to meet minimum costing, acquittal and performance reporting requirements. The information could be used by a CSO to benchmark its performance within the sector.

Funding sources should be rationalised. There are multiple funding buckets within DHHS. This makes accounting and reporting requirements unnecessarily complicated. CSOs continually have to shift clients between funding sources to continue a service. Funding and actual cost don't necessarily match. There can be overspends and underspends between programs where clients meet criteria for separate programs, but funding cannot be moved.

Multiple agreements should be combined and the arrangements for small grants streamlined.

## **Principle 4: Value for Money**

### **Common views**

Funding should be based on total cost, based on actual demand, not an historic basis.

The funding agreement should provide the flexibility to recognize increases and decreases in demand under the new costing model. There should be a mechanism to vary the agreement. Costs change over time. Increasing costs mean diminishing quality of services and or quantity of the service provided. The framework should acknowledge and agree the basis of funding.

Indexation is not sufficient to meet cost increases eg wages and fuel. Is CPI the right measure?

The wages differential between the sectors needs to be dealt with. There is now a \$15-20 k difference in the wages paid by DHHS and CSOs. There is a need to attract good staff to the community sector, which is facing a big demand for services provided.

The community sector needs longer term funding. A one year contract is not acceptable. Rolling or three year term budgets are needed.

The activity being funded must be defined before unit costing can be introduced. There will need to be benchmarking exercises to determine total cost.

### *Unit costing – one size does not fit all*

Jobsearch used a similar unit cost model. It is now being modified to recognize the costs of isolation and scale eg a loading is being added to provide a service on the West coast.

Determining the unit eg a trip (current) or per km, leads to cross subsidies.

Economies of size and dispersal across the State.

Costs change over the life of the agreement eg fuel

Providing services, outcomes in remote locations

More onerous for CSOs, splitting costs over range of activities/services, artificial split of overheads. Cost of administration. Do CSOs and DHHS have the skills and knowledge to apply? Outsource? More cost?

Same service can be more costly between different client groups eg disability and HACC.

DHHS wants a single unit cost. Will DHHS fund fixed costs?

What are we trying to cost?

Cherry-picking by CSOs of most profitable clients, services.

### **Other views**

The funding agreement should provide the flexibility to recognize both increases and decreases in demand under the new costing model. There should be a mechanism to vary the agreement and to reallocate resources within a CSO.

The framework should acknowledge and agree the basis of funding. There could be separate funding streams for service delivery and capacity building. Potentially there should also be separate streams for administrative costs, innovation, research and development, costs of introducing the reforms required by DHHS, capital purchases.

CSOs repay surpluses, but CSOs expected to wear deficits.

Unit costing is already here. It is being rolled out in Disability Services.

There is always pressure to do more with the same funding. Changes proposed within DHHS will mean CSOs delivering greater services. Will there be additional funding? No detriment, a CSO should not be worse off under the new arrangements. Additional funding should be provided to assist the transition if required.

## **Principle 5: Continual Improvement**

This principle is generally supported. However, concern was expressed that improvements will be used to drive down funding.

### **OTHER**

There was discussion of the other reforms being progressed by DHHS and their potential impact on the sector.

**Disclaimer** – the information contained in this document is the “raw” data as received at the by the Consultants ‘Riley & Riley’ at the external consultation forums held throughout the State. This information are the views, opinions and comments as made by attendees only and are not representative of the views of the community sector organisations, the Office for the Community Sector (Human Services, Department of Health & Human Services) or the consultants ‘Riley & Riley’.