



Department of Social Services
**A draft service delivery model for a new integrated carer
support system**

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ATTRIBUTION

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ABOUT ACSA

Aged & Community Services Australia (ACSA) is the leading national peak body for aged and community care providers. It represents church, charitable and community-based organisations providing housing, residential care, community care and home support services to older people, younger people with a disability and their carers. ACSA members provide care and support in metropolitan, regional, rural and remote regions across Australia.

Mission-based and other not-for-profit aged care organisations are responsible for providing services to those older Australians who are most in need. As at 30 June 2016 not-for-profit organisations delivered about 56 percent of residential aged care services and 82 percent of home care packages in Australia.¹

These organisations are visible and highly accessible in the community and as a result, the public relies on them for service, support and care. The broad scope of services provided by ACSA's membership and the leadership they display gives it unique insights into the challenges and opportunities that come with the ageing of the population.

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¹ '2015-16 Report on the Operation of the *Aged Care Act 1997*, Department of Health; pages 31 and 45

DEPARTMENT OF SOCIAL SERVICES: A DRAFT SERVICE DELIVERY MODEL FOR A NEW INTEGRATED CARER SUPPORT SYSTEM

INTRODUCTION

ACSA supports the development of an integrated model for the delivery of carer support services and the four objectives of the proposed model.

Essential considerations in the development and implementation of the proposed model include:

- ensuring there is no reduction in the current amount, and quality, of support available to carers. Carers are worried the proposed model will result in the removal of face-to-face opportunities they have at present leading to loss of wellbeing. Costings for the model need to be made available so this can be transparently assessed.
- considering what carers and caring means for Aboriginal communities at each level of the model including applicable local support services and the implementation of these supports.
- ongoing availability of respite given it is essential carers have access to planned respite that is focussed on the carer.
- not alienating carers from accessing services. The model should not put too much emphasis on technology in what should be a human service. Yes carers need support that is easy to find, that they can access when and how it suits their circumstances, but the answer is not always a website or a call centre. Real support located in the communities where carers live and provided by people with skills, experience and passion for supporting carers is most important.

ACSA's submission expands on these key considerations with comments against relevant sections of the discussion paper.

Section 2 – Overview of the draft service delivery model (pages 7-11 of the discussion paper)

ACSA supports the development of an integrated model for the delivery of carer support services.

Service access

However given concerns about unmet needs of carers under the NDIS, there is concern carers may not actually be able to access supports they need. Anglicare Sydney's December 2016 report *Carers: Doing it Tough, Doing it Well*² raises areas of concern under the NDIS including a possible lack of respite programs and a lack of support in general for carers. Susan King, Anglicare Advocacy and Research Manager said:

'..... a lot of carers were struggling to navigate the system. We know that a lot of carers will really struggle trying ... being on the internet (and) some of them find their caring role is very stressful and they actually don't have time to be spending heaps of hours on the gateway trying to get the information and support services that they need'.³

Technology

A strong focus on technology may alienate carers and prove a disincentive from accessing services. This means, for example, that introduction of 'online channels for service delivery to make services more accessible at a time and place of the carers choosing' (page 7) is problematic for:

² https://www.anglicare.org.au/sites/default/files/Carers_Report_Digital.pdf

³ <http://www.abc.net.au/news/2016-12-05/carers-needs-not-being-met-under-ndis-anglicare-report-says/8091352>

1. Older carers who do not use the internet.
2. Carers in rural and remote areas where there is no, limited or intermittent internet access.
3. Carers with low or no literacy, including English literacy.

As one small, rural respite provider said *'using apps is likely to go beyond the ability of many older carers, some do not even own a tablet/ipad/mobile phone, let alone know how to use apps...most older people prefer face-to-face support'*.

Critical local support

There is concern the proposed model will result in a reduction in the amount of and quality of support available to some carers if the model leads to the loss of local support and community connections/ownership. Carers are worried this will result in the removal of face-to-face opportunities they have at present leading to loss of self-esteem, loss of wellness and increased isolation. Reducing/removing opportunities to meet face-to-face will reduce the number of carers seeking help and in turn increase the number of care recipients or carers themselves entering the more costly aged or health systems earlier.

Carers are concerned that larger government services are difficult to deal with, time consuming and impersonal (for example don't understand rural community living). Using a local carer support person as they are the experts in using the existing system, identifying what is available to solve their problems and getting them the information they need saves time and stress.

This means the new system needs to have a local focus to:

- ensure carers continue to get the services they need; and
- support involvement of volunteers to provide support to carers.

Without volunteers, there will be an increase in costs to staff the supports needed by carers. If there is no local focus in the model it will reduce the likelihood of the community donating their time and money. If existing relationships and infrastructure are lost, the new system will be more costly right from the start.

The draft service delivery model is heavily reliant on carers phoning for information, advice and support. Carers report many examples of the difficulties of getting services via a telephone. Their experiences with Centrelink, NDIS and My Aged Care etc. have shown them that they cannot present their case well over the phone and the waiting time creates tension in the home as the care recipient gets impatient with them or suspicious of what they are doing. Carers like local centres as they are face-to-face allowing for quick responses and far greater capacity to explain their situation.

The draft service delivery model is also confusing in places. For example in the row 'at a national level' for 7.2 Coaching and mentoring, there are activities which are to be undertaken at a regional or local level.

Aged care interface

The discussion paper talks about 'leveraging existing community care relationships and infrastructure' (page 9). It will be important the interface between the carer support system and the aged care system works smoothly. With My Aged Care being the gateway to aged care services expectations of each program need to be clear and carers must not to be bounced between the two due to inaccurate information or expectations. This is particularly important to ensure carers are able to access regular, planned respite.

Service providers have reported that since the introduction of screening through My Aged Care and Regional Assessment Services conducting assessments for access to Commonwealth Home Support Program, there has been a considerable drop in the number of referrals for respite.

It is important the separation of responsibility for the carer support system and the aged care system both at a policy level and at an operational level doesn't lead to unnecessary hurdles or obstacles for carers to receive the support they need.

Regional hubs

So far there has been no indication of where the regional hubs will be and their coverage. These details are needed to understand how the model can work in practice; in particular how the regional hubs will affect the delivery of services. In determining the establishment of regional hubs consideration should include:

1. How the regional hubs will work best in different geographic and demographic areas with the understanding that one model will not fit all situations.
2. Rural and remote regions and the challenges for carers to access services.
3. The risk of regional hubs being too large and not having local knowledge and networks (respite providers have told us that carers tend to use smaller services with whom they have developed relationships).
4. Utilising structures already in place (for example Aged Care Assessment Teams; Regional Assessment Services) and linking with systems currently used. As and where necessary a further breakdown to local hubs would mean better service delivery.

Opportunities to access support and information through regional hubs will need to be actively promoted.

Financial support

The trial of targeted financial support will need to define the target group and be flexible enough to cover different carer groups across metropolitan, regional, rural and remote areas.

Section 3 – program overview (pages 12-15 of the discussion paper)

Discussion questions in paper:

- In relation to the program overview, do you believe that the objectives, outcomes and delivery principles are appropriate for the services required to be delivered under each program? Do you believe that the services proposed to be delivered at the national, regional and local level are targeted appropriately?
- A key factor in the effectiveness of regional hubs will rely upon their ability to understand the local service landscape and identify service gaps. If you were operating a regional hub, how would you undertake service mapping for your region? How would you ensure that you had captured a complete view of the available supports for carers in your region?

ACSA response to section 3:

As noted earlier there are concerns that a strong focus on technology may further alienate some carers and be a disincentive from accessing services.

It will be important that opportunities to access support and information through regional hubs is actively promoted.

There is also concern that small providers at local levels will not have the resources (staff; expertise; income) to implement services. The size of the region may limit the ability of regional hubs to do this well and to maintain the necessary relationships across the region to be effective. A key factor in the effectiveness of regional hubs will rely upon their ability to understand the local service landscape and identify services gaps. The division of activities between the regional hubs and local areas will be critical to ensuring that carer supports are delivered at the right level at the right time.

ACSA suggests service mapping would need to be a comprehensive process and involve a variety of organisations including Primary Health Networks, Carers Advocacy Groups and established community networks including Aboriginal and special needs communities.

Section 4 – detailed service descriptions (pages 15-25 of the discussion paper)

Assessment

ACSA supports the proposed option for face-to-face assessment and planning for those carers not easily able to communicate either online or the phone.

Respite

There are concerns with the proposed approach for respite. The concerns centre on a carers ability to care if they do not have easy access to planned respite. It is important that planned respite focussed on the carer is available over respite that happens because the person being cared for attends a social event, service etc. (respite effect).

The model assumes that planned respite will remain unchanged in the future (footnote 3, page 15) and continue to be funded outside the carer programs delivered by the Department of Social Services. There is a risk that planned respite will fall between the three systems – My Aged Care, NDIS and the carer support system.

Linking short term respite (page 24) (for attendance at activities such as education, peer support or coaching) with emergency respite (needed within 24 hours) risks needs in one area being overtaken by the other. The needs of carers looking for these services can be quite different – one can be planned the other not yet the differences are not currently recognised in the program overview.

Feedback received from small rural respite providers is that accessing planned respite through My Aged Care is a barrier for older carers of the frail-aged. In addition there is some misunderstanding about fee-for-service coupled with a reticence to pay for planned respite which may be leading to a reduction in requests for respite.

Awareness and community linkages

ACSA suggests that medical specialists be added to the list on page 17 of the primary channels for awareness and community linkages.

Centrelink could also be contacted by carers particularly for financial issues relating to people becoming carers, accommodation bonds and aged care payments.

A good example of raising awareness is the work done with schools that gets the message to young carers.

End of life support

The importance of organising end-of-life plans, enduring guardianship and powers of attorneys needs to be stressed so that carers are part of conversations with doctors and specialists and are not excluded from the conversation.

Section 5 – about how carers might experience the model (pages 26-28 of the discussion paper)

Discussion questions in paper:

- It has been identified that outcomes measurement will be essential for a future model. Outcomes measurement involves identifying how effective services are in achieving a

particular objective. This commonly takes the form of a questionnaire which helps to assess aspects of the carer's role. However, there will be a careful balance in measuring outcomes, whilst not placing undue burden on a carer to answer multiple questionnaires, particularly where they may be accessing more than one service. What are some ways that outcomes could be measured and these issues addressed?

- While this model will seek to help more carers, it will be important to ensure that quality services are being delivered. What would you view as the essential components of a future quality framework?

ACSA response to section 5:

ACSA suggests that outcomes should focus on the carer continuing in their caring role while maintaining good health and being able to access the supports they need from within their community.

It is important that outcome measures are able to demonstrate changes over-time, including longer term results that are clearly linked to the intervention(s). Carers feel that outcomes could be measured by looking at wellbeing, if they are coping, have confidence, in-control, physical health etc. A question they felt would say it all was "How would you feel if this support suddenly disappeared?" The outcome they want is that they are coping and in good health (mental, emotional and physical).

ACSA suggests regional hubs could coordinate the process ensuring carers are asked the minimum number of relevant questions once. Approaches to gathering information should include digital and face-to-face; whichever is easiest for the carer. It should never be forgotten that many carers are older, poorer and in locations where there is limited internet access.

Essential components of a quality framework would include:

1. Benchmark standard of service delivery that can be easily measured.
2. Regular feedback from carers to inform assessment against the benchmark.
3. The benchmark needs to be comprehensive and cover governance, operations and service delivery. Aspects of the benchmark would include: accessible for all groups of carers; approachable, friendly, helpful, empathic and caring staff; accurate information provided; consistent, open response to concerns, complaints or compliments; prompt response times to phone calls, referrals, emails, requests for information; high quality services; training of staff in carer issues, group work, grief and loss, dementia and disability.
4. The benchmark needs to focus on outcomes for each carer including improved physical and mental health; ability to keep caring at home; coping ability; learning skills and strategies for challenging situations.
5. Cultural safety and competency is included as a core competency.
6. A central database attached to an existing portal (Carer Gateway) where service providers can add information on carer support services - with carers consent - and quantitative outcomes can be measured. For example: contact with carer; requested support; uptake; links to programs; entry; exit, re-engagement.

Streamlining quality frameworks should be an aim wherever possible so that providers do not need to undergo multiple assessments against varying standards.

It would also be useful to establish partnerships with organisations with expertise in designing measurement tools (qualitative and quantitative) that are easy to use.

Section 6 – implementing a new model (pages 28-29 of the discussion paper)

Section 7 – next steps (page 30 of the discussion paper)

ACSA has no comments on these sections of the paper.

Section 8 – frequently asked questions (pages 30-34 of the discussion paper)

Why is a regional hub model being proposed? (Page 30)

The model seems to contradict some of the feedback received; the online resources, Carer Gateway, national counselling program and telephone and web-based counselling are exactly the centralised model that many carers said they didn't want.

What sort of teams will the regional hubs have? (Pages 30 and 31)

Additional information is needed as there is concern that both the expected staffing qualification levels (basic qualifications - Certificate III in Disability, Community Care, etc.) and the anticipated number of clinically trained staff at the regional hubs will be too low.

How will this model be funded? Block funding, fee for service, or a combination of both? (Page 31)

While ACSA supports user pays in principle the proposal for a fee for service approach for the National Education Initiative and National Carer Counselling programs will limit take up. Carers often do not have much disposable income and often choose not to spend money on themselves. There would need to be a costing done to see if the funds raised by introducing fee for service are offset by carers not accessing support and ending up relying on other more expensive services. It is important that it doesn't end up resulting in cost shifting between sectors.

It is probably unrealistic to consider anything but block funding for the regional hubs; long term (minimum 5 years) and specific resourcing is essential to maintain service viability and retain experienced staff, and the commissioning framework must also remove any conflict of interest (for example regional hub operators who provide respite or other services).

Other comments

A carer needs as much information as possible from the start so they know what to do and where to go to get the information they need. For example, carers need to be made aware they can get a disability parking permit for the person they are caring for.

Carer centred services such as case management are valuable supports that should be available without having to assess the care recipient first. This will likely be a feature of the Carer Gateway but if Commonwealth Home Support Program doesn't fund these programs for carers will the new carer support system?

In order to better understand the viability and benefits of the proposed carer support system, the Department should provide information about the projected costs to both implement the proposed model and to trial targeted financial support for carers. This work is essential to ensure there will not be a reduction in the amount of and quality of support available to carers compared to what is currently available.