From: contact@sira.nsw.gov.au
To: consultation
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Online Submission Form

Thank you for your submission on this consultation.
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Consultation feedback

In the current landscape are there aspects of the WC or CTP schemes that should be extended to the other scheme to optimise WR service provision?:	The cooperation and support of the employer is critical in obtaining a RTW outcome for any employee, this is imbedded within the Workers Compensation (WC) scheme by virtue of the employer being respons ble for the premium and having direct financial and legal obligations to participate in the RTW process. The CTP scheme however has less direct benefit to the employer and supporting an employee to RTW is perceived as a cost and demand on resources. In the CTP scheme, the employer is also often concerned about potential risks and future workers compensation ramifications. Incentivising employer participation in the CTP scheme with a meaningful financial benefit for employers such as a positive impact on workers compensation premiums or other state based levies (as an example) for participating and supporting recovery at work would be beneficial. Incentives offered for returning an employee or for assisting through a work trial or employment of a person with an injury should be consistent across both schemes to avoid confusion and promote participation. Consistency in SIRA incentives will improve the outcomes obtained by workplace rehab providers and ultimately improve the outcome for the injured person and their employer resulting in improved commercial, social and health outcomes across both schemes. Consideration should also be given to reducing the paper-work component of the SIRA incentives. Employer feedback on SIRA CTP incentives is that the monetary value and paperwork required do not offset the costs of supporting an employee to recover at work. The WC scheme allows for ongoing assessment of capacity through independent treating doctors, medical evidence obtained and at the point the claimant reaches pre injury earning capacity they can be exited from the scheme, irrespective as to whether they have achieved a return to full function (except in the case of workers with the highest needs). The CTP scheme only allows for 6 months of defined benefits (weekly earnings, treatment and vocational support) for those at fault or deemed 'minor injury' which is a far shorter recovery time. In the CTP scheme; the need to demonstrate that an injury is more than minor may focus claimants on 'disability' and 'injury'. Bringing the WC and CTP schemes more into line will assist, where independent assessors can identify an extension to treatment after the 6 months if there is evidence, will further increase function and capacity based on gains made. Most injuries should recover within 6 months if appropriate treatment, workplace intervention and addressing biopsychosocial flags occurs. Evidence supports that early engagement of workplace rehabilitation will expedite recovery timeframes and achieve positive RTW outcomes. The CTP scheme has a focus on return to pre-accident function across all activities of daily living. Collaborative goals are set with the injured person based around what they want to achieve (relative to their injury and loss of function) and whole of life goals. The WC scheme has a stronger focus on return to work and earning capacity, rather than an emphasis on lifestyle, health and social outcomes. The option to focus on wholistic and meaningful goals within the CTP scheme facilitates recovery and customer centric service where higher levels of satisfaction can be achieved.

	Work and earning capacity form a part of the goals for an injured person participating in the workforce prior to their accident, however the focus on work and earning capacity in the WC scheme can cause the injured worker to feel that the scheme is only about getting the person back to work rather than returning to previous function. The WC scheme could adopt a more wholistic approach to recovery by also measuring return to function goals around activities outside the workplace and provide treatment support to achieve these goals. CTP would benefit from having more definition around what recovery goals will look like in each area of function. WC would benefit from adding these areas to their measurement of recovery and outcomes achieved. Rehab Providers are in a prime position to assist in setting return to function goals, we have demonstrated capability to develop and achieve RTW goals through consultation and support and can also adapt this measured, goal focussed approach to 'functional goals'. Goals should be set around the pre injury functional areas (both physical and psychological): • Productivity (work or meaningful activity such as volunteering), this can also include family and social respons bility • Self care • Leisure • Rest and sleep • Social participation The WC scheme is highly prescriptive in the services a WR Provider can provide and encourages a tunnel vision approach to rehabilitation rather than a whole of person recovery. WR Providers are unable to set goals or promote treatment that is not directly linked to a RTW goal and there is no incentive or reward to do this. The CTP scheme allows providers to develop a broad variety of meaningful goals. These 2 schemes would benefit from being brought more into a consistent framework of measuring functional levels and goals and broadening the scope of services that can be provided under WC.
Do we have the breadth of WR services, interventions and supports required for optimal recovery and RTW outcomes for injured people in NSW?:	In relation to the workers compensation scheme, No. SIRA has approved 7 services that WRP's are approved to complete: • Vocational Assessment • Workplace Assessment • Functional Assessment • Assessment and development of a SIRA Vocational Program • Assessment and development of a Job seeking strategy development • RTW same employer • RTW new employer The highly prescriptive services that can be provided by WPR's within the Workers Comp Scheme (WC) limits the ability of Providers to set goals or promote treatment that is not directly linked to a RTW goal and there is no incentive or reward to do this. The CTP scheme allows providers to develop a broad variety of meaningful goals where it can be demonstrated that it is 'reasonable and necessary' in promoting recovery. While the prescribed workers compensation services cater to most workers, there are many workers who require support with their recovery to facilitate a return to work whereby the above listed services do not meet their needs. For example workers that present with complex injuries that are not ready to RTW in the short term but require additional support to manage treatment, address and continuously re-assess biopsychosocial flags whilst they are off work. Evidence shows that barriers to returning to work compound the longer the person is off work. Limiting WR service provision to only addressing immediate RTW (or penalising WRs due to long duration cases) leaves many workers and employers in a situation where they are unable to adequately support the worker in their recovery. Given providers have an allied health skill set, continuity of care and addressing the whole person (more effectively than is currently prescribed) would l kely help to build greater rapport, focus on recovery and return to function, which itself can often help to drive more effective outcomes. In the event that an immediate RTW goal is not able to be established, there should still be an opportunity of the WRP to provide services to assist with the co-ordination of treatment, assist with the commencement of goal setting around non-vocational (and where appropriate vocational goals) etc. Worksafe Victoria has recently introduced a service called Recovery Support Service whereby it has been effective in achieving some of these things which in turn has improved the l kelihood and subsequent RTW outcome as well as improving life satisfaction. There is a gap with services noted across the board and opportunities to approve further standalone services that focus on psychosocial assessment, health and wellbeing, counselling and resilience counselling. This is based on the biopsychosocial approach WRPs employ to assist a claimant with the return to work/life goals. If these services could compliment the RTW service then it is believed that better outcomes can be achieved. Currently the following disciplines meet SIRA's minimum requirements to provide WR services; Occupational Therapist, Physiotherapists, Psychologists, Rehabilitation Counsellor, Exercise Physiologists (with accreditation) and Registered Nurses (with additional qualifications). If other disciplines could be accredited under the scheme, similar to other jurisdictions like Victoria's where you can employ Chiropractors, osteo's, paramedics and podiatrist then potentially there is a much broader array of services that could be provided.
What would be the best approach to building capability in WR service provision?:	• Expand on Disciplines / professions who are able to perform workplace rehabilitation under the WC scheme • Currently there are a limited number of disciplines who meet SIRA's minimum requirements to provide workplace rehabilitation services. This limits the capacity of the industry to recruit according to need and capability limiting the ability to match discipline to injury type and best meet a workers needs. Expanding the professions who can complete physical and psychological workplace assessments and RTW services would serve to improve the calibre of service. Worksafe Victoria conditions of approval now allow the following disciplines to complete WR services; Chirporactors, Optomotrists, Podiatrists, Osteopaths, Podiatrists and Paramedics. The WC scheme is highly prescriptive in who is able to service with organisational accreditation required. CTP does not have the same prescription of providers. The ability to prescr be who can provide services is helpful in managing cost and outcomes and promoting a consistency of services which is beneficial, however the tight control of which allied health disciplines can participate can limit the availability of suitability qualified workforces to support the worker's recovery. CTP would benefit from a stronger regulation of providers, and WC would benefit from extending the disciplines that can provide WR services to better match and support workers unique needs. • A consistent induction plan provided by SIRA (DVA does something like this currently) and demonstration of key learning areas for all providers in the scheme would be of benefit. This would more than likely benefit smaller providers given their less mature learning and development structures, however would benefit all. • It also believed that performance orientated remuneration, public recognition of performance etc. would further help to incentivise providers to perform and in turn improve capability. • SIRA funded Professional Development / Standardised SIRA training (on top of the induction modules above) • Quality of NTDs and quality review of AHHRs. If there were incentives for medical professionals to participate in case conferences or greater prescription by the AMA as to who can complete medical certificates and the duties they were obligated to partake in, then this would likely build a more collaborative and effective relationship between treating health professionals and WRP, which in turn improves capability to effectively complete the job. • Reward and recognition on individual, team and

	organisation performance – whether it be through a star rating system, remuneration (similar to claims agents), this in turn should help to drive organisational performance • Accessibility to Performance reporting • More frequent and great visibility of scheme performance, provider performance, comparative data as against our competitor etc. Visual management and the availability of performance data (in addition to what we can pull) is a known driver that correlates with performance. It is preferrable where possible that this is in real time or provided as frequently that is reasonable i.e. monthly/quarterly.
How do we support WR service provision to achieve optimal outcomes?:	From the perspective of Workplace Rehabilitation, an optimal outcome is often defined as a positive, safe, and sustainable return to work and life for the worker and employer. Incentivised payments to WR providers for achieving positive outcomes on complex claims (which have been categorised accordingly) would greatly assist WR to achieve positive outcomes. It would allow adequate resourcing to be placed into claims where extra assistance is required and ensure that workers are appropriately managed. An updated remuneration model which takes into consideration performance would also ensure that high performing WR providers are rewarded appropriately. As currently constructed, the status codes also do not accurately measure a worker's return to life/function (non RTW goals) which is a factor in predicting sustainability of a return to work outcome as well as the social and health outcomes of the scheme. To support WR service provision to achieve optimal outcomes in respect to their return to life, it is suggested that key performance indicators for outcomes are extended to include non-return to work goals (return to life) goals. This will ensure that WR is not disincentivised to assist workers who may not be appropriate for return to work, but still require assistance from WR with the long term goal still being focused on return to work. To ensure that these non-return to work goals are met, it is also imperative that the breadth of services are increased to allow for innovative services tailored to these goals. Investment in WR specific grants will also further assist to incentivise positive behaviours and boost industry performance. The current status codes also seemingly penalise WR providers who manage claims referred by the insurer for the purpose of obtaining information for work capacity decisions, where the purpose of referral is unrelated to RTW. We are also penalised if we are a high performing provider and referred more complex claims. Currently there is no standardisation of performance data to ensure that performance is reflected more accurately, helps to drive internal motivation. Performance metrics of both insurers and WR providers are currently not aligned. Alignment of outcomes and incentives across the scheme will ensure a unified approach to meeting the needs of both schemes. It is also believed that providing greater access bility to training resources will help uplift capability. More frequent industry forums will also help to promote greater collaboration with the regulator and its WRP's including sharing industry insight in a verbal sense would also of benefit.
How do we promote best practice and continued innovation in WR service provision in NSW?:	Promotion of Best Practice: We believe that best practice improvements would be derived from via the following: • Implement a whole-person approach to claims management in workers compensation as is seen more often in CTP. For example, a 'return to life' perspective on rehab and other stakeholder involvement - work is part of this picture but not the whole focus. A whole-person approach to people on workers compensation will support not just the identification of psychosocial barriers (which is commonly completed now) but also include the ability to deliver interventions and services to address these barriers (which currently there is minimal scope to offer these services in the current SIRA framework). • Reduce delays to accessing treatment – there are currently multiple roadblocks and delays experienced by the injured person in accessing treatment, sometimes this is due to lack of understanding of the claimant, lack of clarity from an insurer but also commonly due to lack of access to a treater. • Greater consistency, application and accessibility to WRP services pre-liability would help align with early intervention best practice principles • SIRA could increase focus on assisting, educating and uplifting capability of health providers working in the compensable systems: o Review process for NTD's and Allied Health Providers to ensure they are providing appropriate service i.e. treatment decisions are evidenced based, plans are established around functional goals o Increase education around determining capacity to treatment providers o Increase education about Health Benefits of Good Work to treatment providers o Identify ways to promote and engage treaters in wanting to work with compensable clients – ie. increased rates, reducing red tape, promoting the scheme's positive outcomes via case studies More specifically, we believe the management and outcomes for psychological injury claims could be improved through: • Increase fee rates for treatment providers and provide non-attendance fees to encourage better quality and more providers to provide treatment to people on WC/CTP claims. • Higher rates for WRP for psychological claims given the cost of employment is greater for fully registered/clinical psychologists • Ensuring claims are referred as early as poss ble to workplace rehabilitation, commonly they will be referred to rehab when the relationship with the employer has already broken down whereas our earlier involvement would have likely avoided this outcome • Improved education and support to employers on understanding psychological injuries and how to ensure psychological safety in their workplaces (mandatory training on Bullying and Harassment and clear policies/outcomes for people who engage in such behaviour) • Increased understanding for all stakeholders on capacity (i.e. it is not black and white), impacts of diagnosed condition on function, importance of engagement with the workplace • Acknowledgement that the gap functionally between being off work and at work for an injured person with a psychological injury can be significant and we often need to focus on an intermediate step around building work-related activity and work readiness to facilitate a return to structure and routine / improve confidence and/or ability to cope with interpersonal communication (e.g. this could be activity scheduling, volunteering, work trials) prior to commencing on a return to work plan. • Reintroduce an initial assessment/needs assessment phase for psychological injury – it is not appropriate in some cases to start with a workplace assessment or vocational assessment - however these individuals need clear support mechanisms put in place to prepare them for the return to work journey. Promotion of Innovation: We believe there are multiple steps that can be taken to improve innovation in the workers compensation and motor accident frameworks in NSW including: • Flexibility in service offering – ability to deliver the right services at the right time which we know from the evidence base will support the individual in achieving a return to life and a return to work is important. Currently the WC workplace rehab scope is tightly limited to a small selection of services however the individual's we work with present with multiple complexities (i.e. industrial issues, substance misuse, co-morbid conditions, physical and psychological health concerns). Insurers also often are a gatekeeper in regards to approval of services and some are focused on cost containment or have an anti-workplace rehabilitation sentiment and will not approve delivery of recommended services •

	Incentivise innovation in the workers comp schemes similar to the REM models utilised for insurers • Improve innovation service coding and provide a formalised process for accessing innovation/pilot program code approvals – currently the implementation of pilot programs and innovative services is hampered by unclear guidelines on how to seek approvals, which billing codes should be utilised and also limited access to appropriate non-OR billing codes • Embracing SIRA innovation grants or creating an innovation fund – provision of grant fund rounds specifically for workplace rehabilitation providers to develop novel programs, pilot programs or conduct research and development activities would be welcomed. SIRA has shown leadership in providing a Recovery@Work Mentally Healthy workplaces directed grant however specific grant funding targeting workplace rehabilitation would support providers in improving services and finding solutions • Consistently promote and embrace the innovation message across the schemes – currently there is minimal promotion or discussion around innovation in the workers compensation segment and certainly not in relation to the management of the workplace rehabilitation providers. It would be good to see a greater focus on innovation such as benchmarking WRP performance in this space and providing rewards and incentives for the providers who are leading the way in this area.
How do we most effectively measure outcomes associated with WR?:	In the CTP scheme there is currently no consistent measurement of outcome. Across each panel, performance is measured differently (whilst ultimately still based on goal achievement from a recovery, optimal function and RTW perspective). Given the CTP scheme drivers for recovery and RTW these 3 areas are important, however, standardised measures in the CTP scheme that can be applied and measured accurately and consistently would improve the effectiveness of measuring outcomes for WPR's. The WC scheme could adopt a more wholistic approach to recovery by also measuring return to function goals around activities outside the workplace and provide treatment support to achieve these goals. Rehab Providers are in a prime position to assist in setting return to function goals, we have demonstrated capacity to develop and achieve RTW goals through consultation and support and can also adapt this measured, goal focussed approach to 'functional goals'. Goals should be set around the pre injury functional areas (both physical and psychological). Performance metrics of both insurers and WR providers are currently not aligned. Alignment of outcomes and incentives across the key stakeholders of each scheme will ensure a unified approach to meeting the needs of both schemes.
How can we drive value – as articulated in the SIRA Health Outcomes Framework - for WR in NSW personal injury schemes?:	Value based care focusses on four main aims being: • Health outcomes that matter to those receiving care • Experiences of receiving care • Experiences of providing care • Effectiveness and efficiency of care WR in NSW is currently driven primarily by value as defined by controlled cost, timeframes and outcome measures which all relate to the success of the individual retuning to meaningful work. Whilst there is an element of customer experience within the scheme, the ability for WR to capture this combined with the lack of information provided by the nominal insurer, makes this difficult. However customer experience data helps to drive WR to equally balance cost effective RTW outcomes with customer experience. The current funding models allow for prescriptive interventions controlled by the agent provided by specific approved providers. For Rehab Providers these models promote a focus on a prescriptive goal. They strongly drive participation by both the participant and the employer in achieving an outcome, however the claimant can be disappointed in the outcome where they achieve a RTW but still have significant gaps in achievement of their personal recovery goals. Therefore providing greater clarity and focus on achieving wholistic recovery goals during the course of a RTW program will more than likely assist in achieving most of the aims within the Health Outcome Framework. Within the personal injury CTP scheme there is more scope to set goals that are meaningful to the participant in re-engaging in pre-accident activities that can include work, leisure and personal care. Measurement of the outcomes becomes more complex and provision of services more dependent on the providers ability to identify clear goals and articulate a clear plan of service. There is a larger scope for services provided and no specific approval of providers, hence less ability to manage poor performance. The requirement of participation by participants and employers is increasing in the scheme, however is not as clear as in the WR scheme. A balance between these models is required to promote an outcome focussed model that engages claimants in setting and achieving measurable goals within a cost effective framework. All service providers need to be approved by the scheme to ensure that their quality and outcomes can be measured and that services are meaningful and working toward the agreed goal. Early engagement in the goal setting process will also allow for more positive outcomes before increased psychosocial barriers prevent effective intervention. Value based care at its heart needs to be customer centric. For Rehab Providers the 'customer' can be seen as those providing work and payment and is largely from agents and employers. This needs to continue where Rehab Providers are providing value for money and measurable outcomes. The key customer however is the person receiving care or the claimant within the scheme. With an injury or illness they are often thrust into a system that is confusing whilst navigating a complex medical system and conflicting advice and options from both within and outside the system. The key focus to assist the customer to work through this is clear and early communication and goal setting that promotes overall wellness and wellbeing by participants in the system delivered by services who focus on delivery of these outcomes, rather than focussing on payments and incentives. Return to work needs to remain a strong outcome measure across both schemes, however value by the claimant will also be measured by injury recovery and reengagement in all daily activities or a satisfying achievement of new life goals and activities. For those providing care there needs to be clear value and reward in achieving the given goal. For Rehab Providers the current funding arrangements allows for an hourly rate to be changed, regardless of the service or outcome. This is important as without the steady flow of income providers would be unable to employ and train suitability qualified health professionals to provide positive outcomes. The inherent risk is where providers may over service or have less focus on the outcome where 'revenue' or 'hours' become the primary driver. This is moderated by the need to gain approval from the payer and justify the need for expenses and through this process Rehab Providers need to justify the effectiveness of their spending. Value can be driven by rewarding the positive outcomes that the scheme seeks to achieve. There needs to remain a steady income for Rehab Providers in order to ensure that they can employ the most appropriate staff, however further focus on reward and recognition for Rehab providers could include incentive payments for specific outcomes, more regular and consistent statistical reporting that can allow referrers to compare similar products and refer appropriately and the opportunity for Rehab Providers to see where they sit within the scheme and work to achieve improvements. There can be public recognition annually of top performers with an

	incentive payment offered and public acknowledgement. The risk is that Rehab Providers will decline more complex cases or those in regional and remote areas which are higher in cost due to availability of health care, availability of staff to manage these effectively and the need to be 'expert at everything'. For more complex cases experienced staff are required, who also require higher salaries and rewards to remain in the scheme. Providers in regional areas also have difficulty attracting and recruiting experienced staff which can increase cost in these areas or limit services, these staff also cant be experts in all injury types and will need further support. To address this these referrals need to be weighted to provide advantage if there is a successful outcome. With appropriate reward and recognition focussing on the desired outcomes and satisfaction in service delivery and retention of experienced staff within the industry. There is also opportunity with a better data recording.
What elements does a policy framework need to drive quality, innovation and outcomes in WR in NSW?:	• An overarching statement of what is desired to be achieved, underpinned by the principles, values and purpose. • Broad objectives which explain the goals and value proposition • Strategies to achieve each of the objectives • Clear governance and consistent application of policies • Transparent measurement processes • Closing feedback and continuous improvement procedure.
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