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15 October 2012

Dr Robert Waldersee **Executive Director Corruption Prevention Division** Independent Commission Against Corruption GPO Box 500 Sydney NSW 2001

By email: icac@icac.nsw.gov.au

Dear Dr Waldersee

Response to consultation paper 'Funding NGO delivery of human services in NSW: A period of transition'

Thank you for your letter of 28 August 2012 inviting our office to comment on the consultation paper 'Funding NGO delivery of human services in NSW: A period of transition'. Having examined the consultation paper and questions for submissions, we consider it appropriate to make the following observations, and to draw your attention to a number of public reports and other documents written by our office that are directly relevant.

Probity checks and other measures

In November 2011, we addressed the Australian Public Sector Anti-Corruption Conference on the potential for improper influence in the NGO sector, which drew on our experience in monitoring the delivery of community services in NSW. A copy of the speech is attached at Appendix 1.

In the paper, we indicated that, while we are not opposed to the devolution of responsibility for delivering a range of human services to the NGO sector, our work has identified significant challenges that need to be addressed in order to provide quality assurance. In particular, our work has emphasised the need for greater consistency in:

- the administration of funding contracts; and
- the systems NGOs have in place for probity checking and screening. •

In relation to the need for greater consistency in the administration of funding contracts, we noted that it is critical that government funding agencies ensure that organisations they fund understand and have good governance processes in place to ensure risks are appropriately identified and managed, and that strong and transparent accountability mechanisms are in place to prevent improper conduct from occurring. Whilst we are in favour of strong governance measures and an effectively accountability scheme, we agree with the statement on page four of the consultation paper that '*the controls on the funding cannot be so onerous as to negate the benefits derived from delivery through NGOs*'. It is imperative that good governance and consistent accountability measures are not at the expense of targeted and effective delivery of human services to some of the most vulnerable people in this state.

In the paper, we also highlighted the difficulties associated with the different requirements imposed by funding bodies at a state and federal level around funding administration. We noted the reluctance on the part of NGO staff, service receivers and community members to report problems with NGOs, as highlighted on page 13 of the Commission's consultation paper. This problem is often exacerbated in small towns due to fear of repercussions, including service withdrawal.

With regard to probity checking and screening, the paper highlighted the inconsistent approach taken by government agencies in relation to probity checking requirements imposed on NGOs, and the associated risk that very vulnerable people can be exposed to serious risk of harm.

In this regard, we draw the Commission's attention to our December 2010 special report to Parliament on *Improving probity standards for funded organisations*. A copy of the report is attached at <u>Appendix 2</u>. The report was informed by extensive consultations with NSW government agencies with responsibilities for health and human services; peak bodies representing the NGOs funded to deliver services; and the oversight and regulatory bodies with responsibilities in this area. The report highlights the risks and inefficiencies associated with the confusing array of processes used to screen prospective employees, board members and others involved in planning or delivering government funded services to vulnerable people.

In the report, we argued that there should be, as a minimum, consistent baseline checks of all paid employees and others with key responsibilities in planning and delivering services, taking into account the vulnerability of clients who use the services, with the flexibility to strengthen or relax checking requirements in appropriate circumstances. We believe there are strong public interest grounds for introducing a consistent probity checking system across the NGO human services sector.

We also argued that improvements in the area of probity screening should take place within the context of strengthening broader risk management and accountability systems. Our report outlined a range of measures for strengthening accountability and improving related guidance for funded agencies. These measures include model clauses in funding agreements and other contractual documents; guidelines to promote good practice; information and resources for NGOs to build capacity in risk assessment and management; and transparent systems for funding agencies to monitor NGOs' compliance with requisite standards.

A number of positive developments have occurred since our report was tabled: the Department of Family and Community Services (FACS) is moving towards developing standardised, sector-wide requirements to improve the quality and consistency of probity checking, and that in partnership with National Disability Services, the Association of Children's Welfare Agencies and Aboriginal Child, Family and Community Services State Secretariat, FACS are funding targeted strategies to improve the ability of all funded organisations to deliver in accordance with agreed governance and risk management standards.

The need for a consistent accountability scheme

The shift in delivery of human services to the NGO sector poses unique challenges in terms of governance, accountability, and managing corruption risks. As highlighted in the discussion paper, the transition brings with it difficulties in determining the price and value of human services delivered, and risks associated with decentralisation of decision making. In this regard, we note the need for a consistent, streamlined approach to monitoring and auditing NGOs providing human services. However, we are also cognisant of the need to not unnecessarily burden NGOs with red tape. We are of the view that any accountability measures imposed on NGOs should be commensurate with the amount of public funding received by the NGO.

As you know, NGOs currently fall outside of the Auditor General's jurisdiction. This is despite the fact that many NGOs receive significant amounts of public funding; funding which is often comparable in scale to the funding provided to small to medium-size public authorities. In this respect, we would welcome consideration being given to expanding the Auditor General's jurisdiction to include NGOs.

Place-based service delivery

Of direct relevance to the consultation paper is our extensive work over many years in examining the delivery of community services to Aboriginal communities. Our work in this area has addressed issues raised in the consultation paper, including the need for strong governance and accountability measures, and the benefits of place-based approaches to the delivery of human services.

We have attached our special report to Parliament of October 2011, *Addressing Aboriginal Disadvantage: the need to do things differently*, at <u>Appendix 3</u> for the Commission's reference. Chapter 7 of this report calls for more robust and effective leadership, governance and accountability mechanisms to drive action and to measure results in relation to initiatives aimed at improving service delivery to Aboriginal communities. While our report focuses on improving outcomes for Aboriginal people, the observations are relevant to the delivery of human services by the NGO sector and partner agencies more generally.

At page 59 of our report we observed that in NSW, there are a range of plans and related initiatives aimed at addressing Aboriginal disadvantage, often developed in isolation and without a clear articulation of how they fit together¹. The various plans and commitments have a range of governance structures and reporting mechanisms in place which often overlap and sometimes even conflict. As a result, it is difficult to gain a coherent sense of which elements of the array of existing plans remain relevant, or whether the disparate range

¹ In NSW, there are a number of programs that impact on service delivery to Aboriginal communities. *Closing the Gap*, together with the associated national partnership agreements, provides the overarching national framework for addressing Aboriginal disadvantage. In NSW, the former *State Plan* and *Two Ways Together* were both 'adjusted' to reflect the closing the gap targets. Individual state and federal agencies also have their own plans for how they will provide services to Aboriginal people, as well as plans that are either aimed at specifically addressing particular problems facing their communities (eg. NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities). State and federal agencies also incorporate a significant focus on outcomes for Aboriginal people in a number of broader plans (eg *National Framework for Protecting Australia's Children; Keep Them Safe: A shared approach to child wellbeing in NSW*).

of objectives and strategies they encompass are likely to achieve demonstrable improvements in the lives of Aboriginal people. The Ministerial Taskforce on Aboriginal Affairs is examining ways to improve service delivery and accountability as part of its current terms of reference.

The report notes the impacts of a poorly integrated and inefficient service system, including: the failure to identify and meet the needs of those most vulnerable; the continued funding of NGOs that are failing to provide a good quality service and the limited return on investment from a number of agency programs. The report calls for a centralised approach at the local level to decision-making about the planning, funding and delivery of services.

In a more recent confidential report on our review of a group of 48 school-aged children from two Western NSW towns, the subject of governance and accountability was once again a focus. This review aimed to demonstrate how existing agency information holdings could be used to better identify and respond to children at risk. We noted that in an environment of limited resources and high numbers of vulnerable children and families, it is necessary to examine the most efficient and effective ways for agencies to collectively identify those at greatest risk in local communities. In this regard, we advocated for the adoption of an intelligence driven approach to child protection. We emphasised again that collecting, analysing and sharing risk related data of this type is only one part of the equation and that 'value added' data must be put to good use via robust planning and governance processes.

We highlighted that in small, relatively isolated towns, the funding of programs designed to enhance service availability can create multiple and often 'competing' programs, reference committees and multiagency case management groups – often with overlapping objectives and target client groups.

Our review confirmed that despite the investment in a range of initiatives which purport to promote integrated case management and support to vulnerable families, very few people were receiving such support. We found that only 13 of the 48 children had received assistance from such a program.

Our review again demonstrated the need for an overarching framework to be in place which is tailored to the needs of individual communities that:

- relies on evidence to identify need and to determine priority areas for funding, as part of an ongoing "whole of community" service planning and mapping exercise;
- funds services based on the priority areas that have been identified (and according to a rigorous procurement process that assesses the capacity of individual services to deliver); and
- ensures that the level and nature of services which are provided by funded agencies are tracked, and the related outcomes are monitored.

In our confidential report, we also emphasised the need for robust and effective governance arrangements to drive a genuinely integrated service approach.

Furthermore, our report highlighted that the administration of funding contracts must include ongoing assessments of whether those who are being referred for support are actually receiving a service, and whether the desired outcomes are being achieved by both individual services and the local service system as a whole. In our view, for funding bodies to effectively discharge their planning and contract administration responsibilities, they also need to be constantly assessing where there are service gaps, and taking this into account in their service planning processes. In addition, the funding bodies should be ascertaining those services which are not being fully utilised – this should inform service planning (and related procurement decisions).

From our experience in reviewing human and justice systems in relation to a number of communities, we are convinced that a more disciplined approach to planning, funding and related governance arrangements is essential to building an effective and seamless place-based service system. Such a system is also dependent on the planning and funding decisions (and related governance arrangements) being driven from a 'whole of community' perspective. In order for this to be achieved, the decision making related to planning and funding, and the related governance arrangements, need to be jointly driven by all relevant federal, state and local government agencies working in partnership with key non government and community representatives in building an effective place-based service system. From our community work, we have observed that service systems that lack critical planning and robust governance arrangements not only lack accountability, but also have increased corruption and mismanagement risks and deliver poor service outcomes.

Lessons from the disability sector

The government's reliance on NGOs to deliver services on its behalf is particularly evident in the disability sector. Within the past year, we have tabled two reports to Parliament that have highlighted the need for rigorous systems for monitoring and regulating services to provide quality assurance for people with disabilities and their families. Importantly, both reports illustrate the serious consequences for clients where these systems are inadequate.

- In August 2011, we released a special report on our work over nine years in relation to licensed boarding houses *More than board and lodging: the need for boarding house reform.* A copy of the report is attached at <u>Appendix 4</u>. It is worthwhile noting that the boarding house sector is regulated but not funded by government. Our report highlighted significant concerns regarding the safety, health and welfare of licensed boarding house residents, and points to critical failings we had identified in the existing monitoring and regulatory systems to appropriately support and protect residents. We emphasised the need for reform of the broader boarding house sector to develop and implement an improved accommodation, support and regulatory framework. Section 5 of the report details our perspective regarding regulation and compliance of the boarding house sector. Following our report, the government released the *Exposure Draft Boarding Houses Bill 2012* in June 2012. This work by our office illustrates the potential risk of any reform focusing only on the funded NGO sector.
- In September 2011, we tabled our latest report on the reviewable deaths of people with disabilities in care (see <u>Appendix 5</u>). Our reviews of deaths have identified considerable and continuing problems in how disability services are identifying and managing the risks faced by individuals in their care, and have raised questions about the adequacy of the quality and monitoring systems in place in these organisations. As noted in the Executive Summary and Chapter 3 of the report, these problems were particularly significant in NGO disability services. To reduce the preventable deaths of people with disabilities in care, greater attention is required to improve disability services staff's understanding of effective risk management and associated requirements, and to monitor

staff practice to ensure compliance. Recommendations 1-5 in the report are relevant in this regard.

Strengthening reporting and oversight systems in the disability sector

In the context of the current disability sector reforms under Stronger Together, we have written to ADHC about the need to strengthen the reporting and oversight systems relating to serious complaints and incidents. We consider that there would be considerable benefit in establishing systems for reporting serious incidents in disability services and licensed boarding houses; including allegations of serious abuse, assaults and neglect, and other critical incidents.

In relation to serious incidents, we note that there are robust systems in place for reporting and oversighting the handling of such incidents in the employment-related child protection area, as outlined in Part 3A of the Ombudsman Act 1974. However, no comparable system currently exists in relation to particularly vulnerable individuals with disabilities who receive disability support.

Consideration of expanding the jurisdiction of existing oversight bodies

Finally, the shift in the delivery of services from the government sector to the NGO sector raises important questions in relation to the role of existing independent oversight agencies (such as the Auditor-General; ICAC and the Ombudsman).

In contrast to their jurisdiction over government agencies, the scope for independent oversight agencies to review and investigate maladministration and corruption within the funded sector is somewhat limited and ad hoc. With a move towards a greater reliance on services provided by the NGO sector, there is a need to consider the current reach of the oversight bodies, insofar as this sector is concerned. In this regard, it is important to recognise that the independent and external oversight bodies already play a significant role in examining the NGO sector. For example, the Ombudsman's role in oversighting workplace child protection and our reach under the *Community Services (Complaints,* Review and Monitoring) Act 1993, include a significant range and number of NGOs. However, what has not taken place is a systematic and rigorous examination of the jurisdictional reach of the oversight bodies in relation to the NGO sector from a broad public interest perspective. In our opinion, an examination of this kind is overdue.

I trust that the Commission will find the attached documents and the information outlined in this document useful. If our office can be of any further assistance, please do not hesitate to contact Julianna Demetrius, Director, Strategic Projects Division on 9286 0920 or email at jdemetrius@ombo.nsw.gov.au.

Yours sincerely

C. Amin Slan

Bruce Barbour Ombudsman

Steve Kinmond **Deputy Ombudsman Community and Disability Services Commissioner**

List of Appendices

- Appendix 2: The Ombudsman's special report to Parliament tabled in December 2010, *Improving probity standards for funded organisations*. Accessible online at: <u>http://www.ombo.nsw.gov.au/__data/assets/pdf_file/0015/3381/SR_ImprovingProbityStandards_Dec10.pdf</u>
- Appendix 3: The Ombudsman's special report to Parliament tabled in October 2011, *Addressing Aboriginal disadvantage: the need to do things differently.* Accessible online at: <u>http://www.ombo.nsw.gov.au/___data/assets/pdf__file/0012/3342/SR_Aborigin____al-disadvantage-report.pdf</u>
- Appendix 4: The Ombudsman's special report to Parliament tabled in August 2011, *More than board and lodging: the need for boarding house reform*. Accessible online at: <u>http://www.ombo.nsw.gov.au/__data/assets/pdf_file/0016/3346/SR-Boarding-Houses.pdf</u>
- Appendix 5: The Ombudsman's *Report of Reviewable Deaths in 2008 and 2009, Volume* 2: Deaths of people with disabilities in care, tabled in September 2011. Accessible online at: http://www.ombo.nsw.gov.au/__data/assets/pdf_file/0006/4299/Report-ofreviewable-deaths-2008-to-2009-volume-2-Disability-deaths.pdf