Beyond vision loss

Productivity Commission Inquiry

More Effective Social Services

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Introduction

The Blind Foundation is pleased to have the opportunity to make this submission to the Productivity Commission's inquiry into the purchase of social services in New Zealand. The inquiry is timely given the increasing demands for services from an aging population and increasing complexity of the options for the provision and funding of social services.

The Blind Foundation is New Zealand's main nation-wide provider of independent living services for blind people and those with low vision. Our purpose is to enable blind people and those with low vision to be self-reliant and live the life they choose.

The Blind Foundation's vision is to, ***"empower and support New Zealanders who are blind or have low vision to ensure that they have the same opportunities and choices as everyone else."***

We are coming to the end of our five year strategic plan 2009-2015 and are currently refreshing our strategic priorities. We would like to share our thinking with you and your officials as it relates to the potential restructure of governments approach to the purchase of social services. We are planning research in 2015/16 into the area of social impact investment and the use of regulatory/legislative frameworks to encourage accessibility for the wider disabled community. In this we are using models developed by our sister organisation in Canada who have already demonstrated the value to government of targeted investment in social services.

Background

According to the 2013 Statistics New Zealand Disability Survey[1] nearly 170,000 New Zealanders self-reported that they live with significant vision loss right now. This number will increase as our population grows and continues to age. But we have a gap in data on the full extent of vision loss in New Zealand, especially the extent of functional disability that follows.

In the Access Economics Clear Focus report[2] the economic impact of vision loss in New Zealand including the total health system costs were broken down by component in 2009 and 2020. Overall, health system costs were estimated to rise to $523 million by 2020 or $3,008 per person with vision loss. This compares to a total cost of $198 million in 2009 (1,583 per person with vision loss). The key drivers of health system costs include population growth and ageing, prevalence of disease, income per head, community expectations and knowledge, technological advances and changes in government policy.

[1] Disability Survey 2013 – Department of Statistics New Zealand
[2] Clear Focus: The Economic Impact of Vision Loss in New Zealand in 2009

Given that most vision loss is avoidable and treatable, it is staggering that in economic terms, the total cost to the New Zealand community was $2.8 billion in 2009[3].

There is a gap for people who are living with vision loss. We know that some are unable to access the support they need to live safely and confidently. The impacts of vision loss are well documented in terms of the effect on mood of the clients[4]. Depression and anxiety are common as is social isolation.

The Blind Foundation's Role in the Social Sector

For almost 125 years the Blind Foundation has been the major social sector service provider of services for blind people and those with low vision. We have enjoyed a long and productive funding relationship with government to ensure the most vulnerable people with significant sight loss receive the services they need The Foundation is pleased to offer this submission into enhancing productivity and value in the state sector (focusing on the purchasing of social sector services).

We firstly describe the work we do and then provide our responses to the questions raised in the Commission's issues paper.

The Blind Foundation is a charity and a registered incorporated society. It costs us approximately $30 million each year to provide the vital services which support Blind Foundation clients, ensuring they have the same opportunities and choices as everyone else.

We are governed and led by blind people and those with low vision. We focus on delivering services to our clients wherever they live. We also represent them and advocate on their behalf. Clients have the option to choose whether to become voting members. The voting members elect the Board of Directors. This is a particular strength of our organisation.

The Blind Foundation's core service is "vision rehabilitation" for blind people[5] and those who have low vision of all ages. The term "vision rehabilitation" includes a wide range of professional services that can restore functioning after vision loss, just as physical therapy restores function after a stroke or other injury. Low vision rehabilitation is an internationally recognised model of care for managing the impact of low vision associated with Age-Related Macular Degeneration (AMD) and other blinding diseases.

Low vision rehabilitation is not currently integrated across the continuum of eye health care in New Zealand. To address this problem we recently requested the

[3] Clear Focus: The Economic Impact of Vision Loss in New Zealand in 2009
[4] Lighthouse international - Depression, disability and rehabilitation in vision impaired elders http://www.lighthouse.org/research/archived-studies/elders/
[5] Blind refers to blind and deafblind people

National Health Committee to consider an assessment of low vision rehabilitation services. [6]

Our services include life enrichment elements such as library and information services, community volunteers as well as advisory and advocacy services. We contract services from nine community organisations to deliver additional advocacy, peer support and sport and recreation services. The advisory and advocacy services increase the effectiveness of community services and to ensure that the accessibility needs of blind people and those with low vision are taken into account. Whilst we provide services to enable people who lose their sight to live independently, we see that there are still too many barriers in outside world that limit their choices to fully participate as citizens and consumers.[7]

The Productivity Commission inquiry is timely because of the growing pressure on the services currently available due to the population of our ageing population. Blind Foundation research suggests that despite increased rates of medical intervention, need for services is significant and will continue to grow into the foreseeable future.

The very nature of the services required is changing and the Blind Foundation anticipates a need for a stronger future focus on providing support to better access to information, communications technology, information and communication skills and psychosocial support. There are evidential grounds which suggest the need to examine the point at which services become available. From practice experience we know that earlier intervention can lead to better and more sustainable outcomes that better preserve people's ability to lead independent lives.

We are in the middle of framing our next five year strategic for 2015-2020. This is an opportunity to reshape our services, delivery methods and structures to meet the changing conditions. We are committed to working collaboratively with other stakeholders across the social services sector and especially in the eye-health sector to ensure the best possible care is available for people with significant sight loss, in the most seamless way. While the Blind Foundation is equipped to provide services after all else has failed, we retain a firm commitment to strengthen preventative programmes to reduce avoidable vision loss.

We have included an appendix that describes more about the organisation to assist the Commission's understanding of our responses to the questions posed in the Issues Paper.

The questions in the Issues Paper have been answered based on the Blind Foundation's particular role in the disability sector, and our experience of social sector funding and service provision. In some areas the Blind Foundation has no view to offer and where we do not have an opinion the question is marked N/A.

[6] Blind Foundation request to the National Health Committee for an assessment of low vision rehabilitation services – available on request

[7] Why Accessibility Matters, unpublished Blind Foundation discussion paper, September 2014

If you have any questions regarding our response or about the Blind Foundation in general please contact:

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Question Responses

Q1 What are the most important social, economic and demographic trends that will change the social services landscape in New Zealand?

The big trends we see in this landscape are:

- Increasing numbers of people who are blind or have low vision due to the ageing population;
- Increasing funding pressures due to increased demand;
- Rising consumer expectations on social services;
- Fragmentation in services;
- Increasing competition for the charity dollar;
- Increasing supply pressures on the health and disability workforce; and
- A rapidly changing digital technology environment.

Blindness and low vision typically affects older age groups; for instance 66% of the Blind Foundation membership of 11,700 is over the age of 65. As the baby boomer demographic ages, the numbers of people suffering some degree of sight loss will increase substantially. Estimates suggest the number over the age of 65 will increase by 38% over the period 2011 to 2021 (New Zealand Statistics). Improved treatments will offset some blinding disease but those requiring rehabilitative care and psycho/social support is set to increase by probably 30% over the next 5 years. Not all blind people are clients of the Blind Foundation but we expect to see Blind Foundation clientele numbers increase from 11,700 to about 16,000 by 2021. The increase may be greater if the government was to extend the current funding arrangements to include those suffering from less profound low vision at some stage. (There are some indications that this may be under consideration).

Our recent client research indicates that digital technology is being extensively adopted by blind people and those with low vision. This is positively impacting on their social and economic opportunities. Increasingly the Blind Foundation expects to take more of a lead in being a conduit to technological training and other adaptive technology support for its clientele. These services will be in addition to the Foundation's core vision rehabilitation services which will continue to be provided.

The Blind Foundation relies on government for only 28% of its revenue; the competition for charitable funding is fierce and continues. We are dependent on government funding for contracted services so the growth in the numbers of clients is likely to put pressure on both government and charitable funding sources.

Q2 How important are volunteers to the provision of social services?

We rely heavily on volunteers to support what we do. They support our staff in the library and produce accessible format information including braille. Our volunteers also work directly with clients in the community and help them with shopping, driving, household tasks and social support. In 2013 the Blind Foundation had about 1,500 volunteers who were based throughout the country. Recent client surveys have indicated an increasing need for counselling and support; volunteers are critical to providing social opportunities and peer support to our clients.

Q3 What role do iwi play in the funding and provision of social services and what further role could they play?

At this stage we do not engage directly with Iwi. We work with Ngāti Kāpo which is a national provider of blindness related services to Māori. They ensure services are provided in culturally appropriate contexts. Ngāti Kāpo assists us to reach out to Māori and Pacific People's to make sure they get access to timely and appropriate services. Ngāti Kāpo liaises between our service with tāngata whenua who prefer to use a Māori led service. Clients who are Māori who wish to receive our services directly are able to do so.

Q4 What contribution do social enterprises make to providing social services and improving social outcomes in New Zealand?

A social enterprise uses the proceeds from trade and commercial activities to supplement charitable or other funding to deliver social services. The Blind Foundation has few commercial activities to support its services. But we rely largely on public donations to fund our work. An example of this is the audio book retailing we do in collaboration with publishers or selling commercial space on the Blind Foundation Telephone Information Service. Our experience is relatively limited. While we do not yet have commercial infrastructure and culture we will continue to consider opportunities as they emerge.

Q5 What are the opportunities for, or barriers to, social services partnerships between private business, not for profit social service providers and government?

There are opportunities for increased collaboration between the Blind Foundation and optometrists in providing specialised optical devices and training for clients in the best use of the equipment. Joint management of “low vision” referrals from the private eye health providers could be improved if government was to underwrite the service. There is strong price sensitivity for Low Vision Services. At this time the

Blind Foundation does not have the working capital to invest if the start-up time and eventual commercial payback of the service is lengthy.

We plan to look more toward corporate volunteering and other commercial opportunities involving partnerships in the future. Many New Zealand businesses support and encourage staff involvement in the community for mutual benefit as part of their social responsibility obligations. The Blind Foundation has many roles that could be supported by various types of corporate expertise and partnering.

In the area of technology, whether as social enterprise or as an off-shoot of enterprise created for the whole population, clients benefit from technological enterprise. We see opportunities to partner with the ICT sector to adapt or develop in tandem technologies which have the potential to improve quality of life for people who are blind or have low vision.

Q6 What scope is there for increased private investment to fund social services? What approaches would encourage more private investment?

We see philanthropic input into the eye health sector increasing but not necessarily private investment. Our current service portfolio does not yet include areas that have the potential to generate a commercial yield. Unlike the age care sector where the capital requirements and the resulting cash flows are significant. Our services are skill based, more likely to be episodic and currently targeted at clients who in many cases unable to pay. Our services improve the client's life but are not life-saving. If government was to be the third party funder there is a potential for private involvement.

Q7 What capabilities and services are Māori providers better able to provide?

Māori service providers are better able to manage the channel between Māori consumers and technical service providers, who might be either Māori specific or mainstream providers. Our experience (which is paralleled in many other parts of the health sector) is that Māori clients often do not present to services or take the best advantage of the services without support. For instance, our Māori clientele represent only 7% of the Blind Foundation client profile compared to 15% of the general population.

Q8 Why are private for-profit providers significantly involved in providing some types of social services and not others?

This is mainly due to the nature of the market for those services. In most cases where there is private provision it is because there is a third party funder (mainly

government and insurers) and sufficient cash flow, scale and capital investment that a long term investment can be sustained. Aged care accommodation, home and personal care for older people, mental health and disability sectors are examples. The Blind Foundation began in 1895 at a time when government's interventions in the social sector were minimal and there was a strong reliance on philanthropy. We have been very successful in maintaining our charitable base over many decades and changing economic times. Other charities that emerged later have been able to capitalise on an increased government willingness to fund social services in more recent times.

Q9 How successful have recent government initiatives been in improving commissioning and purchasing of social services? What have been the drivers of success, or the barriers to success, of these initiatives?

There have been many changes over the last 25 years to government commissioning and purchasing of social sector services. At a micro level there have improvements in the technical aspects of contracting and accountability mechanisms. The current contract process of "streamlining" which is being managed by MBIE is a welcome initiative. We can see that it will yield further improvement over time to the productivity and value from this sector.

At a macro level, particularly with the use of intermediary commissioning processes the benefits are less clear. There has been a significant increase in the number of individual contract arrangements which are disproportionate to any increase in the number of funded services. Often the rationale for this is that community based organisations are able to add value at a local level but we are not aware whether this has been demonstrated.

As a national organisation we work directly with few government purchasers who centrally manage contracts. It would significantly increase our overhead costs if we had to negotiate individual agreements at a regional level, if for instance DHBs were given responsibility for the local purchase of sensory disability services. We have limited experience with individualised funding mechanisms and local area coordination. But from what we have observed we would like to be more involved in understanding the costs and benefits of this model as it develops for sensory disabilities. Some Blind Foundation clients (especially younger clients with multiple and complex disabilities) have reported benefits from these funding and coordinating mechanisms; however we do not believe they would be relevant to the vast majority of our clients at this stage. Most of our contracts involve providing episodic, specialised services to adults and older adults.

We have worked with the ORRS funding model administered by the Ministry of Education previously. The programme was not efficient and the administrative costs were significant and detracted from delivering real benefits to clients.

Q10 Are there other innovations in commissioning and contracting in New Zealand that the Commission should explore? What lessons could the Commission draw from these innovations?

Purchase of capacity

Volume based purchasing favours services where there is a predictable and relatively even demand. In more specialised services like we provide this predictability is not always the case and contract volumes can vary year by year. Our staff requires specialised training and we make a considerable investment in growing our work force capability. This training occurs over a long period of time. The Blind Foundation is unable to shed cost if volumes drop or scale up when volumes increase that easily. Contracts need to take the investment and sustainability of the specialised workforce into account.

Support of capital expenditure

The long term pricing of services does not fully account for the capital investment required to sustain complex services. This is particular the case with ICT investment which often is serving government funder reporting needs. Pricing of services is in most cases based on historical data and typically has underestimated long term capital cost.

Investment spending

Shortly we will be investigating a Social Investment Impact (SSI) model that will quantify (in monetary terms) the savings stemming from particular types of blindness and low vision services. The hypothesis is that blindness rehabilitation services do reduce accidental falls in the elderly and consequential health costs are reduced. Similarly, greater independence (both physical, sensory and mental) reduces the need for funded, supported or residential care. Given the age structure of Blind Foundation clients there are considerable cost offsets possible. Contracts could be targeted to pick up risk groups where those conditions apply.

Other SSI areas include increasing support for clients to retain and gain employment and increasing educational support for people who are blind or have low vision. In some cases, higher employment and higher remuneration rates when blind people

and those with low vision are employed can have a very direct cost reduction impact on benefit expenditure.

We also note a recent interest in public investment potential of technological aides to manage sensory loss in the elderly. For the vision impaired this includes forms of optical and digital technology. The flow on economic benefits as a result of sustained independence the aides provide range though many areas of current public spending on health and welfare services. The issue for the Blind Foundation us that a significant part of the cost is in the training of the client to use the new aide effectively. There is a case for more rigorous evaluation of new technology and funding for the purchase and training.[8] We note two significant pieces of research using Social Return on Investment methods. Those are:

- CNIB Newfoundland and Labrador office, Social Return on Investment (SROI) Pilot Project, September, 2012 (Canadian National Institute of the Blind)
- Boyce, T (2011) Falls - costs, numbers and links with visual impairment., Royal National Institute of the Blind UK (RNIB)

The Blind Foundation is in contact with these researchers and proposes to use similar methods to estimate direct investment related savings in New Zealand. This work will be completed in the next 18 months. We plan to invite the participation of government stakeholders to ensure the work is soundly based and can be utilised within any new purchasing frameworks. The Productivity Commission would be welcome to take a role in this work as the methods have broad applicability to the wider social sector.

We are also examining how well or otherwise the law for disabled people works and what remedial measures might be needed to address market failure in the external environment. There is interest in the Martin Prosperity Institute's report on Releasing Constraints[9] which projects the economic impact of achieving higher levels of accessibility on individuals, markets and social units. Currently we are exploring options to commission a similar economic modelling study for New Zealand.

Q11 What other international examples of innovative approaches to social service commissioning and provision are worth examining to draw lessons for New Zealand?

We are interested in understanding more about how an investment approach would benefit clients requiring sensory services within the disability sector. However we are aware that there needs to a broad understanding of the internal and external barriers that create market failure in this sector which requires government policy

[8] JAMA November 5, 2014 Volume 312, Number 17

[9] http://martinprosperity.org/?s=releasing+constraints

intervention. Our sister organisations, the Canada National Institute of the Blind, the RNIB in the UK and Vision Australia are willing to partner with us on an international study to draw lessons about service commissioning and provision in relation to low vision rehabilitation services.

Q12 What are the barriers to learning from international experience in social services commissioning? What are the barriers and risks in applying the lessons in New Zealand?

New Zealand's population is small but spread over a large geographic area. The Treaty of Waitangi introduces considerations that are unique to New Zealand. These two factors make it risky to compare international experience and still come out with valid results for innovative ways to commission services. Although we see opportunities to learn from other nations with indigenous populations and extrapolating from those experiences too.

Q13 Where and when have attempts to integrate services been successful or unsuccessful? Why?

The Blind Foundation is an example of successful service integration. We have:

- A set of related services built around our knowledge of the proven needs of people who are blind or have low vision.
- Services that are designed to match life stages and transitional stages.
- A case managed and assessment based approach that allows the client to transition between services as their needs change.
- No funding barriers or silos for most (all) services.
- A near uniform availability of services nationally.
- Active relationships between referrers in the health sector and other related service providers.

The Blind Foundation service model has evolved over time but always based on the personalised needs of the individual and we are able to provide this integrated service by:

- Concentrating on its specialised client group.
- Being able to integrate its funding streams.
- By having well defined boundaries with other agencies who supply similar or related services.

Q14 What needs to happen for further attempts at service integration to be credible with providers?

In the larger context of New Zealand health and disability services the client pathway is complex and transition from treatment to rehabilitation services can be a problem. Not all clients are referred appropriately or referred at all. Improvements to information flows and processes could offer clients better services and continuity of care in a more timely way. This requires mechanisms to encourage agency collaboration. In some areas the Blind Foundation, by being at the end of the referral chain, is able to initiate information sharing and process changes but rehabilitation is sometimes overlooked in the overall service mix. The Blind Foundation does not see the integrative issues as requiring any restructure of agencies or contractual relationships. But central purchasers could do more to facilitate communications and process change.

Q15 Which social services are best suited to client directed budgets? What would be the benefit of client directed budgets over existing models of service delivery? What steps would move the service in this direction?

The Blind Foundation has reviewed a number of client directed budget options being trialled by Ministries of Social Development and Health. Our observation is that individual funding options best apply where:

- There is a market for the provision of service that allows the client some degree of choice.
- The client has sufficient understanding of their needs and information about the available services.
- The need for the service is over an extended period (justifies the set up and administrative costs).
- The services are generic and possibly are not specialised.
- Accounting and accountability methods to the funder are simple and transparent.

Q16 Which social services do not lend themselves to client directed budgets? What risks do client directed budgets create? How could these risks be managed?

- Specialised services from a single supplier.
- Services where need is episodic.

- Public good type services that do not have a client per se, the Blind Foundation role in public advocacy are a case in point.
- Where the individual end user client has little detailed information on their needs or the opportunities for services.

Individualised funding aims to provide a degree of choice to the client that empowers the client and applies some contestable discipline to the provider. The Blind Foundation's specialisation and the thinly spread nature of the services does not offer the client a choice of supplier, the assessment process used does enable an individualised service to be planned with the client and delivered to meet their specific needs. The Blind Foundation does not explicitly budget its resource per client but is able to flexibly use its funds effectively to achieve outcomes without exposing government to financial risk.

Q17 What examples are there of contract specifications that make culturally appropriate delivery easy or more difficult?

N/A

Q18 How could the views of clients and their families be better included in the design and delivery of social services?

The Blind Foundation's client engagement policy is based on the organisation being client led. We use regular client surveys and maintain local committee structures (40 locations throughout NZ). These enable a two way flow of information regarding client satisfaction and service needs. Survey sampling and focus groups are used for investigating issues and proposals as required including input into business and strategic planning. Each year the CEO and executive team meet with clients and voting members in all of the major centres and many of our provincial offices to seek their feedback on the services and listen to suggestions for improvements.

We are also a member of the Blind Consumer Forum of Aotearoa NZ which is a vehicle for progressing improvements across the blindness sector and supports capability building and leadership, collaboration and innovation.

The Blind Foundation makes widespread use of social media as well as traditional communications to stay in touch with its clients and stakeholders.

Q19 Are there examples of service delivery decisions that are best made locally? Or centrally? What are the consequences of not making decisions at the appropriate level?

As a national organisation with a very distributed workforce and client base the Blind Foundation has to proactively manage tensions between the need for centralised

decision making and flexibility at a local level. This is achieved through management delegation and the use of regular processes that pool knowledge and encourage collaborative decision making. Policy and resource allocation decisions are made centrally. Within those limitations local staff are able to flexibly manage client services. Staff have ready access to escalation channels where normal policy is insufficient. For instance, most decisions about clients and services supplied are dealt with through regional service managers. Where there are unusual conditions the decisions are made centrally bearing in mind the overall implications for equitable service provision and consistent policy.

Q20 Are there examples where government contracts restrict the ability of social service providers to innovate? Or where contracts that are too specific result in poor outcomes for clients?

Traditional output volume based contracts do tend to lock resources into place and it is difficult to change during the course of a contract that might be up to three years. Currently the Blind Foundation is working with its major funder, the Ministry of Health, to revise the contract and reporting structure to focus on the outcomes for clients. This project is within the larger initiative dealing with streamlining government procurement.

Q21 How can the benefits of flexible service delivery be achieved without undermining government accountability?

Accountability and flexibility are not necessarily opposed and government does have the ability to write flexibility into contracts were it has high trust in its provider and where service performance and financial risks are better understood and managed. Improved information systems and more sophisticated analysis enable agencies and funders better and timelier insight. The move toward outcome based contracts is encouraging but there is a timing discrepancy between accountability for resources and outputs over a short term and the evaluation of programme outcomes over a long term. These are mutually reinforcing but should not be confused.

Fragmenting provision to very local levels and the use of intermediary agencies for managing payments such as those used for individualised and enhanced individualised funding will generally mean additional administrative overhead that could create significant financial and reputational risk for government. Managing those risks will add cost to the overall social service programme.

Q22 What is the experience of providers and purchasing agencies with high-trust contracts? Under what circumstances are more relational contracts most likely to be successful or unsuccessful? Why?

Successful relational contracts can occur where:

- A long term stable relationship where there is consistent and personal contact between the two parties.
- Where the relationship managers are empowered to modify and adjust the contact or how it works.
- Where the two parties have mutually agreed individualised service specifications.
- Where the contract is financially realistic for both parties.

Some of these characteristics are not possible where the contracts are fragmented and the purchaser has to deal with a large number of providers en-masse.

Q23 Do Crown entities and non-government commissioning agencies have more flexibility to design and manage contracts that work better for all parties? Are there examples of where devolved commissioning has led to better outcomes?

Some of our staff have worked in social services purchase and commissioning roles for central departments and evolved purchasers (Regional Health Authorities and District Health Boards). In general, both central government and devolved agencies have similar risks to manage and policy frameworks within which to work. The relative closeness of the central agency purchasers to policy units in Ministries can facilitate innovations and at times enable access to contingency funding where Ministers have discretion. On the other hand, the devolved purchase agency has similar opportunities but innovations have less chance of being widely promulgated and can produce an uneven provision of service across regions. In general the proliferation of purchasers and providers increases the administrative overhead costs.

Q24 Are there examples of where government agencies are too dependent on particular providers? Are there examples of providers being too dependent on government funding? Does this dependency cause problems? What measures could reduce dependency?

The Blind Foundation is the major supplier of vision rehabilitation services in New Zealand. It does apply charitable funding to pay for some of these services. Our core services rely substantially on government contract funding. No other agency offers the same range of integrated services or has the capital investment or intellectual property to be able to effectively compete with the Blind Foundation on a major scale at this time.

While this has the appearance of a near monopoly, there are a number of areas where competition could and has occurred. For instance digital technology has enabled an international market for accessible format material such as braille. While the Blind Foundation is the monopoly supplier to the Ministry of Education/ BLENNZ the contract is regularly tendered internationally and we understand it has been contested. Also competition exists in particular sub specialities and locations. For instance BLENNZ chose to employ its own specialist Orientation and Mobility Instructors and there are private practice vision rehabilitation specialists in at least one major centre. District Health Boards generally provide a complementary service to the Blind Foundation but in some areas (Auckland, Wellington and Christchurch) the DHB does provide a low vision service that in some circumstances competes with the Blind Foundation. Other disability agencies have a very competitive role in providing accessibility advice to building developers, transport operators and others.

Other vision rehabilitation services have been set up in past but have not survived. The Blind Foundation is aware of its monopoly status and takes that responsibility very seriously, being well aware that an unbundling of the current contract is feasible if the current arrangements fail.

The corresponding situation is that the Blind Foundation could not deliver the services it does without government funding and there is no other third party funding source such as insurance. The demographic serviced by the Blind Foundation is typically low income with a benefit dependence rate of greater than 90%. There is little probability of the service becoming fully self-funding.

Where there is a monopoly relationship with government both parties must cultivate the relationship and exchange good information on requirements and performance and be open and agile to innovation.

Q25 What are the opportunities for and barriers to using information technology and data to improve the efficiency and effectiveness of social service delivery?

Contract performance reporting is dependent on computer based information and analysis. This will continue to be the case but opens up the possibility of reporting on outcomes rather than outputs. This will enable the purchaser to make more informed decisions based on making a real and programmed difference for the client and community.

The investment in information systems is significant as there are is little economy of scale possible and the software for specialised use has to be configured at high cost.

Q26 What factors should determine whether the government provides a service directly or uses non-government providers? What existing services might be better provided by adopting a different approach?

The Blind Foundation came into existence in 1895 when government did not play a major role in social services and philanthropy was the only source of funding. The Blind Foundation role has changed over time. We have relinquished roles where government has chosen to be the provider directly. Education for blind children is a case in point. In other respects the Foundation has had the specialist knowledge and infrastructure so that government has never faced the situation of having to establish a new service. Also the Foundation has continued to utilise charitable funding sources (including its own investment income). The Blind Foundation subsidizes the price government pays for low vision rehabilitation services.

From government's point of view they are able to obtain a specialist service without having to make any capital investment or carry the employment and other financial risks that ownership entails.

Q27 Which social services have improved as a result of contestability?

We have not observed any improvements through contestable processes. There were some contestable arrangements between the Ministry of Education, the Blind Foundation and one other small independent provider in the past but the arrangement failed when the independent provider was unable to consistently deliver the required services.

Q28 What are the characteristics of social services where contestability is most beneficial or detrimental to service provision?

Contestability has benefits where:

- Market is sufficient size to sustain multiple providers over a long period
- The market ideally has more than one independent purchaser
- The market has relatively low barriers to entry (exit)
- Low levels of information asymmetry between buyers (clients/commissioners) and sellers (providers)

Contestability is less relevant where:

- The market is limited by its nature e.g. a low incidence disability such as blindness
- The services are specialised and demand is episodic
- High levels of information asymmetry that require a regulated and professional provider
- Barriers to entry are significant due to the capital and/or intellectual property investment

The nature of blindness and low vision is that it is an often isolating experience requiring clients to learn a whole new set of life skills in completely foreign territory. The complexity of multiple service provider contestability has the potential to create additional hardship and frustration. This is true even for those living in urban centres. They are isolated not by geography but by diminished opportunity to access the landscape.

While the Blind Foundation lobby strongly and often for accessible environments, information and communication and for increased access to employment, there is a skill set required to be able to take advantage of the range of services for blind people and those with low vision, especially services and information accessed via the internet. People who have vision loss need to have a level of specialised skill and experience that other organisations have not been able to supply to date. Where service providers may wish to offer contested services, the Blind Foundation would still most likely need to be involved in providing specialist advice. This is especially the case in relation to adaptive technology and technical skills training for people with vision loss. Whether or not that creates complexity where simplicity is required is something for careful consideration.

The psychology of clients is also an important consideration. The time when clients decide upon services is frequently in the early days of meeting Blind Foundation

criteria which is stringent enough that the sight loss is severe at this point. Sight loss is a traumatic event and often a deeply emotional, life altering time. Whether clients want to have choice during this time is debateable. In many cases it is more likely that clients and families would choose to be pointed to experts who can offer assessment, services and counselling in a single package rather than shopping around.

Fragmented services provision, that is to say differing services offered by multiple providers, would be detrimental to clients of the Blind Foundation. The partnership in this case is a lifetime journey. In the first instance it involves counselling and adaptive living skills. As clients become ready to reengage in ways that they used to, the Blind Foundation offers services in the way of employment accommodations and support, education transition services and sport and recreation among others. Fragmenting these services would create chasms in the relationship that could require significant backtracking and services duplication.

The Blind Foundation is the foremost advocate for blindness and low vision. Clients know that their interests are represented beyond their personal needs. Clients who are sold services by alternative providers may not feel part of that 'voice'. The Blind Foundation agrees with the sentiment that whoever provides a service is as important to the client as the service itself.

In our experience service provision to smaller communities is a challenge that can only be met by an organisation large enough and well enough established to have the infrastructure that extends the service out from centres to outlying regions. Being able to move around in the community and travel is a major issue for people who are blind or have low vision and especially for older people with sight loss. Expectations of clients to travel to access alternative providers may serve to create inequality for some and complexity in service provision for all.

Q29 For which services in which parts of New Zealand is the scope for contestability limited by low population density?

The Blind Foundation is committed to providing services in all possible locations and is able to monitor its service levels in detail at a local level. Our brief experience in working with other providers is that they were not able or willing to meet the costs of servicing a small scattered client group.

For services to people who are blind or have low vision, scope for contestability is limited in all but the major urban centres. A third of individuals who experience blindness or low vision live in small or rural communities. Their opportunity for reaching services outside of their communities is inadequate. Having multiple service providers delivering services to smaller communities is likely to be uneconomical. Much of this outreaching type work is largely subsidised by the Blind Foundation from the charitable dollar for that very reason.

Q30 Is there evidence that contestability is leading to worse outcomes by working against cooperation?

For services provided to people who are blind or have low vision partnerships must occur behind the scenes and be led by a single provider to ensure that clients are not faced with conflict of choice but rather clear professional services facilitated with ease by a clear provider.

Some opportunities for collaboration between providers exist but these are limited by the expertise available.

Q31 What measures would reduce the cost to service providers of participating in contestable processes?

The Blind Foundation supports MBIEs contract streamlining approach. By focusing more in the pre-contractual stage we see the possibility of the more effective processes especially where there are few or no competitive suppliers in the market. The purchaser can assess the market without having all potential suppliers complete a full proposal.

Larger providers often have longer track records, more expertise and due to their size, have workable results-driven delivery processes. This should not be viewed negatively. The focus should be on the best provision of services not providing opportunities for as many organisations as possible to tender. A possibility might be to enable larger organisations to be able to subcontract to smaller local groups.

It is important for central purchasers/decision makers to understand the needs of clients requiring services ‘where they live’.

Q32 What additional information could tender processes use that would improve the quality of government purchasing decisions?

Outcome based programme evaluations that measure the expected and intended benefits of the investment should be the basis of purchasing decisions. Both purchaser and supplier need to be involved in setting these measurement systems and procedures. The Results Based Accountability (RBA) programme we working with the Ministry of Health on designing will demonstrate how effective programmes are in the long term while meeting the Public Finance Act requirements for output efficiency in the short term.

The actual information requirements are tailored to the particular service. The most important feature is the conceptual shift to measuring what has made a long term difference to people's lives rather just than short term financial and volume measures.

The RBA approach asks how many people were served and in what way and how is success defined and shown. The Blind Foundation agrees that short contract terms create unnecessary bureaucracy and waste. The social services landscape does not change that fast and it would be more economical to have longer term contracts awarded.

Q33 What changes to commissioning and contracting could encourage improved services and outcomes where contestability is not currently delivering such improvements?

Commissioning and contracting should take into account the benefits of an uncontested organisation's ability to outsource for efficiency where appropriate. That is to say where a service is offered in the community that might provide one aspect of services efficiently, it may be more economical for the uncontested organisation to receive funds directly to facilitate the outsourcing of a particular service, where that service would be more efficient, in terms of cost and resource. In this way, the experts can ensure that there is no disruption to service while facilitating the efforts of smaller, less specialised providers.

Q34 For what services is it most important to provide a relatively seamless transition for clients between providers?

There are significant efficiencies gained through specialisation within a single organisation. Unbundling of services and distribution to different suppliers would create a stop start process that would disadvantage the client. There are times when transitioning clients to other providers is the best course of action for the client. This is particularly true for a trusted provider of specialised services who is meeting the needs of a particularly vulnerable group. By the time our clients get to a point where it is possible to transition to another provider they have completed the adaptive living and counselling processes. It is at this point that they might choose alternative sports, social, or advocacy providers or even some ongoing care services. We do this for our clients through Blind Foundation facilitation. For example if a person has a pastime that they would like to resume, once their mobility and adaptive living skills are mastered, the Blind Foundation will attempt to integrate the client back into their mainstream activities.

Q35 Are there examples where the transition to a new provider was not well handled? What were the main factors that contributed to the poor handover?

N/A

Q36 what are the most important benefits of provider diversity? For which services is provider diversity greatest or most limited? What are the implications for the quality and effectiveness of services?

Blind Foundation services provide some basic and general tools to enable blind people and people with low vision to live independently. The client may then choose to use those learned skills to obtain additional services from other providers. .

Q37 How well do government agencies take account of the decision-making processes of different cultures when working with providers?

Consultation is of fundamental value. This question makes an excellent point but should not be limited to cultural considerations. The physical limitations of blindness and low vision mean that engaging and consulting with services presents unique challenges. There is no point consulting in inaccessible ways. If the culture of disability is used as the example then the answer to the question, “How well do governing agencies take account"…is, inconsistently and sporadically. In other words cultural decision making processes and requirements are considered sometimes, in some places, but not all the time everywhere.

Q38 Do government agencies engage with the appropriate people when they are commissioning a service?

We would expect the Ministries responsible for purchasing services for the blind and low vision population to have the expert knowledge about the requirements for this population. If additional input was required that input would be sought from client advocacy bodies and clients themselves to inform purchasing decisions. The Blind Foundation can and does act as both service provider and expert advisor from time to time. We are able to separate out our provider role from our policy advisory role. We have skilled staff who are experienced former senior public sector officials and health service managers who understand all aspects of the government’s requirements in social sector procurement.

The answer to this would be to improve provider capability and resource for availability. This can be achieved by ensuring that those who are tasked to provide the specialist, or culturally appropriate, service are sufficiently resourced to provide the advantages of the larger pool within their own networks, i.e. through partnerships and facilitations.

Q39 Are commissioning agencies making the best choices between working with providers specialising in services to particular groups or specifying cultural competence as a general contractual requirement?

Where possible, partnership is ideal in this situation. The Blind Foundation can serve as the exemplar in this area. We provide a specialist service that it would not be appropriate or successful if a non–specialised cultural group were to supply. New Zealand's population means that it is likely that this is true for all cultural groups providing services – there aren't sufficient numbers in any one cultural group to have the resource, expertise and experience to provide a highly specialised service. There may be the rare exceptions but it is unlikely these can be sustained over time in an effective and efficient way. Instead, partnerships are an excellent model.

The Blind Foundation offers the necessary resource, expertise and experience to all clients and where clients are Māori or Pacific people, we also partner with the services of Ngāti Kāpo to provide cultural support and relationship management services. This scenario may be a win/win setting for commissioning agencies who can enlist the specialist provider for the service who in turn enlists cultural specialists to help define the service and manage the relationships.

Q40 How well do commissioning processes take account of the Treaty of Waitangi? Are there examples of agencies doing this well (or not so well)?

N/A

Q41 Which types of services have outcomes that are practical to observe and can be reliably attributed to the service?

There are four clear areas of importance to us where outcomes can be measured; orientation and mobility, rehabilitation and support services, counselling and support, adaptive daily living, and quality of life. Outcomes are the only truly reliable measures that matter for clients, and in establishing return on investment, and value to the wider population.

Q42 Are there examples of outcome based contracts? How successful have these been?

We don't have an outcomes based contracts but we are currently working with the Ministry of Health to develop in this direction.

Q43 What is the best way to specify, measure and manage the performance of services where outcomes are not easy to observe or to attribute?

Where outcomes are not clear cut, results based outcomes are best and we find it is more effective to negotiate directly with providers who understand what success should be for the client.

Q44 Do government agencies and service providers collect the data required to make informed judgements about the effectiveness of programmes? How could data collection and analysis be improved?

Much data is collected but often of the wrong sort and it is not able to be analysed in a useful and confident way by the purchaser. Often the right data is not collected. Data is critical to inform judgement on purchasing services. The Blind Foundation supplies data to government that we do not use for our own management purposes.

Data collection and analysis often requires funding and expertise unavailable to service providers. Where there are multiple agencies meeting similar needs it is possible to collaborate so that the resource burden is minimised. We would like to work with agencies to test new models of data collection and analysis techniques including mega data analyses. Sampling the blind and low vision population provides a useful window into how effective and efficient social sector service provision is for the disabled population.

Q45 What have been the benefits of government initiatives to streamline purchasing processes across agencies? Where could government make further improvements?

With regard to streamlining government purchases, at present different departments require different information creating redundancies and inefficiencies. Integrated contracting would be a big improvement on this. Ideally ACC, MSD and MoH would get together and create consistency of questions, quality measure and Outcome contracts based on RBA. The focus should be on measuring quality in addition to the Public Finance Act requirements for efficiency based reporting. Examples of these are measuring the return on investment such as savings through diminished uptake of rest home requirements, medical interventions etc.

Q46 Is there sufficient learning within the social services system? Is the information gathered reliable and correctly interpreted? Are the resulting changes timely and appropriate?

We cannot comment about the social services sector in general apart from observing that programmes are often not effectively evaluated and are designed in ways that make evaluation difficult. We don't have a lot evidence of how purchasing decisions are being informed by evaluation studies.

Q47 Does the commissioning and purchasing system encourage bottom-up experimentation? Does the system reinforce successful approaches and encourage reform of less successful ones?

To be able to experiment organisations need to have funds set aside for this type of activity. When delivering contracted services it can be difficult to provide outcomes in the early stages of demonstrating new approaches and testing the impacts. Examples of the Blind Foundation's innovations have been in providing support for Low Vision clinics in DHBs and a user-pays service known as Vision Solutions. The results indicated that significantly more investment from the charitable dollar would have been required to enable the services to become business-as-usual. There was also a limited market for the services; at the price we could supply them.

Q48 Would an investment approach to social services spending lead to a better allocation of resources and better social outcomes? What are the current data gaps in taking such an approach? How might these be addressed?

See the answer to Q 10

It is not possible to apply an investment approach to all purchasing because a full social return on investment (SROI) requires economic data that many social services cannot provide in a reliable and consistent way. Conventional but rigorous programme evaluation can effectively substitute for SROI based evaluation. However, there are some proven economic relationships between types of rehabilitation interventions and reducing costs in other sectors.

Our answer to Q 10 indicates some possible avenues.

Q49 How can data be more effectively used in the development of social service programmes? What types of services would benefit most?

Outcomes measured in terms of population benefit based on data provide the assurance that services (offered through programmes) are working toward the betterment of the whole community. Regular data acquisition from rest homes, hospitals, social groups, hospitals, etcetera, can inform outcomes. For example, Blind Foundation rehabilitation can significantly reduce the incidence of accidents for our clients. This can be measured through ACC data and hospital reports. This is a way in which data collection could make reporting simpler and more efficient from a service provider perspective, as well as a government perspective. The flip side of this is greater efficiency in defining client need. For example if there was a trend in increasing rest home numbers for clients who are blind or have low vision, then this issue might be assessed to determine the nature of the problem and decide on best solution to reduce costs. One of the options to weigh up might be the cost and benefit of a new or additional service to enable older people who are blind or have low vision to remain living in their family home compared to the cost of more residential care provision.

Q50 What are the benefits, costs and risks associated with using data to inform the development of social service programmes? How could the risks be managed?

This is an important consideration and needs to be tailored to different parts of the social services sector. The use of more sophisticated data analysis is critical to ensuring a productive social services sector. The decades of work that has gone into the development of the national health information structure is a case in point. The establishing of a consistent and reliable minimum health dataset is the basis on which health information can be used with some confidence. A similar long term strategy for the disability and wider social services sector is needed. This will require a commitment from central government to invest in and support.

Q51 How do the organisational culture and leadership of government agencies affect the adoption of improved ways of commissioning and contracting? In what service areas is the impact of culture and leadership most evident?

MSD showed leadership in with the Social Sector Trials and the Enabling Good Lives Demonstrations in Christchurch and Waikato. This type of leadership is what is required in developing social innovation in social services. There should a willingness to develop public-private partnerships to increase innovation.

Government has indicated a willingness to take some risks and experiment with new models of service delivery, but more could be done to work with the social sector providers.

Q52 how do the organisational culture and leadership of providers affect the adoption of improved ways of supplying services? In what service areas is the impact of culture and leadership most evident?

We have an ongoing commitment to improvement and using evidence to inform changes in service delivery. There is an inherent tension between delivering business-as-usual and exploring new ideas and testing them. This requires an organisation to develop a culture of innovation and to be willing to risk some of its capital to invest in innovation for the future. This can be very difficult for smaller enterprises.

Q53 What institutional arrangements or organisational features help or hinder the uptake and success of innovative approaches to service delivery?

N/A

Q54 Have recent amendments to the Public Finance Act 1989 made it easier to coordinate across government agencies? Are there any examples where they have helped to deliver better social services? What further measures could be effective?

We have seen some improvements. MSD will now accept audits and documentation produced for other Ministries as part of their provider assessment and approval process. In the Results Based Accountability programme we have yet to see any significant commitment to it from other agencies who have related contract relationships to the Blind Foundation such as ACC and DHBs. We understand that this is on resourcing available to participating organisations. The streamlining of basic contract documentation and organisational reporting (e.g. financial disclosure) will offer small savings in time to providers. However we do not see any major benefits at this stage as each Ministry will still maintain the responsibility for its purchases within the new documentation and process structure. The reporting requirements and the management of service specifications are likely to remain at least at the same level of detail that is currently required.

Q55 Are there important issues for the effective commissioning and contracting of social services that will be missed because of the Commission's selection of case studies?

The disability case study would benefit from including sensory loss as well as other disabling conditions to the work of individualised funding and enabling good lives.

Q56 Are you willing to meet with the Commission? Can you suggest other interested parties with whom the Commission should consult?

We would appreciate an opportunity to discuss our submission with the Commission. Next year will be our 125th anniversary as a charitable social service provider. While we have a long history in delivering essential blindness services, we are also a very contemporary and agile in our approach. We believe that we can contribute t value to this inquiry and look forward to contributing further when the time comes.

Appendix One

Clientele

Our services cater to people at the more severe to moderate end of the vision loss continuum - those with loss greater than 6/24 with corrective lenses or assessed as having severe functional vision loss. We have the ability to extend access to our services to an individual who does not meet the criteria but is deemed at risk, based on a functional assessment.

The Blind Foundation has approximately 11,700 clients who range in age from less than 12 months of age to more than a century. The age banding of the clientele is very much biased towards the older age groups, with 66% of clients above the age of 65.

In the younger age groups the gender balance is mostly equal, but in the older groups females predominate. Given the age structure there is a high mortality rate of clients and turnover is usually around 11% per year.

The ethnic composition of clients is weighted towards European New Zealanders (79% versus 74% in the general population). This is partly reflective of the age structure, but Māori (7%) and Pacific Islands people (4%) representation is less than the proportion in the population at large of 15% and 7% respectively. Asian clients represent 2% versus 12% in the national population.

Clients are distributed throughout the country; the broad distribution is:

- Auckland and Northland - 31%
- Wellington - 27%
- Christchurch and upper South Island -18%
- Central North Island - 16%
- Dunedin/Southland - 8%

The Blind Foundation has major facilities in all of the main centres and smaller services bases in 15 other provincial centres.

Operating Expenditure

The Blind Foundation typically spends about $30 million a year. The distribution of its expenditure in FY13 was:

- Supporting independent living - 51%
- Supporting access to information - 21%
- Fundraising costs - 14%

- Teaching technology skills - 4%
- Quality and communications - 3%
- Property costs - 3%
- Grants to special interest groups (such as Blind Citizens New Zealand) - 2%
- Finance costs - 1%
- Governance - 1%

The budgeted cost (inc GST) for the current financial year for the Blind Foundation Client Services portfolio is $12.419m. Government contract revenue in relation to these services is $6.55m; the balance comes from charitable donations and the Blind Foundation's investment income.

In total the Blind Foundation receives $9.6m (inc GST) in government contracts which amounts to 28% of its expenditure on all services.

Staffing

The Blind Foundation employs on average 275 full time equivalent staff. Of these, approximately 120 are employed in rehabilitation and support functions.

Client Interaction

The typical interaction profile with clients is an initial period of heavy interaction with rehabilitation staff immediately and during the first six months of being a client. This tails off as the client achieves a level of independence and security. The benefit of this client approach is that as people go through transitional phases and/or their condition deteriorates, they are able to access services as needed and there is continuity of support. Naturally this varies from case to case.

In any one month Blind Foundation Vision Rehabilitation staff will see around 12% of the total client base, and in any one year will have direct contact with about 40% of the Blind Foundation's client base.

The Blind Foundation Model of Care

The Blind Foundation's Client Services Vision Rehabilitation model of care encompasses a full continuum of vision rehabilitative and support services, available over a lifetime, extending from the client's home to a national network of Blind Foundation centres, and to regional support groups and residential and day programmes.

The programmes delivered cover functional and vision related needs evaluation, skill acquisition, psychosocial adjustment as well as community integration and

placement. These are provided via the following services broadly identified as Access and Engagement, and Service Delivery.

Access and Engagement

Access

Empowers potential clients, families and whanau to make informed choices using up to date, relevant information about the range of services and service providers related to blindness and vision impairment in their area

Intake

Assesses eligibility, confirms registration and sets up client systems and triggers engagement work

Engagement

Provides the welcome, support and empowerment to clients, family and whanau that form the basis of the remainder of the client journey. Clients are valued and respected and their needs acknowledged.

Alliances are built with other community services, settings and networks.

Referrals and placements are made for clients to other providers.

Provides feedback to quality systems.

Assessment and analysis

Ensures all clients have ongoing, systematic and appropriately defined assessment which provides a range of data to inform programme planning, funding, service delivery pulls and decision making.

Assessments provide an accurate and comprehensive picture of the client and their progress as it relates to service provision.

Assists clients to identify and prioritise their vision related needs and in setting achievable goals.

Access and Engagement teams:

- Child and Family Social Workers

- Adult Vision Rehabilitation Needs Assessors
- Pacific Services
- Deafblind Services
- Information Services

Service Delivery

Spontaneous Immediate Service

Immediate responses to an urgent client need to manage a risk. Service response is reported retrospectively.

Quality Individualised Specialist and Speciality Services and Support

Programme planning

Ensures the client has a current, documented, individual client service plan that focuses on sight loss and contains meaningful outcomes and promotes achievement.

Service providers contribute to and support the client's individual programme across settings.

Implementation

Ensures clients have regularly monitored individual programmes that are implemented and that are motivating and meaningful.

Service providers contribute to and support the implementation of programmes across settings as stated in the agreed plan.

Review

Ensures that clients have client service plans that are current and relevant.

Ensures that closure processes are positive.

There may be a return to the assessment and planning phases as new goals are set or the programme is modified.

Member Active Review

Surveillance of client needs at predetermined times to sustain service gains, capture emerging needs, and maintain client engagement.

Goal Attainment Evaluation

Evaluation of client goals occurs following completion of service delivery.

Service delivery team

- Vision Rehabilitation
- Adaptive Communications and Technology Services (ACATS) (Technology training and specialised communications skills such as braille)
- Recreation
- Counsellors
- Developmental Adaptive Daily Living and Orientation and Mobility
- Employment
- In addition to vision rehabilitation, the Blind Foundation provides support services:
- Accessibility and Awareness Education
- Vision Equipment Supply
- Volunteer Support
- Library Services
- Client led community groups
- Accessible information services and Accessible Format Production

Eligibility for Registration with the Blind Foundation

New Zealand residents are eligible for registration with the Blind Foundation if in the opinion of a registered ophthalmologist or optometrist, they have best corrected visual acuity of 6/24 or worse in the better eye, or the residual visual field is generally no greater than 20 degrees.

Children and young adults must also have a referral from an ophthalmologist or optometrist. All children and young adults (21 years of age and under) who are currently registered with Visual Resource Centres, regardless of their degree of vision loss, may apply to become a Blind Foundation client.

In addition, a small number of people are registered as Chief Executive Approved Extraordinary members. This judgment is based on a functional vision assessment.

Other Foundation Services

Volunteers

Volunteers provide support across all Foundation services and activities.

We currently have over 1500 volunteers who regularly give their time. These numbers swell to around 13,500 when volunteers assist with the two Blind Foundation national annual appeals.

The volunteers provide support in four main areas of work:

- One-to-one support for members.
- Support for group activities.
- Involvement through a community committee or member support group.
- Support to the organisation behind the scenes.

Volunteers undertake a myriad of tasks on the Foundations behalf. They provide one-on-one vision support to clients for various tasks in their everyday lives such as providing assistance at home, or driving them to an appointment or shopping.

The teams also operate some of the local and national services such as the Telephone Information Service (TIS), which provides audio recorded local information and news to clients via the telephone.

Behind the scenes, volunteers work to support our very popular talking book service, support Blind Foundation Guide Dogs and provide specialist skills to assist the organisation.

Equipment

The Foundation offers a range of vision related products through our online equipment shop.

We also hold equipment display days which are open to members and the public. The days provide an opportunity to learn about different items, try some of them and place orders. Staff are on hand to demonstrate items, answer questions and provide advice on pricing.

Information and Advice

The Foundation provides a free information and advice service to our clients, their families and the general public.

There is a dedicated team available to answer any questions that New Zealanders have about blindness, the Blind Foundation and our services. This team is often the first point of contact for people recently diagnosed as being blind or having low vision, as well as their families.

The Information and Advice team receives over 5,000 queries by telephone and email per year.

The service is available 8.30am to 5:00pm every week day. (0800 24 33 33)

Library Services

We have two libraries that cater to our clients across the country. The Blind Foundation Library provides library services for adults, and the BLINK Library (Blind and Low Vision Information Network for Kids) provides library services for children and young adults.

Blind Foundation Library

The Blind Foundation Library, which is located at the Blind Foundation's head office in Auckland, provides library services to our adult clients from all over New Zealand.

The Library has approximately 9,000 DAISY audio books, 4,500 braille books, 40 different audio magazines and a growing collection of accessible electronic texts (e-texts). As patrons are unable to "browse the shelves" book selection is managed by an automated process based on the patron's preferences. The predominant format is audio and the audio books are supplied to members on CDs that are burnt to order and posted to each user as required. The library carries a substantial stock of braille and hard copy items and other digital formats.

The library circulates approximately 30,000 catalogued items to 4,300 library users and has a circulation volume of about 700,000 items in all formats each year. In any one month about 24% of the members actively use the library and in any one year nearly 40% of members will have some contact with the library service.

BLINK Library

The BLINK Library (formerly known as Homai Special Formats Library) is located at the Blind and Low Vision Education Network of New Zealand (BLENNZ) campus in Auckland. It provides library services for children and young adults. Borrowers use the Library for material that supports the school curriculum or just to enjoy leisure reading.

The team is available to answer questions, provide advice and assist with requests for material in accessible formats that may not be available in the Library.

Accessible Format Production

A key service for Blind Foundation clients is the production of accessible format material such as braille, e-text, large print, and other specialised information formats.

The Blind Foundation provides much of the classroom material used by the Ministry of Education as well as meeting a variety of vocational and recreational information needs for its adult members. Between three and four thousand items are produced each year for about 350 end users. In most cases accessible format production items have to meet strict deadlines and to comply with contractual requirements and professional standards.

Current Government Contracts

Ministry of Health (Disability Support Group)

- Value $5.077m per year (+GST)
- Term 3 years (expires 30 March 2016)

The contract is for vision rehabilitation services and covers nine specified individual service lines. The total price for the contract is a single bulk sum for all nine service lines

The performance reporting requirements are volume based outputs for each service line segmented for regional locations age group and ethnicity of the clients. Reporting data is volume of direct hours, numbers of clients on "waitlists" and total clients and new clients seen on the reporting period. The reporting is 3 monthly. The quarter report also requires exception reporting of incident or risk situations, a narrative report dealing with specific projects, quality parameters, new innovations and interaction with other stakeholders.

Ministry of Social Development

- Value $2.214m (+GST)
- Term 2 years (expires 30 June 2015)

The contract covers Employment Support, Transition (students leaving school) and Audio Books Distribution. Each of the three service lines is priced and reported separately. In all cases reporting is output based dealing with volumes of clients, hours of client contact and volumes of transactions. Quarterly narrative reports note quality matters, risks and sector activity.

The transition service is priced on a standard list of charges for transition stages completed by the student. There is no set budget but eligibility for the programme is limited and preapproved by MSD.

Ministry of Education

- Value $1.055m (+GST)
- Term 3 years (expires 30 March 2015)

Total Value including GST $9.6m

The contract covers the provision of accessible formats material for schools (braille, large text, and electronic texts and derivative formats and media). Also the contract covers the provision of a library service (students only) for BLENNZ. Reporting is mainly volume based and includes delivery timing targets and quality measures. The contract price is by volume.