**DELIVERING AN INTEGRATED CARER SUPPORT SERVICE**

**RESPONSE TO THE DRAFT SERVICE DELIVERY MODEL**

**FROM THE VICTORIAN CHSP CARER PROGRAMS NETWORK**

**DECEMBER 2016**

**BACKGROUND**

The Victorian CHSP Carer Programs Network is a state wide network of service providers with CHSP funding to provide respite for carers of older people. Representatives are nominated from each region to attend quarterly meetings. Information and queries from regional networks is raised at the state-wide meeting and responses are disseminated back to the regional networks. Aims of the network are:

* to maintain a clear understanding of the role of CHSP Carer sub-stream and other services within the broader service provision arena and remain informed of developments and issues within this arena.
* to analyse the impact of changes to policy and other changes or developments in the broader service system arena and will advocate on behalf of carer focused service providers and carers to the federal and state government departments and other relevant stakeholders (e.g. Commonwealth Respite and Carelink Centres).
* to provide a forum for regional CHSP & CRCC representatives to meet to advocate on behalf of CHSP Carer Programs service providers to federal government department representatives about issues for respite service providers supporting carers

**RESPONSE**

Objective: The Victorian CHSP Carer Programs Network generally agree with the Primary objectives of the model

Comments:

* Overall a comprehensive plan which covers all areas of carer support and service delivery. Although supported by the Victorian CHSP Carer Programs Network the lack of detail compels us to make comment regarding the objectives and respective mechanisms on how they will be achieved.

**OBJECTIVE:**

Encourage and normalise earlier uptake of services proven to help carers, in their caring journey

* This assumes that carers will self-identify early in their journey that they are in fact in a caring role. Ensuring this happens at an early point in time can be difficult, particularly when caring for someone over the age of 65 years. Often carers of our aged population are family members who do not seek support and assistance until there is a real need – the model assumes that there is a defined point in time where family members will make the transition to recognise themselves in a caring role, rather than fulfilling their commitment to someone they love. Often family members will not identify as a carer until a crisis presents itself, or there has been a significant impact on either the carer or care recipient requiring support – this also is very evident in terms of our Young Carers who often do not want to be ‘labelled’ or identified to be in a caring role.
* The option of online services, although convenient will be limited to providing a resource for those capable of using internet and online resourcing. We have an increasing ageing population, many from rural and remote areas, where internet coverage is poor or knowledge around the use of internet services is limited or inaccessible, the online resourcing will not suit all carer cohorts and those unable to access it will be disadvantaged in terms of flexible accessibility options.
* Through reducing operational and administrative costs there is some assumption that the model considers direct service delivery as the answer to meeting respite needs and that a ‘physical structure or place’ is not valued or necessary for meeting initial carer support. This is further supported with other recent initiatives such as NDIS and CHSP transition, where there is a strong focus on the care recipient and direct services. Many carers often make initial contact needing a high level of emotional and practical support currently received through the carer respite centres. Without a physical local presence, or with the view that the initial referral will be made at a National level, there is concern that carers will not receive or be supported to identify their own needs through this model until a crisis presents. It is recommended and supported that ‘access channels preferred by particular carers are available and the benefits promoted’, however the model fails to provide detail how this will occur at a local level outside of Carer coaching and mentoring.

Deliver a Service Carers Value

* + - Given the recent experience of My Aged Care, there remains some concern regarding the level of knowledge and information that would be required at a National level. The existence of regional hubs, will not ensure that lower qualified staff will understand client need and appropriate service matching to meet the clients need. How will Regional Hubs ensure they have the capacity and ability to fully understand the diversity of each area of the region?
		- The information provided in the model about Regional Hubs and reduction of operational costs indicates there will be fewer Regional Hubs across the nation meaning large geographical areas with greatly differing populations and multitudes of service providers – service matching without local knowledge may compromise positive carer outcomes.
		- In rural and remote areas, we are seeing an ageing, shrinking population – often with limited access to supports. The model considers the delivery to carers that is preferred, however the concern is whether it will be available in terms of outreach to these areas?
		- The model discusses the implementation of carer coaches and mentors, and those with a lived carer experience – whilst the concept may work and be valued by some, in smaller communities this may again not be an option due to local relationships and concerns regarding trust and confidentiality – this issue will also present for other marginalised groups such as ATSI and CALD communities.

Provide a service carers find easy to access and use

* + - With the 3 tier approach the model indicates that carers would need to be referred through from a National level to be able to access supports.
* There is some concern the story and journey may need to be told more than once with limited capacity to provide face to face assessment. Case studies have proven that Carers will often underplay their caring role, particularly when assessment of need is conducted outside of a face to face consultation by experienced staff. Again, access needs to be considered for all carer cohorts and carefully consider those who are regional and remote or where English is not the primary language. Trust also is a concern within the indigenous community as we have seen over time, particularly with mainstream services.
	+ - My Aged Care currently refers clients on the basis of the type of service identified as being appropriate for clients following assessment. In many cases this may limit flexible responses- clients wishing to access respite should be given the opportunity to use one or more flexible respite options to meet their needs and the National Gateway should support generic referrals to respite with decisions about type of respite identified throughout the carer/ client journey.

In Summary:

* There lacks detail in terms of how the objectives will be met under a three tiered approach, currently the CRCC model allows needs identification and local service delivery as an end to end service, fragmenting this process may leave many carers frustrated in terms of sharing their story with more than one point of entry.

**STRUCTURE:**

The Victorian CHSP Carer Programs Network agree with the following aspects of the Structure in terms of

National level:

* + - There is a need for well trained staff that provide consistent, reliable information to carers.
		- Training requirements for assessment staff working with carers was identified in the Working with Carers Co-design workshop held in Canberra in November.

Regional level:

* + - Success will depend on ability of the regional hub to connect with local services in rural, remote and metropolitan areas. The size of the Regional Hub catchment may impact on this ability. There is a need to ensure reliable, specific service information and referrals (note MAC experience)
		- Carer issues can be complex (see attached Case Studies)- the model states that ‘the regional hubs would have staff with basic qualifications (Certificate 3) and a clinically trained staff member to provide a clinical skillset and clinical oversight for carer coaches and other staff within the hub’. Concern has been expressed that staff with base level qualifications would not have the skills to effectively manage more complex issues.
		- Concept of ‘Carer Coaches’ is supported however concern was raised regarding the level of monitoring, vetting, training, supervision and review of efficacy of carer coaches when regional hub staff are primarily Certificate 3 trained. Availability of appropriate carer coaches in regional/ remote or with CALD/ minority cohorts. Some concerns have been noted re confidentiality particularly in small rural communities or within CALD communities
		- Needs assessment and planning done by regional hubs- success of the model is dependent on the number of regional hubs and the size of the region they cover. Face-to-face assessment limited to carers who need assistance to communicate- who will be responsible for this assessment at a local level if the regional hub is far removed?

Local level:

* + - There is a clear need for assessment to be separated from service delivery at the local level.
* The model assumes that CHSP respite services will be available to support the respite needs of carers. With the ongoing aged care reforms and proposed changes to CHSP services in 2018, availability may not be guaranteed. A reduction in block funding may jeopardise centre-based services and there are issues of staff retention and program viability (particularly where there is a perception of uncertainty of ongoing funding).

**PROGRAM OVERVIEW**

The model would be supported by funding of the following four programs:

National Education and Training Initiative;

National Counselling Program;

Regional Hub Program; and

a supporting National Infrastructure Program.

* For all programs, secure ongoing funding needs to be available. Clear delineation of funding should be identified as well as ongoing roles e.g. under Peer Support it is noted that funding for supporting technology is available but no other supports for peer group facilitation (research, funding for infrastructure e.g. lease of rooms/venue, refreshments, stationery) is identified.
* Targeted educational programs are to be delivered by carer support staff at regional hubs and would also be delivered locally. Dependent on the size of the region, local education may only be practical if delivered online which disadvantages older carers or carers with minimal computer skills.

**OUTCOME MEASUREMENTS**

Carer Survey- possible questions to identify outcomes for carers- formal or informal basis:

* Does the carer know how to access support?
* Is the carer satisfied with level of support provided at each level (national, regional, local)?
* Does the carer have an emergency plan in place?
* Does the carer feel supported to make decisions for themselves and/or person they support?

Management of Outcome measurements query:

* How will the outcome / review process be funded and at which of the levels will this be undertaken – that is, National, Regional or local?

**IMPLEMENTATION**

The implementation of the model indicates a short time frame in terms of delivery – consideration needs to be given to educating existing services to assist and support carers to transition under the new model with little to no impact on current carer supports.

Questions put to the broader audience:

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?

* Concern expressed regarding the role of regional hubs in assessment and service delivery: Issues of lack of independence, equity and referral to local providers
* The number and size of regional hubs will impact on provision of appropriate supports to cohorts far removed from physical location of hub.

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[[1]](#footnote-1) for your region? How would you ensure that you had captured a complete view of the available supports for carers in your region?

* Gather data on all services currently funded under CHSP/ DSS and DHHS Vic
* Cross reference with MAC
* Advertise widely for services to self refer into the program
* Collect data from carers- introduction of new valued (by carers) resources
* Identify types of services likely to be accessed by carers
* Codesign- invite carers to share info about services they have found to be beneficial or would like to access.

**QUALITY OUTCOMES**

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?

* Carers need to be included in the design of any new framework, the **Carers Recognition Act (Commonwealth) 2010** principles would be appropriate to consider.
* Quality Framework could be drawn from the Home Care Standards with clear outcomes for carers identified such as:
	+ Access to emergency respite and response times in emergency situations
	+ The availability/ timeliness of Counselling, including assessment of reasonable waiting times.
	+ Reduced documentation/assessment requirements
	+ Access to face-to-face services and supports
	+ Clear carer goals identified, actioned and reviewed.
	+ Framework to accommodate self-assessment and co-design principles.
1. [↑](#footnote-ref-1)