1. Multiple audits

Unnecessary duplication of auditing processes has long been recognised by the sector, the Ministry and Treasury as a drain on public resources.

The compliance burden of multiple audits is a significant constraint on greater efficiency, collaboration and service integration. We urgently need a system that enables the Ministry and DHBs to share auditing information so that well-performing NGOs are not subjected to repeated visits and inspections by auditors all examining the same systems and documentation.

Significant cost-savings for both DHBs and NGOs could be made through better knowledge sharing of audit results. The multiple audit barrier is a classic opportunity to implement the Minister of Health's desire for improved back office efficiency.

The audit process needs to move beyond a compliance mindset to a quality improvement context that enables best practices to be shared across providers. We all need to understand what is working well, and where, so we can progress purposefully beyond a baseline of minimum standards. Our current sets of auditors do not appear to have the skills, capability or desire to build a context for provider benchmarking and constructive comparison. Staff engagement and pride is not driven by audit compliance, it is fuelled by recognition of service excellence!

Despite various workshops etc in the past, and some limited attempts within regions to co-ordinate audits, NGOs still face situations like the following:

> *"Sometimes it seems like we have almost a rolling audit situation. One week one auditor wants to look at residents' files, the next week there may a certification audit and the next week another checking the contract requirements.*
>
> *"It takes up staff time and creates additional cost," says Phil Grady, CEO of Odyssey House in Auckland.*
>
> *"It takes staff away from frontline clinical service delivery and the collaborative relationship building. Sometimes different auditors are looking at the same things repeatedly, but they don't seem to take into account the findings of another audit.*
>
> *"We will say 'we've just had X in', but that doesn't matter to them," says Phil, adding that it's not clear why they will not accept another auditor's findings.*
>
> *"The Northern region's DHBs have worked hard to co-ordinate audits so they are all happening at the same time, but a co-ordinated solution didn't seem to suit the other funders," Phil laments*.

Task

- Generate some ideas and strategies that might improve the current situation.
- What is your key message for the Minister of Health and/or the Director-General of Health?

2. Contractual compliance burden

Funding-related administrative and reporting procedures are perhaps the biggest constraint on greater collaboration and service integration. For many, the burden of output reporting is getting worse – not better – and often these are proven providers with good reputations for effectiveness and quality. The variety of timeframes, different reporting requirements, constant negotiation of numerous short-term contracts, ad hoc changes and multiple audits are a drain on resources – wasting the money government has provided to deliver services. (It is likely a comparable burden on the public service too.)

High Trust contracting, Whānau Ora, Alliance contracting and Integrated Contracts are welcome attempts to reduce this burden and support service delivery, but their implementation has been slow and few in the health sector have benefited – despite the fact many have contracts with multiple government agencies.

As a result, 'servicing the master' takes the focus away from delivering frontline services and achieving better health outcomes.

Changes to Header Agreements, insertion of new contract clauses without discussion, unnecessary variations between DHB processes and unexplained delays in negotiations are ongoing challenges for NGOs and the public service.

At a high level, many of these issues could be handled better. The Ministry works through negotiations with PHOs via their co-ordinating body PSAAP. Might a similar negotiating body work for NGOs?

Extending joined-up funding models (such as Whānau Ora and Integrated Contracts) can reduce providers' purchasing and contracting compliance burdens. Levers such as contracting for bundles of services and pooling funding streams can deliver better value and improve provider performance. Smarter contracting and funding approaches must be underpinned by good intelligence about costs and price.

What other approaches could reduce the burden of bureaucracy?

Task

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3. Diverse, sometimes disconnected sector

Many in the health sector have little idea of the size and scope of the health and disability NGO sector. They struggle to have any understanding of what NGOs are present in their communities or what services they provide – and have no idea how to find out. This is sometimes given as a reason for exclusion from projects. An alternative excuse is that there are "too many" NGOs and they don't know which one to ask.

There around 7,000 health and disability NGOs throughout the country – some are big, some are small. They offer an extensive range of services including health promotion, clinical services, client and whānau support in homes and social support for a wide variety of health conditions. Some NGOs focus on specific issues (e.g. cancer or asthma) or particular populations of need (e.g. children) or particular communities of need (e.g. Māori providers).

It is challenge for anyone, including DHBs and PHOs, to connect with such a large and diverse NGO sector. Some parts of the sector, such as mental health and disability have umbrella groups that others can work through or with – but many parts of the sector are not so lucky.

- How can NGOs make it easier for Ministers, government, DHBs and others to engage in a timely manner?
- Is there a potential role for IT and social media?
- Could the Health and Disability NGO Working Group take a bigger role?

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4. NGOs a big unknown to GPs and others

Research shows a lack of awareness of regional NGO services amongst GPs and PHOs despite a range of information sources, including data held by DHBs.

Various public repositories of health NGO information, such as *Healthpoint, Healthpages, Health Connection, Webhealth* (may have seen this in the exhibit area), *Right Service Right Time, Family Services Directory, Contract Mapping*, and the *Charities Register*.

The current lack of knowledge about NGOs hinders timely referrals and limits the provision of collaborative, wrap-around health services that help people to stay in their homes.

The group with Joanne Hayes is now hearing about one IT approach that is helping to address this – it involves a process where the Southern PHO vets NGOs so they gain 'accreditation' – and they can then be included in the computer system that GPs use – GPs can make referrals using a drop-down menu of 'approved' NGOs.

There is need to make better use of the extensive health provider data available to make it easier for information to be updated and so GPs can connect patients to a broader range of services.

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5. How can small NGOs develop enduring relationships with government, DHBs and other health service organisations?

Small NGOs often struggle to develop new and enduring relationships with government agencies, DHB's and other health sector organisations. They either lack the time, resources or contacts to build the relationships or they are not seen as 'key stakeholders' and not provided with opportunities to have input.

Their priority commitment is targeted towards providing information, support and advice to consumers and families when they have a health crisis, so it leaves little time or resource for networking.

Many NGOs have evidence-based examples of how things can work more effectively, but they struggle to get Ministry or DHB funding and planning staff to engage with them.

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6. MoH, DHBs and PHOs hard to navigate

A lack of communication from some parts of the Ministry and DHBs and PHOs is an issue – exacerbated by high levels of recent changes of PHOs and within the Ministry of Health.

Established relationships have been lost and many people in the sector do not know who to contact. Some NGOs had good relationships with small PHOs, which are now part of much bigger PHOs often based a long way from where the NGO is.

How can the Ministry, DHBs and PHOs make it easier for NGOs to stay in touch and informed?

Are there things they do well that you'd like to see extended or copied? (e.g. The National Health Board e-newsletter.)

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7. Sharing innovations across sector and regions

The NGO Working Group's recent Primary Health Care project identified a number of promising examples of collaboration and innovation – by PHOs, DHBs, general practices and NGOs, yet many were not known beyond the group or region involved. Even those involved in something new were often unaware of similar developments in other parts of the country – thinking they were the only ones working in that way.

In many cases, such as IT projects like shared care records, it would seem beneficial for those tackling similar challenges to exchange ideas and resources – but innovation is often happening in isolation.

Greater sharing of progress on new developments would do a lot to lift the mood of those working in the sector, who often expressed (via the online survey) the view that 'X' should be happening, when in fact it already is somewhere else.

How can we collectively make it easier to share what is happening across the sector without sucking up people's precious time or bombarding them with irrelevant info?

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8. Tapping into social sector to address causes

It is well-recognised that social, cultural and economic factors are the main determinants of health – and the current health system has little control over these.

Community-based NGOs often work with the most vulnerable populations – the ones with the worst health outcomes and high mortality rates.

Many NGOs are deeply embedded in these communities and strong connections exist between individuals/whānau and their NGO health workers. Many of the people who most need help are very engaged with these NGOs.

Because many of these population groups face multiple challenges – social, economic, educational – the NGOs working with them are skilled at working in multi-disciplinary teams and are well-networked with other providers to deliver a seamless, holistic, client-centred service.

But often NGOs are only funded to provide support for the symptoms, rather than through co-ordinated approaches to address the causes of problems.

How can NGOs engage better with government agencies in Health, Social Development, Housing, Education and Justice to do more prevention work?

The Social Sector Forum has proposed the use of 'Departmental Joint Ventures' as a way of bringing together funding and accountability for cross-Government initiatives. What are your thoughts on this?

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9. NGO input to governance and planning

NGOs' experience delivering one-stop-shop health services and working with high-need population groups can provide vital insight to those developing Integrated Family Health Centres, planning a wider range of care and support for patients or shifting secondary care services to communities. Dialogue with a broader range of NGOs is essential to avoid 'reinventing the wheel' and wasting resources.

NGOs need to increase representation on decision-making groups to complement the views of hospital clinicians and GPs – especially at the governance level. (e.g. on the National IT Board, on the Health Workforce NZ Board, at the Health Quality and Safety Commission).

Clinicians and often consumers how have a voice in governance and planning, but NGOs are still overlooked.

Some of the barriers include a lack of funding and resources to support such relationships, but there is also a lack of opportunity. Key committees and groups don't understand the positive impact NGOs can make sitting at the table where decisions are made. Ministerial appointments are particularly problematic.

The absence of NGO input to policy setting and strategic planning at the senior governance level is a barrier to whole-of-sector thinking and successful implementation of more community-based services.

- How can this change?
- What issues/areas could NGOs be especially useful in?
- How can NGOs convince the 'powers that be' that their voice is useful?

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10. Service duplication & perceptions of competition

It is not uncommon for DHBs to set up and fund their own in-house services when there are already established not-for-profit providers in the region. PHOs also often start their own service, instead of using existing NGO services.

- What might be the reasons for this?
- How we can avoid such duplication in future?
- Is it due to a lack of confidence in existing services or a lack of knowledge about them – there must be a better way forward?

In some regions, there are excellent examples of DHBs divesting themselves of services and supporting community provision of activities such as Cardiac Rehab. How could we see more of this type of community collaboration – beyond the areas of diabetes and heart health?

Many NGOs are well-placed to help DHBs deliver integrated services so older people can stay independent at home. Other NGOs can help DHBs improve young people's access to youth, alcohol and other drug services, as per government priorities.

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