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Auditor-General

Accommodation for People with a Disability

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Victorian Auditor-General's Office

Auditing in the Public Interest

The Hon. Robert Smith MLC
President
Legislative Council
Parliament House
Melbourne

The Hon. Jenny Lindell MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my performance report on *Accommodation for People with a Disability*.

Yours faithfully

A handwritten signature in black ink, appearing to read 'DDR Pearson', written in a cursive style.

DDR PEARSON
Auditor-General

12 March 2008

Foreword

Disability is, and will continue to be, a serious health and social issue for the community. Around 6.5 per cent of Victorians have a severe or profound disability and require intensive support. The demand for intensive support is rising rapidly. Already, some people are receiving insufficient support, and some no support at all.

This audit found that much effort had been applied to refining the disability service model, through legislative and other changes. I consider the service model to be conceptually sound. That the model now has a greater focus on human rights and the needs of individuals, is a positive development. Some changes, such as the establishment of adequate quality assurance processes, have not yet been completed. When they are, they should assist in improving service quality and making service providers more accountable.

Based on the results of the audit, I have doubts that the service model will be successfully applied by service providers. There is a large disconnect between what is currently happening in the accommodation houses we examined and what the service model aspires to achieve. It was particularly concerning that three core aspects of service delivery raised in VAGO's 2000 disability audit have yet to be resolved.

The Department of Human Services needs to ensure that service providers have the capacity and expertise to provide the required support; the support plans of people in supported accommodation are prepared consistently and to the required quality; and the allocation of funding is more closely aligned to individual needs. The Department faces a major challenge to align on-the-ground delivery with the goals and principles of the service model. I urge it to promptly address the issues raised in this report.



DDR PEARSON
Auditor-General

12 March 2008

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1 Executive summary

1.1 Introduction

Victorians living with a disability face significant barriers to social and economic participation in the community. These barriers are exacerbated by the difficulties people with a disability experience in accessing adequate and appropriate care and support.

The *Disability Act 2006* consolidated the *Intellectually Disabled Persons' Services Act 1986* and the *Disability Services Act 1991* and provided for a more whole-of-government approach to service provision. The new Act recognises (as did the previous Act) that resources are limited and that people with a disability cannot expect universal and total access to disability services. Only those who request support and meet criteria specified under the Act are eligible to receive support. That support is provided in a manner based on the Department of Human Services (DHS) assessment of priorities, and subject to the availability of the required support. The new Act states that if a person is assessed as disabled, that assessment of itself does not provide an entitlement to services.

For people at the high end of the scale with the most severe or profound disabilities, DHS provides shared supported accommodation (SSA). Currently, around 4 600 people reside in 914 SSA houses. They live usually in groups of four, five or six, with 24-hour rostered support. In 2006-07, DHS allocated \$395.6 million for SSA. DHS funds community service organisations (CSOs) to provide around 40 per cent of this support (\$156.6 million in 2006-07).

People with disabilities that are less severe than the high end of the scale, but whose disabilities are still nevertheless severe, are supported by DHS to live in the community through the provision of individualised packages such as home help services, equipment and respite care for carers (\$141.1 million was allocated for these types of support in 2006-07). Around 8 260 individual support packages were issued in 2006-07. Packages ranged from under \$10 000 (77 per cent) to over \$55 000 (1 per cent). Eight packages exceeded \$100 000.

The *Disability Act 2006* was written within a human rights framework. It reinforced the transition of the disability support model from a medical model (health care) to a social model (one of facilitating more flexible support for persons with a disability to achieve their individual needs and aspirations).

Under the new Act, the accountability requirements for SSA service providers have been strengthened. In 2006, DHS's Quality Framework for Disability Services established the parameters for best practice and quality improvement. The framework has minimum standards for the condition of houses and administrative systems, and processes for monitoring compliance with the standards. The framework also incorporates outcome standards, which reflect the quality-of-life aspirations of people with a disability, and the measurement of these outcomes.

The objective of this audit was to determine the extent to which people with a disability receive accommodation and related support services commensurate with their need. We selected 32 houses to visit across two rural and two metropolitan DHS regions. Of the 32 houses, 16 were managed by DHS and 16 by 11 CSOs. At each house, we selected one resident's file to examine in detail.

1.2 Findings

DHS has taken positive steps to address long-standing system shortcomings. Establishing the Quality Framework should contribute to improving the quality of support provided and the quality of accommodation facilities. Focusing on each person's support needs rather than delivering a broad-based service should improve the level of support. The framework for measuring outcomes will also help in this regard.

Significant issues remain which, unless addressed, will continue to impede the transition from a medical to a social model of support.

Capacity and expertise of service providers

DHS has not yet conclusively assessed whether the disability sector has the capacity and expertise to adopt the changes (though DHS has identified the need for such an assessment). Nor has it established a strategy to address gaps in capacity or expertise. Service providers are struggling to meet their existing obligations for supporting residents, particularly in regard to the time required to provide individualised support. Their capacity to provide additional individualised support is limited. There is considerable variation in staff skills and qualifications, which results in variability in service provision.

Unmet demand for support

DHS is unable to provide support for all those requesting it (unmet demand is around 1 370 people or 30 per cent), yet demand is increasing by around 4 to 5 per cent annually and DHS has not accurately quantified future support needs or the associated need for resources. The reactive nature of DHS's response to accommodation needs, combined with the stringent prioritisation criteria, is likely to continue, and therefore perpetuate a crisis-driven system.

Block funding for SSA

Funding for SSA is delivered to each service provider (per house) in a block, based on the level of support a particular house provides. As funding is tied to the service provider rather than the individual, it reinforces a 'group approach' to service provision rather than a system that services the needs of the individual.

Availability of SSA houses

In 2003-04, DHS identified the need to replace or upgrade approximately 443 of its SSA houses, at an estimated cost of \$225 million. DHS subsequently identified that approximately 200 of its houses did not meet current building access requirements for people with a disability and occupational health and safety standards, and therefore needed to be replaced or substantially upgraded. To date, DHS has requested \$123.2 million over time to meet the liabilities identified. Since 2004-05, DHS has received \$44.5 million which has provided for 51 new (replacement) houses and nine major refurbishments. A further \$10 million was funded for minor upgrades to facilities that did not meet occupational health and safety or building regulations. In 2006-07, \$15 million was provided to replace facilities and provide equipment to the CSO sector.

Some houses operate from an 'institution' mindset, catering for residents' physical needs rather than operating like a home where residents are encouraged to develop an independence limited only by their own capacity. DHS has not assessed the suitability of its houses in regard to the goals of the State Disability Plan and the *Disability Act 2006*. Likewise, operators of CSO houses have not assessed the suitability of their houses.

Due primarily to the high cost of SSA, DHS has in the last decade been moving away from these services to the provision of less costly services and more flexible accommodation options. More support is being provided for people to live in the community through, for example, community access programs or home-based support. Nevertheless, DHS has estimated demand for SSA will grow by around 4 to 5 per cent annually from the current level of 4 600 people. Some steps have been taken to address this growth but not in the structured and cohesive manner necessary to reliably address this growing demand.

Over the past four years, DHS has created 77 new facilities to replace unsuitable facilities but has not increased SSA bed capacity.

Individual support plans

DHS has not clearly specified the detailed contents of residents' support plans, and the form they will take, beyond the key elements. As such, there is a risk these support plans will not be prepared on a consistent basis or to a quality consistent with providing individualised service responses. Existing plans, prepared under the previous legislation, often lack relevant detail. In consequence, approaches to planning by DHS and CSOs lack consistency and coordination.

1.3 Conclusion

Due to the significant issues identified in this audit, there remains a disconnect between the new support model and the actual delivery of the model by service providers. It will be critical for DHS to address these issues. In particular, DHS needs to establish mechanisms to monitor how well the new service model is being implemented and applied.

Of particular concern to audit is that the three issues of capacity and expertise of service providers, block funding for SSA, and individual support plans were raised by us in 2000. In the course of the present audit, DHS advised us that it had initiated actions to address these issues. It remains to be seen whether these actions will have the desired effect.

The future service requirements of the people currently receiving support need to be better understood. In addition, there is a need to identify those people who may seek, and be eligible for, support in the future. Some initial work has been undertaken but it needs to be far more extensive and systematic. Without this information, DHS is poorly placed to plan for and manage the full extent of its future resourcing requirements. This may perpetuate a service system that is reactive and crisis driven.

1.4 Recommendations

- DHS should:
 - provide focused support, guidance and resources to facilitate the development of individualised plans by service providers. This should involve:
 - adopting a team-based approach to preparing plans, comprising relevant support and professional staff
 - on-the-job training (**Recommendation 3.1**)
 - allocate specific resources for undertaking individual planning for residents within SSA (**Recommendation 3.2**)
 - develop its information systems to provide relevant historical information relating to SSA residents for support staff to assist in meeting residents' day-to-day and long-term needs (**Recommendation 3.3**)
 - review the SSA funding model to better align it with the new service model of individualised support (**Recommendation 3.4**)
 - systematically assess the capacity and expertise of SSA staff to deliver support services in accordance with the new service (social) model and to address gaps subsequently identified (**Recommendation 3.5**)
 - guide and support service providers on the conduct and documentation of the review of individual support plans (**Recommendation 3.6**)
 - assess residents' satisfaction, directly or through their family and friends, with their accommodation on an on-going basis, and incorporate the results into a system of continuous improvement (**Recommendation 4.1**)

- expand its demand management strategies and explore options for accelerating the implementation of existing demand management strategies (**Recommendation 5.1**)
- systematically measure projected need and develop strategies, such as alternative delivery mechanisms and a workforce management strategy, to meet future resourcing requirements (**Recommendation 5.2**).

RESPONSE provided by Secretary, Department of Human Services

The Department of Human Services (the department) welcomes external examination of the operation of accommodation services for people with a disability through the Auditor-General's report. This report rightfully acknowledges that progress has been made to enhance the operation of disability accommodation services and that reforms will continue into the future. The Victorian State Disability Plan 2002-2012 and the Disability Act 2006 have placed stronger emphasis on the rights and needs of the individual. Positive changes are occurring but the department acknowledges that there is more to be done.

Over the past five years the department has implemented significant policy and practice changes to enhance choice and opportunities for people with a disability. It is important to recognise that the Auditor-General's review occurred during the latter part of 2007 and examined the performance of a relatively small number of disability accommodation services during a period of substantial transition. This period included:

- *implementation of the Disability Act 2006 on 1 July 2007*
- *implementation of individualised planning approaches and support and choice initiatives. These approaches are putting in place new processes to tailor planning to the individual's needs and aspirations and reinforces plans are to be directed, to the greatest extent possible, by the person and their network to promote participation in community life*
- *revision of the Quality Framework for Disability Services resulting in a stronger emphasis on service quality being aligned with personal outcomes for people with a disability. This resulted in outcome standards being added to the existing industry standards and planned major changes to monitoring and reporting arrangements*
- *introduction of the Industry Plan to enhance the capacity and networking of Disability Services within Victoria. The Plan focuses on five key result areas: creating individualised support responses; workforce planning and development; increasing community awareness and valuing of diversity; community strengthening through partnerships and industry governance, management, planning and investment*

***RESPONSE provided by Secretary, Department of Human Services
– continued***

- *initiation of the department's Community Sector Investment Fund in 2003. This resulted in the allocation of \$7 million for initiatives to support efficiency and sustainability for community service organisations*
- *workforce development and planning initiatives, including a five-year workforce planning strategy to increase workforce attraction, retention and culture change*
- *funding for residential accommodation support in Victoria has increased by 65 per cent from 1999-2000 to 2007-08.*

These changes mean that the environment today is substantially different from that of five to six years ago. The previous Auditor-General's report on Disability Services was released prior to the proclamation of the Disability Act 2006 and since that time there have been many changes, and there will continue to be, to systems and processes in accordance with the principles of the Act.

The department welcomes the Auditor-General's office's constructive comments regarding how improvements may be made to achieve a more individualised support approach for people with a disability living in disability accommodation services.

It is worth noting however that whilst this model of accommodation support offers many benefits for people with a disability who are amongst the most vulnerable in our society, it does present limitations to individual choice inherent in living in a group home.

The department has commenced a number of initiatives to reduce barriers to individual choice for people with a disability in accommodation services including:

- *person centred active support*
- *personal outcome measures as part of the revised Quality Framework for Disability Services*
- *a sustained program of culture and practice changes to help staff work differently to support people with a disability.*

The department is mindful that it needs to maintain a constructive and collaborative partnership with the Disability Services sector to continue the positive change agenda for people with a disability. In this way, it will be possible to build further capacity of the sector to embrace and respond to the changes.

The planned move to independent certification of Disability Services from 2009, along with the monitoring framework for the health, housing and community services sectors, will help build a sustainable funded sector by strengthening and monitoring accountability arrangements.

The department supports eight of the nine recommendations (3.1, 3.2, 3.3, 3.5, 3.6, 4.1, 5.1 and 5.2) and partly supports one recommendation (3.4). Further comments made by the department are contained in parts 3, 4 and 5 of this report.

2 Background

2.1 Background

2.1.1 Introduction

In 2003, Victoria had an estimated 992 300 people with a disability. Of these people, 323 300 are considered to have a severe or profound limitation that inhibits their ability to care for themselves, communicate clearly or undertake normal cognitive or motor development tasks. These 323 300 people represent approximately 6.5 per cent of all Victorians under 64 years of age.

Victorians living with a disability face significant barriers to social and economic participation in our community. These barriers are exacerbated by the difficulties people with a disability experience in accessing adequate and appropriate care and support.

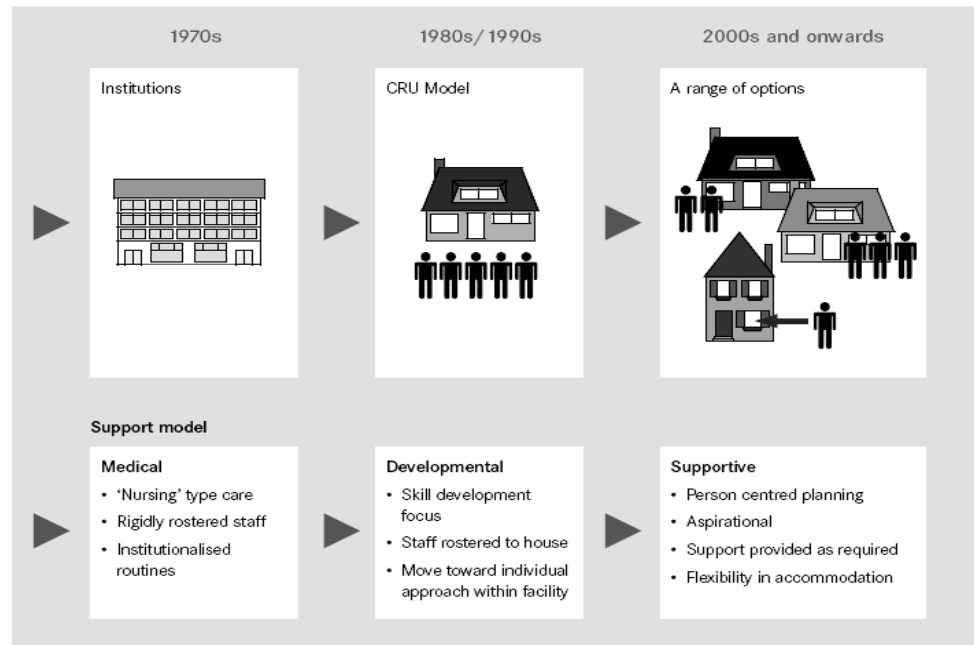
Until the early 1980s, the majority of people with a disability who required support services (such as housing, special equipment and care) received them in institutionalised settings. The government was responsible for the institutions and their residents. Most disabled people in government institutions had some form of intellectual disability.

In 1984, the government began a program of de-institutionalisation with the closure of St Nicholas Hospital and the relocation of its residents into shared houses in the community. Many people were relocated, and those living in the community who could no longer access institutions, required 24-hour support. The resultant model – now referred to as ‘shared supported accommodation’ (SSA) – is a house shared by four, five or six residents who are supported by rostered support staff.

Victoria’s Department of Human Services (DHS), has continued the program of de-institutionalisation. Accommodation for people can now take many forms, such as remaining at home, sharing with another person or living by themselves (see Figure 2A). DHS is examining resident options for the remaining two institutions.

Of those people in SSA, some will remain in an SSA until they die. Others will have the ability to leave the SSA and live independently in the community.

Figure 2A
Changes in community based accommodation



Source: Department of Human Services.

DHS also funds community service organisations (CSOs) to support people with disabilities. CSOs are not-for-profit entities. Some have a specific focus, such as supporting people with cerebral palsy or multiple sclerosis, while others have a general focus, and grew out of parents wanting to keep their children out of institutions.

2.1.2 Who are the people with a disability?

Figure 2B provides the statutory definition of a person with a disability.

Figure 2B
Definition of person with a disability under Disability Act 2006

The *Disability Act 2006* defines a person with a disability as someone who has:

- (a) a sensory, physical or neurological impairment or acquired brain injury or any combination thereof, which —
 - (i) is, or is likely to be, permanent; and
 - (ii) causes a substantially reduced capacity in at least one of the areas of self-care, self-management, mobility or communication; and
 - (iii) requires significant ongoing or long term episodic support; and
 - (iv) is not related to ageing; or
- (b) an intellectual disability; or
- (c) a developmental delay.

Where a developmental delay means a delay in the development of a child under the age of 6 years which —

- (a) is attributable to a mental or physical impairment or a combination of mental and physical impairments; and
- (b) is manifested before the child attains the age of 6 years; and
- (c) results in substantial functional limitations in one or more of the following areas of major life activity
 - (i) self-care;
 - (ii) receptive and expressive language;
 - (iii) cognitive development;
 - (iv) motor development; and
- (d) reflects the child's need for a combination and sequence of special interdisciplinary, or generic care, treatment or other services which are of extended duration and are individually planned and coordinated.

Source: Disability Act 2006.

2.1.3 Resources

DHS – through its Disability Services Division – provides various types of support including:

- respite services
- shared supported accommodation
- support for living at home (which is provided through an individual support package)
- aids and equipment (such as wheelchairs and hoists).

In 2006-07, DHS's Disability Services budget was \$1041.3 million. Of that amount, \$395.6 million was allocated for SSA: \$239 million for SSA provided by DHS and \$156.6 million for SSA provided by CSOs. DHS funds 914 SSA houses: 708 are owned by DHS, (including 205 by the Office of Housing), 43 by a private company, and 163 by CSOs. The houses provide accommodation and support to some 4 600 people.

DHS also allocated \$141.1 million to individual support packages. Around 8 260 packages were provided from this funding. Packages ranged from under \$10 000 (77 per cent) to over \$55 000 (one per cent). Eight packages exceeded \$100 000.

2.1.4 Shared supported accommodation

Shared supported accommodation (SSA) is provided through:

- DHS regional offices
- CSOs funded by DHS under a service agreement. Service agreements set out the services to be delivered by the CSO, performance measures and targets, service standards and guidelines, and data collection requirements.

The Commonwealth Government also funds disability services through the Commonwealth State and Territory Disability Agreement. This agreement specifies that services be directed towards people with disabilities who require significant ongoing and/or long-term episodic support and who have a disability that manifests itself before the age of 65 years.

In 2006-07, \$139.6 million was provided under the agreement. At the date of audit, a new agreement covering the five year period 2008-12 had not been signed.

2.1.5 Policy, legislative and regulatory environment

Policy environment

The three key policy documents that set the context for disability services are *Growing Victoria Together*, *A Fairer Victoria* and the *State Disability Plan 2002-2012*. These documents build a picture of a fairer society that reduces disadvantage and respects dignity and diversity; and that has a high-quality, accessible health and community services system.

A Fairer Victoria specifically addresses disadvantage in Victoria by seeking to increase access to services, reducing barriers to opportunity, strengthening assistance for disadvantaged groups and places and ensuring that people get the help they need at critical times in their lives.

The State Disability Plan reaffirms the right of people with a disability to live and participate in the community on the same basis as other Victorians, and to participate in activities of their choice. The Plan commits government to providing more housing options for people with a disability – enabling them to participate in their local communities – and to support their living in settings best suited to their individual needs and wishes.

Legislative and regulatory environment

The Commonwealth *Disability Discrimination Act 1992* seeks to prevent discrimination against people with a disability.

In January 2008, Victoria introduced a Charter of Human Rights and Responsibilities. The rights of people with a disability are also protected by the *Equal Opportunity Act 1995*.

Victoria's *Disability Act 2006* was enacted on 1 July 2007. It uses a human rights framework and addresses the inclusion of people with a disability in the community; supporting their needs and aspirations; service planning, funding and provision; and the accountability of service providers to people accessing disability services.

The *Disability Act 2006* repealed the *Intellectually Disabled Persons' Services Act 1986* and the *Disability Services Act 1991*. The 1986 Act included specific departmental objectives and responsibilities with respect to people with an intellectual disability. The 2006 Act re-enacted these objectives and specified the role of the Secretary; and transferred DHS's specific responsibilities to a higher, overarching whole-of-government level.

The 2006 Act gives DHS's Secretary an explicit power to decide whether services are provided or not, even where a person is assessed as disabled.

2.2 The audit

2.2.1 Objective

The audit objective was to determine the extent to which people with a disability receive accommodation and related support services commensurate with their needs.

The audit's three sub-objectives were to determine:

- whether individual plans are prepared and implemented, and whether they appropriately address the support needs of the individual and encourage participation in the local community
- whether services are provided at appropriate standards of quality and timeliness
- the adequacy of mechanisms for measuring service demand and whether the needs of people with a disability are reliably identified and assessed.

2.2.2 Scope

The audit primarily examined the practices of DHS's Disability Services central and regional offices, but also included a number of CSOs funded by DHS to provide accommodation and related support services. We examined how DHS assesses service demand, how it assesses clients and allocates support packages. This included examining how a person with a disability enters the system and how their needs are met.

We selected 32 SSA houses to visit across two rural and two metropolitan DHS regions. Of the 32 houses, DHS managed 16 houses and 11 CSOs managed the other 16 houses. At each house, we selected one resident's file to examine in detail.

In November 2000, the Auditor-General tabled a report *Services for people with an intellectual disability*. Core issues reported by that audit were re-visited in the context of issues identified in this current audit.

The audit was performed in accordance with the Australian auditing standards applicable to performance audits, and included tests and procedures sufficient to enable audit conclusions to be reached. The total cost of the audit was \$412 000. This cost includes staff time, overheads, expert advice and printing.

2.2.3 Acknowledgements

The audit team thanks those who participated in the audit, particularly the residents, DHS and CSO staff who dealt with the team and provided access to their homes.

Specialist assistance was provided by a reference committee, comprising Associate Professor Christine Bigby (Reader and Associate Professor, School of Social Work and Social Policy, Faculty of Health Sciences, La Trobe University), Kevin Stone (Executive Officer, Victorian Advocacy League for Individuals with a Disability Inc) and Kerry Presser (State Manager, National Disability Services).

Additional advice was provided by Dr Paul Ramcharan, Senior Lecturer in Disability, School of Human Sciences, Royal Melbourne Institute of Technology.

3 Supporting people with a disability

At a glance

Background

Only those people with a current need that meet eligibility criteria are recorded on DHS's Disability Services Register. Support is provided based on a prioritisation process and matching vacancies to individual circumstances. An individual plan and a support plan are prepared for each person who receives support.

DHS has adopted a person-centred planning approach for preparing resident support plans to meet the requirements of the *Disability Act 2006*. Person-centred planning should be driven by the resident's needs, goals and aspirations and how these are to be achieved.

Key findings

- SSA resident information continues to be fragmented and not systematically recorded. There is no clear format specified for individual plans, and no recognised capabilities established for the people who prepare them. In consequence, plans vary widely in format and in quality.
- Planning for individual residents has been inconsistent. There is confusion at operational levels about what a 'person-centred planning approach' means, and what constitutes a support plan and an individual plan. Residents' involvement is not always clear. The variability in the quality of individual plans and approaches to preparing the plans was raised in our 2000 audit of disability services.
- Funding arrangements are inconsistent with the person-centred planning approach, with accommodation and day program funds allocated to service providers and not to the resident.
- A practical response to limited transport options and staffing is that houses often carry out group activities rather than adopt tailored individual approaches.
- In consultation with CSOs, DHS needs to identify core elements to be included in individual planning processes, and establish systematic monitoring and review.

At a glance - *continued*

Key recommendations

DHS should:

- provide focused support, guidance and resources to facilitate the development of individualised plans by service providers. This should involve:
 - adopting a team-based approach to preparing plans, comprising relevant support and professional staff
 - on-the-job training
- develop its information systems to provide relevant historical information relating to SSA residents for support staff to assist in meeting residents' day-to-day and long-term needs
- review the SSA funding model to better align it with the new service model of individualised support
- systematically assess the capacity and expertise of SSA staff to deliver support services in accordance with the new service (social) model and to address gaps subsequently identified.

3.1 Do SSA residents meet DHS eligibility criteria and are they adequately assessed?

3.1.1 Introduction

Under the *Disability Act 2006*, anyone with a disability can be assessed to establish eligibility for services and then approach a service provider to prepare for them a 'support plan'. A person who requests assistance is initially assessed for eligibility against the criteria specified in the Act.

Eligible people who have an individual plan are then assessed against DHS's criteria for registration on the Disability Services Register (DSR). The criteria applied are:

- they have a current and ongoing need for support
- mainstream or generic services are not available
- the disability support is not the sole source of support but a contribution
- they are supported within their own cultural identity
- the support will meet the person's needs in the most innovative and cost-effective way.

A person can be listed on the DSR with priority status if:

- they are a child in facility-based care
- their current living situation puts them at serious risk of harm or of harming others
- the support will maintain them in their home (or with their family, in the case of a child or young person) where the only and immediate alternative is a facility based setting; for example, in the situation of the serious illness or death of primary carer
- they are in a custodial placement or residential treatment facility after completing their order
- they want to move out of disability supported accommodation or a residential institution
- they have a degenerative condition and are deteriorating rapidly.

Before the DSR, DHS recorded people's service needs on the Service Needs Register (SNR). The SNR recorded people with current needs as well as those who may have a future need. The DSR only records those people with current needs (and those who's current need will manifest within 12 months) and matches these with an available resource based on prioritisation criteria.

People on the DSR are given a priority listing if they meet one or more of nine criteria specified in the DSR guidelines. At the same time, service providers (DHS and CSO) declare any vacancies within their SSAs. When a vacancy is declared the DHS region convenes an assessment panel. DHS officers put forward profiles of a number of people they consider best suit this vacancy. The panel determines who is offered the opportunity to fill the vacancy. The panel allocates individual support packages in the same way. A service provider must prepare a support plan for people with a disability receiving ongoing support.

3.1.2 Eligibility assessments

Audit found that:

- DHS has established policies and procedures to guide assessments of people to establish their eligibility for support
- of the 32 residents' files we reviewed, all met the disability eligibility criteria.

3.1.3 Conclusion

Processes for assessing eligibility were considered adequate.

3.2 Do SSA residents have individualised plans in accordance with the legislative requirements?

3.2.1 Introduction

Before 2006, there were two types of support plans:

- a general services plan – reviewed every three to five years, or as required – that identified a person's life-goals and required supports
- an individual program plan – reviewed annually – that supported the general services plan and addressed short-term skill development needs.

An individual plan (prepared by the person with a disability or a person they nominate e.g. parent, family member) was also required (and still is) in order to seek assessment for registration on the DSR.

The *Disability Act 2006* requires people with a disability to have a support plan if they are allocated SSA and it is anticipated that their support needs will be ongoing.

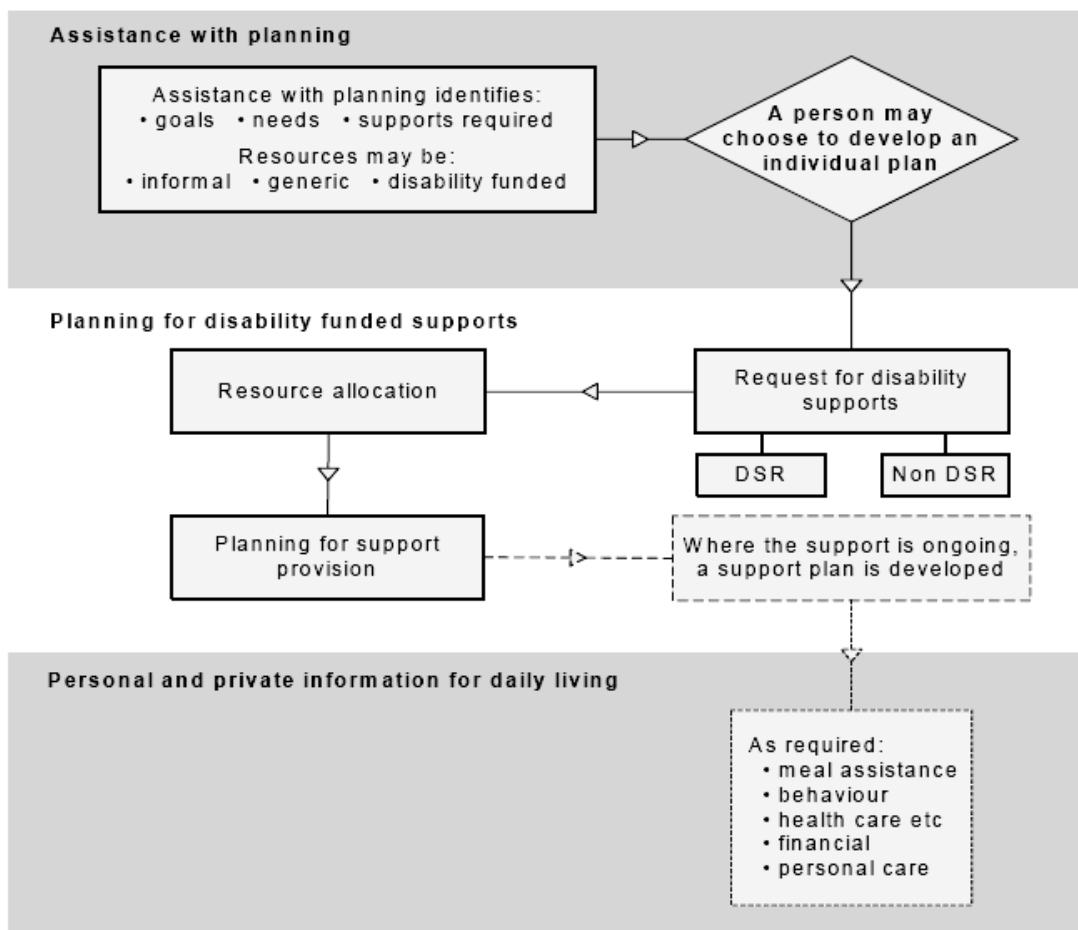
General services and individual program plans prepared before 2006 continue to have effect until their review date, at which time the requirements of the 2006 Act come into effect. These pre-2006 plans must be updated to reflect the 2006 Act's requirements by 1 July 2008.

Before 2006, the plans of the residents were designed around the available services. Plans prepared since 2006 focused on support needed to fulfil residents' goals and aspirations.

DHS has adopted a person-centred planning approach for preparing resident support plans to meet the requirements of the *Disability Act 2006*. Person-centred planning is directed by the resident (or a person nominated by the resident such as a family member) and describes their needs, goals and aspirations and how these will be achieved. The *Disability Act 2006* states that resident's should direct their planning and have the ability to exercise control over their lives.

Figure 3A shows DHS's approach to preparing a resident's support plan.

Figure 3A
Preparing a resident support plan



Source: Department of Human Services.

3.2.2 Consistency of support plan preparation

With respect to support plans, the *Disability Act 2006* specifies that, 'Planning encompasses a range of responses from a brief discussion and agreement about actions required through to an extensive process and the development of a plan across a whole range of life areas documented in a format that is meaningful to the person and their network.' The Act does not specify the content or format of support plans nor minimum qualifications for people who prepare the plans.

All 32 residents' files we examined included a plan: 26 of which having been prepared in 2007. Most files had three or four different plans (as well as general services and individual program plans) that addressed issues such as health and nutrition, care, behaviour management, day program attendance and external activities.

There is no mechanism to ensure the resident makes an informed decision about whom they choose to prepare their plan. There is also no mechanism to ensure that the person doing the planning will have access to all relevant resident information, as this information is kept in many different places.

We found that the content of plans and approaches to their preparation varied widely. Specifically:

- plans varied considerably in quality and detail: for example, some plans consisted simply of lists of tasks while others were more comprehensive, with specific staged goals and suggested activities on how to achieve these goals
- plans were developed by various people (for example, case manager, house supervisor, team leader, health professional, all of whom had different qualifications and backgrounds, resulting in a variety of plans of variable quality)
- the level of involvement by the resident in the development of their plan was not always clear, even where a person-centred planning approach had been used.

The results of our file reviews were consistent with a 2007 DHS quality review of one region's disability services. This also identified that plans were not current and needed review; that resident profiles were outdated; and that a recommended pain management plan had not been written. The review recommended that all residents' profiles include critical information about each resident including any specific behavioural issues and associated management.

We found it particularly difficult to determine whether information was current, as dates were often missing. The absence of dated documentation made chronological histories hard to compile from the resident's files: indeed some older DHS forms did not even have space for a date.

Finding of 2000 audit

The variability in the quality of individual plans and approaches to preparing the plans was raised in our 2000 audit of disability services. That audit concluded, inter alia, that, 'The quality of individual program plans varied as did the processes for developing and reviewing them. Overall, they were not of a standard adequate to meet the legislative intent. Common problems include: the absence of objectives to promote the development or community integration of clients; plans written in a way that did not allow progress on objectives to be assessed; and lack of documentation on progress and poor processes for reviewing plans.'

3.2.3 Revising plans to meet new legislative requirements

The *Disability Act 2006* requires residents' general service plans and individual program plans prepared prior to 2006 to be revised in line with the new requirements.

DHS has not assessed the resourcing implications of this legislative requirement.

We observed that DHS's person-centred planning approach required a greater staff time commitment. Only one of the four DHS regions we visited had allocated extra time for staff to carry out this work. Most regions expected staff to take on this role after attending training.

CSOs have traditionally had a planning function, or referred planning to a more appropriate service. However, CSOs have not received additional or specific funding to enable them to bring residents' plans into line with the new Act.

In the CSOs we visited, we saw active support and person-centred approaches embedded in their service delivery. In DHS houses, those involved in a pilot program to introduce person-centred planning had a greater understanding of what this meant for their work practices. In other areas, staff had not yet been trained and did not understand the implications for their work practices.

3.2.4 SSA residents' information

SSA residents' information is held at a variety of places:

- the early history, assessment information and general service plans of DHS residents was kept on a client services file held at the regional office
- recent information and individual plans were kept on an accommodation file at the SSA house
- background and assessment information on DHS's Client Relationship Information System (CRIS).

CSOs and DHS record residents' information differently. DHS recently completed transferring data from its disability information system (DISCIS) to CRIS in an effort to standardise client information. Staff of some DHS regional offices confirmed that not all data had transferred across from DISCIS and that locating original assessments on CRIS relied on the ability of the staff member to remember the assessment date. We also encountered this problem with our file reviews.

A number of staff in DHS regions commented that the recent adoption of CRIS had reduced their efficiency. For example they missed resident's information, had difficulties in navigating the system and had no ability to reconcile information with the previous DISCIS database.

The problems DHS staff encountered with CRIS may be temporary. The staff from one DHS region that had involvement in the development and testing of CRIS and had been using it for a longer period viewed the system's functionality favourably. Roll out of CRIS and training of DHS staff is underway.

As house staff do not have access to CRIS they relied on manual records. At least one DHS region is planning to make CRIS accessible from accommodation houses. In CSO houses we found that intake information (including original assessments) remained with the DHS regional office in a client services file. CSOs do not have access to CRIS. DHS has advised some CSOs have requested access to CRISSP (external agency version of CRIS) and that this will be organised.

Resident information was fragmented and not systematically recorded: for example, information was kept in house folders, day books, sheets on the wall, filing cabinets, DHS regional offices and on CRIS. Information about the residents' health and behaviour management – and their individual plans – was recorded separately. Residents' history, assessment, proposed treatment and evaluation information was not stored in a consistent place (such as a book or file) or in a logical way.

Because residents' information is not managed strategically, it is difficult for support staff to have the information they need to hand to manage residents day-to-day. It also creates problems for staff when residents transfer between DHS and CSO houses. It is also difficult to readily identify residents who are suited to live independently outside their SSA.

These issues had led one region to review their residents' complete histories in an effort to improve their knowledge of residents and to be better informed when preparing support plans. Most houses we visited had prepared a simple (usually one-page) summary of available information to enable support staff to manage the resident day-to-day.

A number of the CSOs we visited – and some DHS regions – had started to standardise their residents' information. However, the information had only been standardised within the CSO or region.

DHS has developed a quarterly data collection (QDC) report to gather information about SSA residents to meet state and Commonwealth Government reporting requirements, assist in planning and inform policy development.

3.2.5 Conclusion

Consistency of support plan preparation

Although in line with the *Disability Act 2006* a support plan is prepared based on a person-centred approach, there is no evidence this plan will be any more effective than previous planning approaches.

Planning for individual residents is inconsistent. There is confusion on the ground about what a 'person-centred planning approach' means, and what constitutes a support plan and an individual plan. The extent of a resident's involvement is not always clear.

The broad description of planning in the Act needs clarification. A more consistent approach to planning and assessment could be achieved by identifying appropriately qualified people to carry out this work and determining the key elements required in the support plans, and the form they will take. DHS also needs to assess whether DHS and CSO employees have the capability and capacity to prepare new plans and revise existing plans.

A more consistent approach is required to enable DHS and CSOs to reliably develop individualised support plans and to facilitate monitoring and evaluation. A consistent approach should also narrow the information gap that can occur when residents transfer between DHS and CSO SSA. This should also better integrate the sector and thus lead to better outcomes for residents. The need for greater consistency in the preparation of individual plans was raised in our 2000 audit, yet it remains to be resolved.

Given the prominence of individualised planning in the new service delivery model, it will be important for DHS to address these issues. If it does not there is a risk that significant resources will be ineffectually applied.

Revising plans to meet new legislative requirements

Regions who had allocated specific time for staff to review and revise plans achieved a better result than those who required support staff to complete this task on top of their normal duties. It is difficult to see how CSOs and some DHS regions will achieve the legislative requirement to have individual plans prepared by 1 July 2008 unless time is set aside for staff to complete this task.

Resident information

DHS has not taken a systemic approach to determining 'who needs to know what'. Information is inconsistently collected and its storage in many different places greatly reduces its usefulness. This makes support staff less efficient and less able to address the needs of residents.

SSA residents suitable for relocation into the community would be better identified if there was one standard statewide information system used by all DHS and CSO service providers.

Recommendations

DHS should:

- 3.1 provide focused support, guidance and resources to facilitate the development of individualised plans by service providers. This should involve:
 - adopting a team-based approach to preparing plans, comprising relevant support and professional staff
 - on-the-job training
- 3.2 allocate specific resources for undertaking individual planning for residents within SSA
- 3.3 develop its information systems to provide relevant historical information relating to SSA residents for support staff to assist in meeting residents' day-to-day and long-term needs.

RESPONSE provided by Secretary, Department of Human Services Recommendation 3.1

This recommendation is supported and the department has strategies in place that it will continue to implement.

The department has provided support, guidance and resources to facilitate the implementation of individualised planning. It is acknowledged that there is an ongoing need for training and support for staff in SSA services to continuously improve their individualised planning practice.

The individualised planning approach is fundamental to achieving the goals and objectives of the Victorian State Disability Plan 2002–2012 and the Disability Act 2006. This legislative and policy framework provides a mandate for planning that is tailored to each person's needs, is directed, to the greatest extent possible, by the person and their network and promotes participation in community life.

***RESPONSE provided by Secretary, Department of Human Services
Recommendation 3.1 – continued***

The proclamation of the Disability Act 2006 (the Act) on 1 July 2007 has provided a new legislative framework for people living in SSA. The Act requires that a disability service provider must ensure that a support plan is prepared within 60 days of a person commencing to access a SSA service. The support plan must be developed in consultation with the person and their network and must include goals and strategies related to the supports being provided.

In preparation for the implementation of the Act, Disability Services has undertaken a number of activities to provide support, guidance and resources for disability service providers, people with a disability and their families and carers and the broader community, with regard to the new individualised planning approach. This included:

- a highly consultative approach to the development of the Planning Policy that involved all key stakeholders and included public forums, a working group, and the release of a draft policy document in February 2006 for broad consultation and comment*
- information forums across the State from April to July 2007, for disability service providers that provided guidance about the changes to practice and the associated responsibilities*
- resources provided prior to the proclamation of the Act, outlining the legislative and practice requirements for individualised planning, including the Disability Services Planning Policy and the Disability Act 2006 – A guide for disability service providers*
- information forums across Victoria, in July – August 2007 for people with a disability, their families and carers and the wider community*
- provision of the Planning Policy Resource Kit and Implementation Guide to provide a foundation for shared practice amongst all disability service providers. The Resource Kit offers information, practical advice and resources to guide best practice in individualised planning*
- learning and development initiatives across Victoria for both government agency and non-government disability service providers, including SSA providers to further develop their capacity to undertake planning within an individualised framework. These initiatives provide training for staff on preparing plans, facilitating planning meetings and developing behaviour support plans.*

RESPONSE provided by Secretary, Department of Human Services
Recommendation 3.1 – continued

The legislative and policy framework for individualised planning clearly articulates that where a person with a disability is receiving more than one disability support, planning should be collaborative and coordinated. The Planning Policy outlines that a SSA provider has the responsibility to offer the person with a disability the opportunity to involve their other disability service providers in the development of the support plan. In line with the guiding principles for planning in the Act, a person with a disability can choose the people who are to be involved in the planning process. This team-based approach to planning may include family and friends, relevant professionals, support staff and other community service providers.

Whilst some progress has been made, the department will conduct further professional development for staff in department managed shared supported accommodation. Additionally the department will discuss implementation of similar strategies for community service organisations' (CSOs) managed homes with National Disability Services (NDS) and the Disability In-service Training Support Service (DISTSS) funded by the department to provide learning resources and support to the funded sector.

A learning resource for use by both department and staff employed in CSOs to develop support plans is in progress, and planned for implementation by July 2008.

Community Services Training Package Review – The Disability Services Division is actively involved to ensure the redeveloped community service training package meets current and future needs of the workforce. The new Community Services Training Package is due for implementation in 2008.

A number of team based approaches to planning and training opportunities are operating within the department's regions:

Communities of practice relating to individual planning. Five communities of practice across the Barwon South-West region are being established to support planning practitioners. Outcomes of the project will be that people with a disability will have access to planning and services which provide them with the skills to lead their own planning as much as possible, provide opportunities to direct their lives as much as possible and maximise their opportunities to be part of their communities. These communities of practice include Disability Services staff in Disability Accommodation Services and Disability Client Services as well as CSOs and people with a disability and their families.

Funding has been provided to regions to progress a number of learning and development opportunities for staff in relation to the requirements under the Disability Act 2006.

These approaches will be reviewed and a broader statewide strategy developed in 2008.

**RESPONSE provided by Secretary, Department of Human Services
– continued**

Recommendation 3.2

This recommendation is supported in principle.

Resources are currently allocated by the department to undertake planning. Further resource allocation for planning needs to be considered alongside other demand and resource priorities.

The department and CSOs also continue to provide learning and development opportunities for staff to drive culture and practice change within existing resources, for example, implementation of person-centred active support across department-managed accommodation services and some CSOs. Many residents within SSA have key workers appointed who are responsible for the development of the resident's plan. A range of resources have been developed to support staff when preparing plans which complement the Planning Policy resource.

Recommendation 3.3

The department agrees that its information systems need to be enhanced to provide more relevant and streamlined information to SSA staff to assist them in meeting residents' needs. The department has investigated the applicability of the existing Client Relationship Information System (CRIS) to SSA units, and has found CRIS information required at the regional level for planning, intake and assessment purposes to have limited application at a group house level.

An integrated ICT strategy for Disability Services, aligned with the Disability Services Division's strategic planning process, is currently in development and will incorporate residential services' information and IT requirements.

It is recognised that records management is an area that requires an ongoing focus and work continues to occur to standardise processes at the regional level. The Disability Services Division will implement a number of strategies to address records management. In 2007-08, funding has been allocated to support records management and systems improvements within department managed group homes. In one metropolitan region this initiative is focusing on documentation being consistently held and consolidated within the house and is up to date. The Disability Services Division will discuss the implementation of similar strategies with National Disability Services, for application in CSO managed homes.

3.3 What are the potential barriers to implementing plans effectively?

3.3.1 Block funding of SSA houses

DHS regions and CSOs receive block funding for SSA, which is based on providing accommodation and personal care assistance to residents.

Funding for accommodation and day programs is allocated to the service provider and not the resident. Thus, when residents are ill, and they cannot attend their designated day program and remain in the house, the house must cover the cost of day staff for them (except if they have flexible rostering, as one we visited did). One CSO recouped the resident's day program funds when the resident did not attend the program. These types of arrangements were rare but did indicate how a more individualised service could be achieved.

Houses often carried out group activities rather than tailored individual approaches. This was a practical response to limited transport options and staffing arrangements. A number of houses did not have regular access to vehicles, or used a bus-type vehicle. This often meant residents' individual wants were subsumed and activities were carried out as a group. This was a particular issue in rural areas and outer suburbs where public transport was limited. In the metropolitan area, public transport is proving a useful way to encourage residents to integrate into the community.

Our 2000 audit concluded that, 'The Department cannot be assured that current resource allocation processes for shared supported accommodation are always delivering services for clients on the basis of relative need. Nor do they allow the expectations of the Act and the Victorian Standards for Disability Services to be met, regarding opportunities for all clients to develop and maintain skills and to participate in the community.'

This finding is still relevant today. There has been little systemic change to resource allocation processes in that:

- SSA continues to be block-funded, based on an historical assessment of the residents' needs rather than assessed current need
- in 2004-05, DHS assessed the needs of around 2 000 residents in DHS managed houses to better determine resourcing requirements. However, there is no ongoing system for aggregating residents' needs and using this to influence budget requests and allocations. Information about residents' needs is gathered through budget meetings between central office and regional staff but is based on local knowledge rather than an aggregation of needs identified within the support plans

- both DHS and CSOs identified instances where funding had not matched residents' needs (for example, many residents are ageing and their support needs increase as they age). An increase in support needs translates to an increase in demand for staff assistance or services, such as physiotherapy, massage, taxis, attendance at a medical or employment or leisure activity or active night shifts
- as the disability pension is not indexed to the consumer price index its purchasing power is declining over time. It is evident that funds were shrinking in real terms and this limited the activities that residents could do and hence the extent to which individual plans could be realised.

3.3.2 Incompatibility

The compatibility of residents is a key factor in the successful placement of a resident in SSA and in the successful implementation of their support plan. DHS considers compatibility in the placement of a resident in SSA. The DHS region's case manager prepares two or three potential resident profiles that are discussed at a regional assessment panel meeting. CSOs then choose the person they consider would best suit current residents. Residents are not involved in this initial selection process, nor are they advised they are being considered (so as to avoid disappointment).

We found instances of incompatibility that had adverse effects on the resident. Staff and residents' file notes sometimes revealed deterioration in their health and well-being. In some houses staff recognised the problem and tried to make adjustments; whereas in others, staff did not see an issue and accepted the situation. Some examples of the impact of an incompatible placement were:

- one resident had a disorder that meant they were not suited to communal living yet there was no option but for them to live with others, and staff had to manage the conflict that arose with other residents. This resident reacted positively when staff worked with the resident one-on-one. DHS has rented flats for aggressive residents in the past, but considers this to be too expensive as a longer term solution
- DHS could not find suitable accommodation for one person listed on the DSR and about to be paroled as neither CSO nor DHS houses considered this person to be compatible with their residents. The likelihood of this person's successful integration back into the community diminishes if a suitable support plan cannot be implemented for them
- some residents find themselves living in SSA although they do not want to, and this reinforces their – and other residents' – unhappiness. This may also reflect a service gap in that the service provider may not be able to provide individualised support.

3.3.3 Staff qualifications and work loads

Qualifications

Staffing is the most important influence on budgets and the quality of service delivery. It is particularly important as, under the new service model, the role of disability support staff changes from that of carer to providing more holistic support.

Notwithstanding the importance of staffing and the changed role, we found that there are no industry-wide minimum requirements for the qualifications, training, experience or competencies of staff who provide direct care and support to people with an intellectual disability. DHS has established standard selection criteria for staff employed in government-run services, but not for staff in non-government services that it funds.

The importance of establishing minimum staff qualifications was also raised in our 2000 audit.

In 2007, about 94 per cent of DHS staff had a Certificate IV qualification (compared to DHS's estimate of about half at the time of the last audit). Many CSOs we audited did not have a minimum qualification requirement for their staff. Instead, they chose staff on the basis of their attitude and ability to provide support rather than care.

Work loads

In most DHS and CSO houses we audited, funding and work arrangements did not readily allow for staff to care for residents individually. Staff were often under pressure to complete basic care tasks in the time allotted (6.30 – 9.30am and 3.30 – 9.30pm). In some houses, supervisors were only allocated one hour a week to:

- match residents goals with activities provided
- review residents' progress against their support plan and to adjust individual programs.

In almost all SSA houses, support provided to residents' through the day was highly structured and little time was devoted to helping them develop new skills. Staff were well-equipped to manage residents' daily activities (such as meals and personal hygiene) but had limited time available to implement all aspects of resident support plans including residents' aspirational goals.

The 2000 audit also found that, 'Overall, there are insufficient mechanisms to ensure that all direct care staff in all services are of sufficient numbers, or appropriately competent to provide quality services in line with the principles of the Act and the Victorian Standards for Disability Services.'

DHS is now addressing the issue of workforce planning and development through its disability industry plan *Partnering for the Future: The Victorian Industry Development Plan for the provision of support for people with a disability*. One aspect of this Plan, which was issued in 2006, is the development and implementation of a five-year workforce planning strategy aimed at ensuring there is a skilled and qualified workforce.

Service providers generally accepted the need to professionalise the workforce and standardise service delivery conditions regardless of where the service is delivered, whether it be a DHS house, a CSO house or the disabled person's own home. Service providers also noted the difficulties in recruiting and retaining qualified staff.

Residents with high physical support needs (such as those who cannot walk unassisted) usually need at least two staff when they go out (such as shopping or go to movies or concerts). DHS advised that it does not have fixed staff ratios and that staffing levels are set according to residents' needs. Most houses we visited had five residents: DHS and CSOs would roster on two staff in the mornings, evenings and weekends (and would have one staff sleeping at the house on each night), regardless of level of disability of residents. Two houses had staff who remained on duty throughout the night.

3.3.4 Fitness for purpose of disability housing

DHS has audited its houses against the following criteria:

- occupational health and safety requirements
- disability access standards
- functional suitability
- building regulation (compliance)
- building condition.

DHS has not assessed the fitness for purpose of its houses in terms of achieving the goals of the State Disability Plan (except for newly constructed houses) and the *Disability Act 2006*. Specifically, DHS has not assessed its houses from the perspectives of being able to integrate residents into the community, being able to provide support to residents and the houses primary purpose, being a comfortable home for residents. We observed some conflict between residents' requirements (of living in a comfortable home) and staff requirements (of working in a safe and efficient workplace).

Many SSA houses we visited were easily identifiable from the street as SSA, by factors such as ramps, the style of construction and sometimes their state of disrepair. Community acceptance of SSA houses is mixed. Some houses have good relations with their neighbours. Others have no contact with their neighbours. The design brief of one older house included a buffer zone to isolate it from its nearby rural community.

We observed differences in the layouts and furnishings of houses that we consider correlate with the approach that staff adopted with residents. In two houses, residents had incontinence problems. One house had linoleum floors extending half-way up the walls, and staff took a hospital-like approach to deal with the results of incontinence: they cleaned up after the event but not necessarily with due regard for the residents' privacy and dignity. In the other house, staff were focussed on maintaining the privacy and dignity of residents and ensured that staff were available to monitor events immediately they occurred so as to prevent issues escalating rather than simply expect that they would occur and deal with the consequences later.

Many houses visited had design features (such as the linoleum walls) that clearly communicated to staff and residents the now-outdated paradigm of care, versus support. In some houses, staff identified the shortcomings of their environment and were overcoming them. Others had not recognised that the house design was affecting residents' behaviour and staff attitudes to residents. We observed that the former were more likely to advocate changes to better meet the individual needs of their residents, such as changing staff from a sleepover shift to an active night shift where staff stay awake all night.

3.3.5 Conclusion

A number of impediments have emerged which create a disconnect between the new social model and its actual delivery by service providers. Two of these impediments — block funding of SSA houses and the capacity and expertise of service providers — were raised in our 2000 audit yet have not been resolved.

DHS needs to establish mechanisms to monitor how well the new service model is being implemented and applied. It will be critical for DHS to address these barriers if residents are to achieve their goals.

Recommendations

DHS should:

- 3.4 review the SSA funding model to better align it with the new service model of individualised support
- 3.5 systematically assess the capacity and expertise of SSA staff to deliver support services in accordance with the new service (social) model and to address gaps subsequently identified.

***RESPONSE provided by Secretary, Department of Human Services
Recommendation 3.4***

This recommendation is partially supported.

The department will consider the framework for the SSA funding model and options to align it with new models of individualised support following consideration of its application to other services. The department has focussed individualised support on in-home support and day activity services in the first instance where an individual support package is more easily applied.

Work on a SSA funding model has commenced. The approach recognises that an individualised support model needs to take account of a number of factors. Initiatives, such as Person Centred Active Support and the Community Residential Unit exit strategy, demonstrate that individually tailored approaches can occur in the group home setting. While the principle of individualised funding continues to be a priority for the Disability Services Division, in the short to medium term the focus will, in the first instance, be on areas such as day programs, individual support plans and respite to realise the objectives and intention of the State Plan and the Disability Act 2006.

As a funding and resource benchmarking tool, the SSA output model will be the subject of reviews and refinement to take account of contemporary best practice, including policy changes within the context of an individualised planning and support framework.

Recommendation 3.5

This recommendation is supported.

Given the relatively small number of houses examined as part of the review, the report does not acknowledge the mechanisms already in place and the scope of activities underway to enhance the capacity and expertise of service providers.

The Disability Act 2006 was implemented following a four year consultation and development process, and reflective of changing approaches in the provision of support for people with a disability.

The guiding principles for planning outlined in the Disability Act 2006 reflect the principles of an individualised planning and support approach, which was introduced, through the Support and Choice initiative in 2003.

The Monitoring framework for health, housing and community services sectors (August 2006) incorporates complaints management as core monitoring and the Quality Framework for Disability Services in Victoria was introduced in 1999 (including industry standards associated with complaints management) and is not a new requirement.

RESPONSE provided by Secretary, Department of Human Services
Recommendation 3.5 – continued

As part the implementation strategy, the Disability Services Division will be conducting an evaluation of compliance with the Disability Act, following the first year of implementation to identify areas where additional supports/mechanisms are required to increase the capacity of support providers.

In 2006-07, the government allocated \$1 million to assist the disability support sector to meet the compliance requirements of the Act. Part of this funding supported National Disability Services Victoria, to provide information about the Act to member organisations, promoting member participation in information sessions, consulting about draft policies and assisting member organisations to undertake practice and cultural changes required by the new Act.

It also resulted in local implementation strategies and activities being developed, including opportunities for shared learning, coaching and mentoring activities such as communities of practice. For example, one metropolitan region allocated funds to CSOs to assist in the development of initiatives in relation to access and planning, residential rights and restrictive interventions and a range of procedures and documents to assist CSOs to comply with the complaints mechanisms and quality requirements under the Act.

Initiatives to address gaps in the capacity and expertise of SSA staff to deliver support services focussed on individualised approaches also include Person Centred Active Support (PCAS) being implemented across all department managed group homes. PCAS provides a person-centred approach to working with residents and encourages the choice and participation of residents in all aspects of their daily living.

By the end of June 2008, PCAS will be implemented in 60 per cent of all group homes, with support staff receiving formal training in this approach. PCAS will continue to be rolled out to the remaining Group homes during 2008/09.

The evaluation findings of the implementation of PCAS across DHS rural regions are due to be released in March 2008.

A number of CSOs continue to also implement person-centred planning and active support.

The department has also introduced changes to the health planning requirements for people who reside in DHS managed group homes. These changes guide staff through a process of integrating all health-related programs and procedures, and result in a more individualised health planning process for people. Commencing in December 2007, the revised process enables a streamlined health monitoring and review process for every person in SSA that incorporates comprehensive health assessment, nutrition and swallowing risk screening, weight monitor, health promotion, medication review and specific health management. The new health planning process facilitates the maintenance of up-to-date records that are relevant to day-to-day supports for residents.

***RESPONSE provided by Secretary, Department of Human Services
Recommendation 3.5 – continued***

Additionally introduced in July 2007, the Residential Services Practice Manual reflects significant practice improvements around issues such as medications and monitoring change in health status. The manual also guides staff in a person centred approach to the development of support plans, including active support concepts.

Commencing in mid 2007, the Promoting Better Practice in SSA initiative aims to strengthen the capacity of Disability Services to anticipate and respond to critical incidents through reviews of department-managed SSA to identify areas for improvement in systems and practice affecting safety and quality. The methodology incorporates a systemic quality audit and surveillance approach to analyse causes and develop approaches that can lead to a reduction in incidents and minimise their recurrence and impact. The demonstration project is due for completion in March/April 2008.

The department acknowledges that these approaches should be consolidated and systematically applied, across SSA. The Department will undertake this work in relation to department managed group homes and discuss similar approaches to be applied to CSO managed homes with National Disability Services.

3.4 Are SSA residents' plans regularly reviewed?

Plans – to match the circumstances of people's lives – must be considered living documents. As such, they should be regularly reviewed and updated, as well as implemented by staff with the skills and knowledge to do so. The *Disability Act 2006* requires that a support plan be reviewed at least once every three years, and that the support plan of an SSA resident be reviewed annually (or when so requested by a resident, staff or other health professional).

3.4.1 Conduct of reviews

We found that reviews of plans varied considerably in quality. Some reviews were conducted by checklist where the same boxes had been checked for up to three years. Only one CSO had documented how residents were progressing towards their goals. No reviews audited referred to the goals of the resident's original plan, or noted their progress toward their goals. Reviews were not always signed. Staff with varying levels of qualification and experience had conducted the reviews.

One DHS region had developed a standardised person-centred planning format that included a section for recording issues to be included in a review. One CSO kept records of residents' annual reviews but these were archived off-site and not accessible. Only one CSO house visited kept comprehensive notes of the review process on file. Other agencies and most DHS houses had little review documentation on file.

Residents' progress — and how residents could be best supported to achieve their goals — was discussed at staff meetings. In DHS houses, one worker was assigned to each resident. That worker reported verbally to the meeting about the resident's activities, well-being, concerns or wants (such as holidays and sporting interests). In the houses we visited, staff meetings were held weekly, fortnightly or monthly and were rostered. All DHS houses had rostered staff meetings. This was not the case with CSOs, one of which told us that it was not funded to cover staff costs of its weekly staff meetings.

Where meetings were minuted, we could not identify where a resident's reported progress was used to update their individual plans, or how plans were used to guide decisions about their activities. Residents' progress was documented in various places, such as daily handover communications, progress notes, communication books and house diaries. We noted instances of the failure to document progress resulting in oversights including a seemingly significant medical request for an ECG not being followed-up.

Resident care relies strongly on support staff's (undocumented) knowledge of a resident's needs and plans. Because an individual resident's information is held in numerous locations (both on- and off-site), we found it extremely difficult to track residents' progress from assessment, to planning, to achievements, to further review. Where there was documented information from reviews, the consistency and quality of this information varied from house to house: DHS has no prescribed format for documenting reviews.

The houses visited did not have standardised filing systems. DHS and CSOs had standardised formats for some files, but the quality and accessibility of files varied.

Some houses had compiled information sheets or folders for individual residents in addition to their accommodation file. These information sheets were a snapshot of a resident's basic care requirements and planned activities and enable support staff to quickly understand a resident's daily support needs. There was often not a clear link between the information sheet and a resident's support plan.

Some CSOs took the view that support plans were dynamic (not static) and should be reviewed whenever needed.

3.4.2 Conclusion

The outcomes of planning review processes were neither well documented nor generally reflected in updated plans.

DHS needs to engage with CSOs to:

- identify core elements for inclusion in individual plans
- determine how information from reviews of plans would be best recorded and analysed.

If support staff are to take a person-centred approach there needs to be a more consistent way of recording and storing resident information. The connection between (and recording of information about) a resident's needs, their support plan and its implementation needs to be clear, as the basis for a sound and useful assessment.

Recommendation

- 3.6 DHS should guide and support service providers on the conduct and documentation of the review of individual support plans.

RESPONSE provided by Secretary, Department of Human Services

This recommendation is supported.

The department has provided advice in the Planning Policy and Resource Kit and Implementation Guide regarding the process and practice for the review of support plans.

In line with the intent of the guiding principles for planning in the Disability Act 2006, disability service providers are required to adopt a flexible and individualised approach to planning. It would be contrary to this intent to develop a standard format for the recording of support plan reviews however, the Planning Policy describes the key elements that must be included in every review process.

The department will undertake further work with SSA providers to conduct reviews in line with the Planning Policy requirements whilst developing the capacity to document support plan reviews in formats that are tailored to each person with a disability.

4 Accommodation and service delivery standards

At a glance

Background

By 2003, all service providers were required to fully comply with service standards established by DHS in 1997. Five outcome standards that align with the goals of the State Disability Plan were also developed by DHS in 2006.

Key findings

- Commencing in 2009, a selection of houses operated by all service providers will be independently audited to assess compliance with service standards.
- DHS has identified approximately 200 of its houses did not meet building and occupational health and safety standards and has begun a process to address the issue.
- By July 2008, service providers are required to have provided residents that entered SSA prior to July 2007 with a statement covering aspects such as the respective rights and duties of the provider and resident.
- A more systematic approach is required for measuring resident satisfaction with SSA accommodation.

Key recommendation

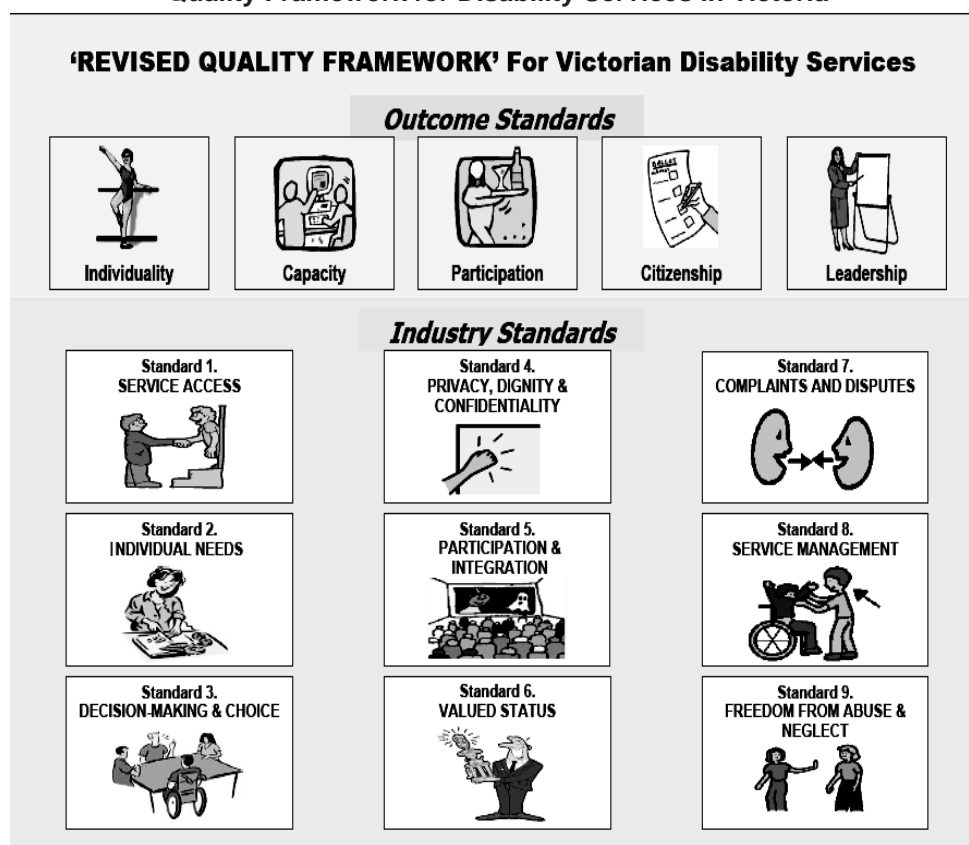
- DHS should assess residents' satisfaction, directly or through their family and friends, with their accommodation on an on-going basis, and incorporate the results into a system of continuous improvement.

4.1 Accommodation and service delivery standards

4.1.1 Are SSAs subject to service standards and do they comply with these standards?

In 1997, DHS issued nine Victorian Standards for Disability Services that set minimum operational standards for DHS and CSO service providers. By 2003, all service providers had to fully comply with these standards. In 2006, DHS developed a further five disability outcome standards to align with the goals of the State Disability Plan. In 2007, DHS incorporated the nine operational standards and five outcome standards into its *Quality Framework for Disability Services in Victoria* shown in Figure 4A.

Figure 4A
Quality Framework for Disability Services in Victoria



Source: Victorian Advocacy League for Individuals with a Disability Inc (VALID).

Figure 4B shows the implications of each of the five outcome standards for the person with a disability and their support provider.

Figure 4B
Disability outcome standards and their implications for disability support services

	Standard 1 Individuality	Standard 2 Capacity	Standard 3 Participation	Standard 4 Citizenship	Standard 5 Leadership
Individual	Each individual has goals and aspirations and makes choices about their life.	Each individual's abilities and potential are identified and encouraged.	Each individual is able to access their community.	Each individual has rights and responsibilities as member of the community.	Each individual has the opportunity to inform the way that supports are provided.
Support provider	Support providers actively encourage individuals to be themselves and to make choices and decisions about their life and their future.	Support providers work together, develop their capacity to respond to individuals.	Support providers work with individuals to assist them to actively engage in their community.	Support providers actively encourage and support individuals to exercise their rights and responsibilities.	Government and support providers develop, promote and implement good practice.

Source: Department of Human Services.

Monitoring compliance with the industry standards

Service agreements between DHS and CSOs require a CSO to assess itself against the industry standards and to develop and implement a quality plan. They also require a CSO to conduct two new quality improvement activities each year.

All SSA houses visited had conducted an annual self-assessment report. However, they placed little value on them and DHS provided no feedback about the reports. CSOs considered the process would be improved if the report was used to benchmark their performance against other CSOs and against DHS houses.

DHS advised the exercise was considered as a self-assessment and that it had never intended to provide feedback. DHS publishes aggregated results of the self-assessments on their website.

In 2008, DHS proposes to follow-up all service providers that do not submit self-assessments. It has asked houses to identify what they did well throughout the year, what they could improve and whether improvements identified in the past year's report were implemented.

Under the *Quality Framework for Disability Services in Victoria*, a selection of SSA houses will be independently audited over a three-year period commencing in 2009. All DHS and CSO houses we visited were aware of the intention to introduce the quality framework, and were concerned they would not meet its requirements.

Since 2007, DHS regional disability services managers, independent of the house, have been conducting 'better practice' audits. Aspects reported on include:

- compliance with mandatory training requirements (such as first aid, fire and emergency and cardiac pressure resuscitation training)
- the completion of police checks of new staff and those staff who have not had a shift within six months.

At January 2008, 40 houses had been subjected to a 'better practice' audit.

DHS and CSOs noted the challenge of measuring quality-of-life outcomes for residents, and all considered it important but difficult. They considered the new quality framework to be a step in the right direction, but not the final answer. About half the CSOs we visited had established their own quality assurance processes (mainly an internal audit function), including resident satisfaction surveys. Three of the 11 CSOs covered by this audit were also monitoring residents' quality-of-life outcomes.

Compliance with administrative requirements

All the houses visited had carried out some form of internal auditing. Some regions relied on house support staff to identify problems while others used non-house officers to conduct internal audits.

DHS monitors whether or not CSOs comply with the requirements of service agreements. These include occupational health and safety standards, building regulations, emergency responses, financial accountability, employee safety screening and complaints management.

4.1.2 Office of the Public Advocate — Community Visitor Program

Under the Community Visitor Program, volunteers visit each house and report to the Office of the Public Advocate, among other things, about resident satisfaction, the physical condition of the house, living conditions with other residents and the support provided. Many SSA support staff valued this program but saw it as focusing on micro, rather than macro, issues. All the houses we visited had been visited by community visitors in 2007. In any year, the community visitors make repeated visits to their allotted houses. The reports of community visitors mainly focused on physical condition issues, with very few focusing on residents needs (such as their support plan and their compatibility with other residents). Although the community visitors annual report (tabled in Parliament) raises more substantive issues, neither DHS nor CSOs are required to act on the recommendations in the report.

The Community Visitors Program is the only independent review of houses. If community visitors find a problem at a house, they record it in their record of visit, identify any required action and follow-up with a management letter.

DHS and CSOs value the program. They acknowledge the work of the community visitors by endeavouring to resolve concerns as quickly as possible and to maintain cooperative relationships with their community visitors. We also support the program.

4.1.3 Monitoring the condition of houses

In 2003-04, DHS carried out condition audits of 458 DHS owned houses (this excluded houses owned by the Director of Housing and a private company). The audit found significant condition, functional and occupational health and safety issues. DHS estimated it would cost \$225 million to bring 443 houses up to the required standards.

DHS subsequently identified that approximately 200 of its houses did not meet current building and occupational health and safety standards, and therefore needed to be replaced or significantly refurbished. The cost to bring these houses up to standard has not been estimated by DHS.

To date, DHS has requested a total of \$123.2 million (\$59 million in 2005-06 over three years and \$64.2 million in 2007-08 over three years). To date, funding totalling \$44.5 million has been received which will provide 51 new (replacement) houses and nine refurbished houses. A further \$10 million was funded for minor upgrades to facilities that did not meet occupational health and safety or building regulations. There will be no net increase in beds.

In 2006-07, \$15 million was provided to replace facilities and provide equipment to the CSO sector.

We found no evidence that any house kept a maintenance schedule, other than maintenance relating to fire risk and occupational health and safety.

The response to maintenance requirements differed among house owners, as did whether it was in a metropolitan or rural area. The private company that owned SSA houses responded promptly to minor requirements (such as a door hung or hole in the wall) in rural areas, but resisted responding to larger works (such as hand rails and hoists), believing these would reduce resale value.

DHS's Office of Housing maintains its houses and those owned by DHS's Disability Services Division. CSOs that managed DHS houses advised that they often carried out maintenance because it was quicker and easier than going through DHS.

4.1.4 Conclusion

DHS has established appropriate service standards with the development of the *Quality Framework for Disability Services in Victoria*. The Framework, which will apply to DHS and to CSO houses, establishes minimum service standards. Although quality assurance processes have been in place they are being strengthened. Compliance with the standards will be monitored through independent audits of SSA houses to be completed over a three year period commencing in 2009.

The Framework also incorporates outcome standards for residents and a process for progressively monitoring results, which has not occurred to date.

In addition, several CSOs have proactively established quality assurance systems to measure residents' satisfaction and outcomes. The work done by some CSOs clearly goes beyond minimum requirements and indicates leadership and innovation in meeting residents' needs.

DHS has audited the condition of its houses but lacks resources to implement all the identified improvements required. To date, DHS has received \$44.5 million of the \$123.2 million it requested to bring its SSA houses up to the required standards. This indicates a significant proportion of houses (approximately 200) still do not meet current building and occupational health and safety standards.

4.2 Are systems in place to monitor residents' satisfaction with their accommodation?

4.2.1 Addressing grievances

The SSA houses visited had various processes to ensure that residents could raise concerns or grievances and participate in day-to-day decision making. While processes varied among houses, residents' meetings were the most common mechanism used. Some houses had documented grievance procedures and explained them to residents. In others, we found no evidence of these procedures.

Where residents found verbal expression difficult or impossible, support staff relied on staff knowledge of the resident. Some houses encouraged a resident's family or guardian to attend meetings. There was little effort to find alternative means of engaging residents, although some residents were supported by external advocacy groups. We identified primary carers, support staff and families as the most active advocates for residents.

We found that DHS and CSOs listened and usually acted on grievances expressed by residents and their families. However, while DHS and CSOs generally acknowledged the need for grievance processes, most were internal processes with little independent accountability: residents made their complaints known through staff, who may have had a conflict of interest.

The *Disability Act 2006* establishes a Disability Services Commissioner. The Commissioner will, among other duties, investigate complaints, conciliate where complaints are made in relation to a disability service provider and publish information about complaints. The effectiveness of the Commissioner is yet to be tested.

4.2.2 Residential statements

Under the previous Act, service providers were not obliged to provide residents with a statement outlining the obligations of the service provider and the resident. The *Disability Act 2006* requires, from July 2007, a residential statement for all residents upon entry into their accommodation. A residential statement includes items such as the period of residency, a description of the services provided, the respective rights and duties of the service provider and the resident, and the conditions under which the service is provided.

The *Disability Act 2006* also requires all residents that entered SSA prior to July 2007 to have a residential statement by 1 July 2008.

4.2.3 Resident surveys

DHS had carried out surveys of residents in some regions but not all.

Some CSOs have established a 'client committee' to help them gauge the impact of their services. Several CSOs conduct satisfaction surveys of residents. One such survey identified a range of needs including support arrangements for the resident being unsustainable because the resident's parents were very old. The CSO then identified the need to register this person on the Disability Support Register.

4.2.4 Conclusion

DHS and CSO grievance processes should be improved by making houses more accountable for addressing the concerns of residents.

The recent (2006) establishment of the Disability Services Commissioner, and other changes to the Office of the Senior Practitioner, may provide the accountability that has been missing to date.

Adopting a more systematic approach to measuring resident satisfaction in all DHS and CSO houses would provide useful information for improving service delivery.

Recommendation

- 4.1 DHS should assess residents' satisfaction, directly or through their family and friends, with their accommodation on an on-going basis, and incorporate the results into a system of continuous improvement.

RESPONSE provided by Secretary, Department of Human Services

This recommendation is supported.

There are a range of activities across programs, regions and agencies that assess satisfaction but this needs to be more systematic, and the data aggregated so that it can be used for continuous improvement activities across the State. Some examples of activities are client surveys, annual 'Family Forums', Program Advisory Group meetings and house meetings. Feedback from these is incorporated into strategic planning and also used to inform the planning process for residents.

Service user satisfaction with services and continuous improvement of those services are driving principles of quality management in disability services. Processes to drive both are articulated in quality management systems documentation from 1997 – the Disability Services Self Assessment System [DSAS] – and 2007 – the Quality Framework for Disability Services in Victoria [Quality Framework 2007]. Both systems apply across all disability service providers and not just to accommodation services.

DSAS incorporates organisational self-assessment and reporting but lacks verification. However, service user [including families] feedback is integral to the process of self-assessment. The DSAS handbook documents an annual, three-stage process of self-assessment – beginning with service user assessment - and provides guidance on potential feedback mechanisms. These include satisfaction surveys however, it is neither a mandatory nor singular requirement.

The Quality Framework 2007 includes a process of organisational self-assessment against industry standards and outcome standards as well as independent monitoring for verification proposed for implementation from 2009. In the Quality Framework, the importance of service user satisfaction with services is identified. The Outcome Standards require the person's perceptions of service to be reflected in assessing service provider performance and it is through this process that information on satisfaction with services will link with continuous improvement.

5 Managing current and future accommodation needs

At a glance

Background

In 2003, DHS identified two main ways to manage demand: reduce the number of people demanding services in future, and shift demand from relatively intensive types of service (such as SSA) to less intensive types of service (such as community access programs or home-based support).

DHS uses the Disability Support Register (DSR) to monitor met and unmet demand. The DSR is used to allocate accommodation, individual support packages and aids and equipment.

Key findings

- Currently, demand for SSA exceeds supply by around 30 per cent (1370 people).
- DHS has conducted some broad demand studies but does not have systematic data collection tools to monitor growth in demand accurately.
- DHS has conducted regional projects to investigate the impact on service demand of factors such as ageing carers. These projects have to date not been extended across the State and have not been collated to give a clearer picture of expected demand growth.
- If the present shortcomings in demand measurement persist, it is unlikely that DHS will be prepared to meet future demand. As a consequence, residential service recipients will suffer and the system will continue to be crisis driven.

Key recommendations

DHS should:

- expand its demand management strategies and explore options for accelerating the implementation of existing demand management strategies
- systematically measure projected need and develop strategies, such as alternative delivery mechanisms and a workforce management strategy, to meet future resourcing requirements.

5.1 How well does DHS manage demand?

5.1.1 Introduction

A 2007 report by the Australian Institute of Health and Welfare described four categories of service demand in the disability sector:

- **met demand:** people receiving a service that meets their needs
- **unmet demand:** people who have asked for a service and met eligibility criteria but are not receiving the service, or receiving an inadequate or inappropriate service
- **unmet need** (often used interchangeably with unmet demand): people with an expressed need for a service who may not be eligible for that service (but may perhaps be eligible for another type of disability or mainstream service)
- **potential need:** people with a severe or profound disability who may in future need, but have not yet expressed a need for, services. This category also includes people with an inferred and predicted need for services.

Under the *Disability Act 2006*, DHS's Secretary has an explicit power to decide whether services are provided or not, even where a person is assessed as disabled. This in part is recognition that there are limits to available resources.

In 2003, DHS commissioned a report to identify strategies to improve outcomes for people with a disability, to make services more responsive and to improve the use of available resources. The report identified two main ways to manage demand: reduce the number of people demanding services in future, and shift demand from relatively intensive types of services (such as SSA) to less intensive types of services (such as community access programs or home-based support).

5.1.2 The Disability Support Register

DHS uses the Disability Support Register (DSR) to monitor met and unmet demand. It is used to allocate accommodation, individual support packages and day activities. Once people are registered, then assessed as a priority, DHS considers them for a SSA vacancy.

The DSR replaced the former Service Needs Register (SNR) in April 2007. The SNR reflected both unmet demand and, to a certain extent, an indication of potential demand (i.e. a person who may have a future need could be registered). This differs from the DSR which only records people assessed with a current need. The DSR is used to match a resource (such as a vacant SSA place or unspent individual support package funds) with an eligible person who needs that resource based on prioritisation criteria.

Difficulties in meeting current demand

The DSR aims to equitably and in an accountable way allocate SSA to the highest-priority people. However, DHS faces real difficulties in meeting the current demand for accommodation.

There is no spare capacity in the system to provide SSA as needed. When faced with the recurrent crisis of people in need, DHS is forced to find a solution (such as a rented unit, hotel room or respite care). Often the solution is unsustainable, due to incompatibility problems that arise from mismatching residents, lack of resources to meet individualised needs and the use of one-off funding sources to fund ongoing support needs. DHS does not have a suite of alternatives to deal with the complexity of people's individual circumstances.

In some cases we found respite care was used to meet the accommodation needs of a person on the DSR awaiting SSA. DHS measures respite in episodes, however, an episode is not well defined as it can mean one day for one person or for another person, one day a week for a year. Also a person can receive a respite package or respite as part of an individual support package.

Little preventative work is being done, for example, on life pathways to help people and families through the coming years. DHS has identified the circumstances when families are most at risk but is usually unable to intervene early in crises: as it often does not know who these families are as they do not present until the crisis occurs.

DHS was unable to provide a meaningful cost for the provision of accommodation and support to clear all of the people listed on the DSR as the specific level of support required will vary with the extent of informal support provided by carers.

How long does a person wait for support?

At December 2007, there were around 1 370 people on the DSR who had a current need for SSA. Of these, around 230 had priority status.

Due to technical difficulties with the DSR, DHS was unable to provide an accurate analysis of the time span from registration to the provision of support.

Are people waiting for SSA supported?

We reviewed the files of 16 people listed on the DSR as requiring 24-hour SSA, to find out what happened while they waited for SSA. While they all had accommodation, the support provided either did not fully match their assessed needs or was not sustainable long-term.

Our file review also showed that the system generally did not respond until families reached a crisis point. DHS and CSO staff would then work hard to pull together interim support funding until a suitable placement arose. People requiring 24-hour SSA are very hard to place and rely on interim support funded by the DHS region. Often, they are placed in respite care.

We found instances where:

- carers were ageing and in need of support themselves
- people's conditions were deteriorating and their support needs exceeded those available at home
- people's behaviour was not managed and they posed a threat to their immediate carers or the community at large. This was particularly the case with people leaving the criminal justice system: the DHS SSA service includes the Forensic Statewide Service that provides secure accommodation for eligible people with a disability who have been released from gaol or the youth justice system.

Is the DSR operated consistently by DHS regions?

We found that DHS regions use the DSR differently. How they use it is influenced to some extent by their size and the extent to which they can achieve economies of scale to increase efficiencies and improve residents' choices. One region registered all eligible people for accommodation but did not necessarily assign them priority status. Other DHS regions screen applicants further and only register those with current needs who meet the priority status criteria.

To manage DSR vacancies, some service providers relocate residents internally. This results in a low support need vacancy being declared when the vacancy had actually occurred in a high support need house. Some service providers only register a person on the DSR if they have no SSA. Others register people already in SSA but needing to be moved.

One region had a good system for monitoring the expenditure of individual support packages. That region found that some recipients do not spend all their allotted funds: by identifying these unspent funds, the region could provide further smaller packages to others on the DSR. This region was also exploring ways to make better use of their information so that they could make limited resources go further.

The composition of regional assessment panels, who match potential residents to SSA vacancies, varied across regions: some had community representatives on the panel, and the duration of panel membership varied.

5.1.3 Shared supported accommodation

DHS's approach over the last decade has been to support as many people to remain in their own (or their parents) homes as long as possible. More and more funding has, and continues to be, provided for individual support packages while SSA capacity has been capped. This approach has enabled DHS to achieve some benefits for residents and some cost efficiencies.

Currently, demand for SSA exceeds supply by around 30 per cent (1370 people). DHS forecasts that demand will grow by around 4 to 5 per cent annually. DHS has begun to explore how unmet demand can be addressed using alternatives to SSAs and has established the Disability Housing Trust to provide 100 places with \$10 million over three years. The Trust aims to use contributions from families to leverage housing options.

In 2007-08, a budget allocation of \$10 million was provided to DHS to provide up to 75 places in alternative supported accommodation models. These will be for people with complex care and high-support needs. It will also provide funding for new, non-SSA housing options for people with a disability who do not need 24-hour support and can live independently in the community.

SSA houses are not always available where people need them because they were built near the institution they replaced, or where a CSO has volunteered to establish one. Regions are allocated funds each year according to the regional equity formula, with regional adjustments. This formula is gradually redressing historical anomalies created by the existence of institutions. For example, one rural town has 16 SSAs for a population of 9 000, while in the same region there are 17 SSAs in a town with a population of 90 000.

Another factor affecting unmet demand is the increasing life expectancy of residents, which in turn reduces resident turnover. DHS has recently built some larger eight to ten bed facilities so that elderly residents can be relocated into a purpose-built aged-care facility. Many aged-care facilities feel unable to care for people with a disability and often refuse them entry.

SSA places are not easily freed up and often result only from a death.

DHS set regional targets for the number of residents to be moved out of SSA to live independently in the community. In the past four years (2003-04 to 2006-07), DHS has moved about 127 residents. In addition, 32 people are expected to move out by 30 June 2008 and a further 11 could move out if resources become available. Of the 32 residents files we examined, two residents were considered by support staff as suitable for living in the community. Residents remained in SSA for various reasons including:

- not having access to suitable, low-cost accommodation
- the region not having funds to provide them with an individual support package
- their guardian not believing them capable of living more independently, but preferring them to stay in SSA for their own safety.

5.1.4 Conclusion

DHS has no legislative obligation to provide a service to people with a disability who do not present or even to those who do present. DHS cannot fully meet the needs of those people it assesses as having a current need. These factors have created a reactive service while demand for accommodation support grows.

While DHS has initiated a number of demand management strategies, progress to date has been slow and there is little assurance of meeting the growth in demand.

Estimating the cost of providing accommodation and support for all people listed on the DSR would assist DHS in better understanding its future resourcing requirements.

Recommendation

- 5.1 DHS should expand its demand management strategies and explore options for accelerating the implementation of existing demand management strategies.

RESPONSE provided by Secretary, Department of Human Services

This recommendation is supported and work has commenced to address this issue.

The Department of Human Services (the department) is currently working collaboratively with the Departments of Education and Early Childhood Development, Planning and Community Development, Premier and Cabinet and Treasury and Finance to develop approaches to demand for disability services. The approach will build on existing strategies including:

- *providing a broader range of service responses in community settings*
- *more coordinated individualised planning at key life transition points, including entry to early childhood services and school*
- *building individual and carer capacity through early-intervention and episodic services*
- *developing the capacity of the disability services sector to ensure efficient and high-functioning disability services*
- *building community capacity for more inclusive and welcoming mainstream services and communities.*

5.2 How well does DHS manage future demand?

5.2.1 Measuring future demand

DHS does not systematically measure people in need of support who have not presented to DHS on a regular basis. DHS has conducted three studies since 2002 using Australian Bureau of Statistics data to help quantify the expected population, service usage rates and people listed with DHS as needing a service. The studies forecast that demand for accommodation support will grow by over 50 per cent from 4 600 to around 7 100 clients by 2016 and that growth will increase by 38 per cent in metropolitan areas compared with 31 per cent in regions.

To meet forecast demand growth over five years for SSA individual packages, a DHS commissioned study estimates a total investment of \$524 million is required. This represents an increase of annual recurrent growth funding from 1.5 to 2.5 per cent.

DHS has worked with the Department of Education and Early Childhood Development to identify the future needs of young people who might need assistance. The Futures for Young Adults Program is exploring alternative pathways for younger people between 18 and 21 years of age.

Regions have identified several groups of people that will need accommodation in the future and for which there is no current provision. These groups include:

- young people aged around 18 or 19 with acquired brain injuries
- people in their 50s and 60s with degenerative diseases (such as multiple sclerosis and motor neuron disease) and do not want to be in a nursing home with very elderly people.

These people have high support needs that are not being planned for.

5.2.2 Conclusion

DHS has conducted some broad demand studies but does not have systematic data collection tools to accurately monitor growth in demand. DHS has also conducted regional projects to investigate the impact on service demand of factors such as ageing carers. These projects need to be extended across the State and collated to give a clearer picture of expected demand growth.

Recommendation

- 5.2 DHS should systematically measure projected need and develop strategies, such as alternative delivery mechanisms and a workforce management strategy, to meet future resourcing requirements.

RESPONSE provided by Secretary, Department of Human Services

This recommendation is supported and work has commenced to address this issue.

State, Territory and the Commonwealth Ministers have agreed that one of the national priorities for disability services is “Better Measurement of Current and Future Need for Specialist Disability Services”. Victoria will work with other jurisdictions to develop a national approach in this area.

In parallel, the department is currently developing a Performance Management Framework to identify and articulate its key information needs, and to support the development of a more-robust and rigorous program of strategic analysis and reporting.

The department’s move to a more individualised planning and support approach represents a critical shift in the way it delivers services to people with a disability, allowing more flexible and early-intervention approaches to meet future demand for disability services.

Supporting this approach is the department’s Industry Development Plan, which includes development of a five-year workforce planning strategy to ensure a skilled and qualified industry workforce will be available to meet the future needs of people with a disability.

The Victorian Industry Development Plan was released in October 2006 after extensive public consultation with a range of stakeholders. It will complement the directions of legislative reform.

The purpose of the Industry Plan is to develop and support the disability services sector to meet the goals of the Victorian State Disability Plan, and the vision for a stronger and more inclusive community in which people with a disability have the same opportunities as other Victorians.

Key priorities of the industry plan implementation are:

- in partnership with people with a disability, carers and disability service providers, develop and implement a five-year workforce planning strategy for the disability support sector, to ensure that there is a skilled and qualified workforce*
- explore and implement opportunities for increasing workforce flexibility, in response to the lifestyle choices of people with a disability*

RESPONSE provided by Secretary, Department of Human Services

Recommendation 5.2 – continued

- *develop sector-wide staff training and development strategy with a focus on values, skills and competencies that promotes contemporary models of support*
- *develop the disability sector as an industry of choice for future workers and create opportunities for career pathways.*

Implementation of the Industry Plan is an ongoing process. The department is also currently working with the Community Services and Health Industry Skills Council, the organisation which has carriage for the development and maintenance of national training packages for the community services sector, to ensure competencies contained within the Certificate III and Certificate IV in Disability Work qualifications are relevant to the changing skill requirements of workers in disability services in both government and community managed services. In particular, this recognises the need to have a workforce which has the capacity and capability to work with people with a broader range of support needs, in more diverse settings.

The National Community Services Training Packages are currently being reviewed, with completion due in June 2008. The change in focus of these qualifications (and thus knowledge and skills of workers) includes a greater focus on skills in individual planning and support, supporting people with more complex needs, including significant health care needs and a stronger focus on working in a more flexible community based model.

Auditor-General's reports

Reports tabled during 2007-08

Report title	Date tabled
Program for Students with Disabilities: Program Accountability (2007-08:1)	September 2007
Improving our Schools: Monitoring and Support (2007-08:2)	October 2007
Management of Specific Purpose Funds by Public Health Services (2007-08:3)	October 2007
New Ticketing System Tender (2007-08:4)	October 2007
Public Sector Procurement: Turning Principles into Practice (2007-08:5)	October 2007
Discovering Bendigo Project (2007-08:6)	November 2007
Audits of 2 Major Partnership Victoria Projects (2007-08:7)	November 2007
Parliamentary Appropriations: Output Measures (2007-08:8)	November 2007
Auditor General's Report on the Annual Financial Report of the State of Victoria, 2006-07 (2007-08:9)	November 2007
Funding and Delivery of Two Freeway Upgrade Projects (2007-08:10)	December 2007
Results of Financial Statement Audits for Agencies with 30 June 2007 Balance Dates (2007-08:11)	December 2007
Local Government: Results of the 2006-07 Audits (2007-08:12)	February 2008
Agricultural Research Investment, Monitoring and Review (2007-08:13)	February 2008

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