

Carers ACT submission to

Draft Regional Delivery Model for the Integrated Carer Support Service

March 2018

About Carers ACT

Carers ACT supports, connects and empowers the diversity of people living in the ACT and Southern NSW who provide unpaid personal care, support and assistance to family members and friends living with a:

- disability
- chronic health condition
- mental illness or disorder
- drug or alcohol problem
- terminal illness, or
- who are frail aged.

Carers are partners, spouses, parents, children, family, friends and neighbours who provide informal unpaid help with the activities of daily living. Whilst caring is rewarding, it can also bring financial hardship, social isolation, stress and other health and wellbeing issues.

There are around 48,500 unpaid informal carers in the ACT, and they are an integral part of our aged, health and disability systems.

Carers ACT has a constitutional mandate to represent the voices of carers to government and the wider community. We consult regularly with a diverse range of carers and caring families to enable improved understanding of their needs, and better inclusion for them and the people they care for.

Carers ACT also provides advocacy support to Canberra's many Foster and Kinship carers that care for children and young people in out of home care.

Carers ACT provides services under the Commonwealth Respite and Carelink Centres in the ACT and Southern NSW. In addition, Carers ACT provides supports to people who are frail aged and their carers in the ACT through the Commonwealth Home Support Programme. Carers ACT is also funded to provide a range of services to carers through ACT Government funding.

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Carers ACT commends the Department of Social Services for the co-design process that has been undertaken to develop the Integrated Carer Support Service. We thank you for the opportunity to provide feedback on the Draft Regional Delivery Model and look forward to continued collaboration in the implementation of the new model.

Key issues with the approach to structuring the service areas

The significant issue with the approach to the structuring of the service areas is the omission of the Australian Capital Territory (ACT) as a region in its own right. State and Territory boundaries have been upheld in every jurisdiction other than the ACT and this is a fundamental flaw of the structuring of the service areas and will result in unnecessary complexities in the delivery of services that will not be experienced by any other Regional Delivery Partner (RDP). We could not find any evidence that the ACT is not a separate region for any other federally funded programme. The complexities of working across two jurisdictions are significant and force additional overheads to meet varying compliance and legislative differences. In addition not recognising the ACT as separate to NSW diminishes the acknowledgement and value of Carers within the ACT and reduces the engagement of local services, community and local government in the support of Carers within the ACT.

The two proposed areas in the Draft Regional Delivery Model paper would result in the Australian Capital Territory (ACT) being included into an area increased in cohort size from 44,800 carers (ABS Disability, Ageing and Carers, 2015) to either 171,400 carers in option A or 342,800 carers in option B. The ACT is an existing service area and a recognised region and should remain so. In the proposed model the Northern Territory will remain one region with a carer population of 11,500 in recognition of its size but also its distinct characteristics and its designation as a Territory. Likewise the ACT is a designated Territory with its own legislation, regulation and governance and should remain as a distinct region in its own right. To not identify the ACT as a region simply on the basis of the lack of coverage of metro, regional and rural areas is not fair or reasonable.

The Regional Delivery Partners (RDP) draft (pg 11) suggests that 'each service area is approximately the same size' in option B. Tasmania is relatively the same geographical and population size as the ACT and is designated as its own region with an estimated carer population of 84,900. In option B the ACT would be incorporated into a region with a significantly higher geographical and population size with an estimated 342,800 carers. These are not approximately the same size.

The ACT is the only state and territory boundary crossed in the proposed regions. Containing regions within state and territory boundaries is a sensible move as each jurisdiction has its own legal and regulation requirements. Incorporating the ACT into NSW will mean that the RDP provider will have to work across the two jurisdictions and manage issues such as differences in working with vulnerable people checks, differences in programs, differences in regulatory bodies, differences in legislations (for example there is a difference in who is a mandatory reporter in the ACT and in NSW). These factors will undoubtedly affect functionality and efficiency.

One of the fundamental drives for the formation of the Integrated Carer Support Model was the development of a one-stop shop concept for Carers where RDP's could connect and lever local service delivery to ensure that Carer needs could be met through one entry point. There is a significant reliance on local service delivery in the model to ensure connectedness and integration of

services where possible. In the ACT this model is already operational. Having a local service provider focused on the ACT has enabled the service to lever local funding and community donations and sponsorship to create an integrated carer service model. In addition we have utilised our relationships with local service providers to develop and deliver a quality brokerage model for respite services. There is significant concern that incorporation of the ACT into NSW, even under a consortia model, would jeopardise these relationships, including the relationship with the ACT Government, and thus reduce the current level of local service delivery.

Regardless of whether or not the ACT is its own region, we believe that the regions sizes proposed under either option are too large to be effective and efficient whilst also maintaining consistency in service delivery and approach, managing local service mapping, building and sustaining local services in a brokerage model and most importantly building a sense of connection and relationship with local Carers. In reality the operation model of the RDP to a service in a region of the sizes proposed would result in a large number of services provided in metro areas and a once a fortnight visit to regional and remote areas. The areas of Australia that have the lowest capacity to engage with online services will also receive the lowest amount of in person service delivery as well.

Carers ACT current provision of CRCC services is effective and efficient. Increasing the area of service, as well as the increased range of services to be delivered, may well impact the effectiveness of service delivery. It is supposed that option A would incur higher funding costs to establish more RDPs. The purpose of the paper was to identify, 'whether there (currently) are suitably capable organisations with capacity to form consortia to fulfil the role'. The model seeks organisations already in existence and therefore not requiring extensive establishment costs. If no changes to current CRCC areas are made, then establishment costs would be minimal compared to the changes they would need to make to transform into a RDP that could cover the vast areas proposed. What is hoped is that larger RDP's will, 'achieve economies of scale in their service delivery model' the reality of organisations becoming larger is that they become more complex and managing this complexity incurs its own cost which over time risks not being financially viable in the long term (Hindle, 2008).

It is contested that this model would automatically reduce overhead costs due to subcontracting arrangements. This most likely will not be the case as the cost of providing some services in house are often cheaper than brokering them. Brokered services generally incur duplicate overhead costs with both agencies charging management and operational costs.

The boundaries of the proposed regions need to be reviewed. In some cases the boundaries proposed split towns or regions in half and will lead to confusion about who the local provider is and will result in duplication of activities such as local service mapping and planning. The region boundaries do not reflect local area health networks in states such as NSW and this will result also in confusion and duplication between the two providers and place pressure on local services who will need to engage with two RDP providers. In some cases staff from one RDP will need to drive through the town of a second RDP to reach Carers in the regional population which is not an efficient way of delivering services.

Using Statistical Areas to determine the regions may not be the best determination of demographic data for service planning. These regions do not match any other region for service delivery that we could find. They do not match the regions for the Commonwealth Home Support Service, My Aged

Care, NDIS or the Primary Health Networks – all of which contain demographic data more relevant to Carers than labour force data is.

The size of the areas proposed would mean the loss of local knowledge and ‘localness’. For example, Carers ACT has developed a responsive respite booking service based on the ability to gain and use local knowledge. The size of the regions may also jeopardise carers sense of connection with the RDP and reduce their sense of feeling engaged and supported.

Currently a number of CRCCs have been successful in garnering community ownership of Carer issues. In the ACT, we know and involve local carers - such as is evidenced in working with the Capital Health Network to include Carer issues in their needs assessment and in working with the ACT Government to create and fund the ACT Carer Strategy. In the large service areas organisations would lose connection with local Carers and what they need.

The draft mentions wanting to avoid services cherry picking which is laudable, but this model would force a cookie cutting approach. Thereby providing a standardised indistinguishable service model despite the different needs and stressors of carers in the various areas. Canberra is a different cohort to other regions with inherently different needs. A one size fits all approach will miss individual need, the opportunity to be creative, capture local input, and therefore local buy-in. It would also limit the innovation and creativity implied through an integrated approach to carer supports. Currently Carers ACT is able to lever local and federal funding to provide a comprehensive and integrated range of supports under a ‘one stop shop’ approach. Incorporating ACT into NSW and having regions the size proposed in the discussion paper will severely limit this. Local funding will become diversified amongst different organisations to the RDP and the ability to continue to provide an integrated one stop service will become limited.

Capacity and capability of organisations to establish and manage a regional presence throughout a large service area, including the ability to lead a consortia-based model, and undertake service area planning.

Under the proposed model, it is feared that the RDP would no longer be a local service for local people. This would be particularly relevant to the ACT where it is likely that the main office of the RDP would be located in NSW with a minimal staff presence in the ACT. A consortia model may work in regions that exist in one state or territory jurisdiction however we believe this model will not work across jurisdictions.

Consortia models are often presented as a way to increase geographical coverage, lower establishment and operational costs and share skills and resources. In practice however, consortia models tend to be resource intensive to establish and maintain, are often not sustainable and are generally filled with tension. The costs that might be saved through a consortium are often surpassed by the costs and resources needed to maintain the relationships within the consortia.

Whilst a consortia model may overcome issues of local service delivery in regions the size proposed in the model, they are often not an efficient use of resourcing. Business Queensland identifies that:

To ensure consistency and quality, a consortium will usually require more resource-intensive management while developing the tender and delivering the contract.

The cost and risks of consortia models are identified internationally across numerous sectors including business, hospitality and social services. In the UK, Gwynedd Local Council developed resources to encourage consortia formation due to the low numbers of large organisations in the area. The listed the disadvantages of working in a consortia model as:

- a. Management costs can increase*
- b. Consortium development can be a time consuming, complex and costly.*
- c. The liability for the failure to deliver or breach of contract by any one member will be carried by all through “guilt by association” and could seriously affect all members’ ability to compete for future tenders as a stand alone organisation or as part of another consortium if the issue is not rectified.*
- d. The differing values and cultures of consortium members can cause friction.*

The list the advantages as including shared skills and experience, increased capacity and geographical coverage and shared development costs. Carers ACT agrees that these are advantages of a consortia model however our experiences of working in this model leads us to conclude that the disadvantages far outweigh the advantages. These advantages and disadvantages are repeated in research and practice.

Consortia models often start out well as the agencies involved have a vested interest in joining together to strengthen a tender bid. Once the contract has been obtained however the relationship can sour and the resulting model is one that more reflects a sub-contract agreement. If this was to happen under the ICSS model there would be operational costs for the primary contract holder, operational costs for the sub-contractor and additional operational costs for subcontracted local brokered services, all resulting in much larger overhead costs and less service delivery funds. What is gained by the Department in lowering the number of contracts is lost in the overhead cost duplication in consortia models. Whilst the establishment costs may lower with a consortium our experience is that there is an increase in ongoing operational overheads in this model. Forcing a consortia model will push together competing agencies, therefore, the quality management of creating such a consortium would entail a great deal of time and money.

Experience with consortia models indicates that it would be difficult for an RDP to guarantee a consistent level of quality and the Department guarantee a nationally consistent service. Many funded consortia models have failed due to the complexities involved, the inherent frictions, the inability to provide strong governance over independent entities and the inability to hold accountability on partners for the delivery of outcomes and quality. This has been demonstrated strongly in the employment services sector.

Research indicates investment in small local service encourages buy-in from the community, increases community skills, and inspires inventive creation of individualised meaningful services (Buchan, 2003). To enhance community wellbeing is to foster community engagement through consultation and participation and the trend is that the public are demanding to be heard and acknowledged (Sarkissian, 2002). This has also been the case for carer participation in the ACT as evidenced through the ACT Carer Strategy. This approach has also enabled Carers ACT to obtain and sustain significant funding through sponsorships and donations which will be lost through a larger consortium approach.

The service mapping required to deliver the ICSS already exists within currently identified regions through the Primary Health Networks (PHN). This mapping has focused on health and wellbeing, which in some regions has had input and influence from Carers which can be duplicated across all PHN regions. Combining PHN regions together to form ICSS regions would be a better option than the regions proposed as it would allow the RDP to lever from the work of the PHNs. It may also result in a more sustainable and effective consortia model as there would be clearer delineation of the service area and funding for each consortium partner.

The capacity and capability of organisations to lead and work within consortia models depends on the maturity levels of the organisations involved. Key factors to the success of this model would include:

- the need to include a strong commitment to effective and true collaboration from all parties (and evidence to support this)
- strongly aligned and demonstrated values and commitment to Carers
- a commitment from each partner to the coverage area, required outcomes from each provider and funding levels for the consortia to work.
- Smaller consortiums are generally more successful than larger consortiums and require less investment in relationship management, negotiation and maintaining service quality levels.
- The lead agency would need to demonstrate that Carer services and programs are a core component of the work they do. This would ensure that the lead agency has the focus at Board and Executive level to ensure that focused high-quality carer service delivery is and remains the focus of the consortia and the governance of the lead agency. This will increase the level of investment by the lead agency to ensure the success of the consortia model and reduce the likelihood of a lead agency slowly taking over the smaller consortia models or losing focus on Carer service delivery as their core function.
- For the model to work we would strongly suggest that lead agencies must have current experience in the delivery of CRCC or NCCP or CISS to ensure expertise and a strong focus on Carer supports.

There is a strong need to ensure that there continues to be localised service delivery and a localised service identity. If a consortia model is adopted this needs to be a core component of the service delivery model and must be sustained throughout the longevity of the funding. People’s connection and relationship to places and sense of community impact on their health (Baldwin, 2014). An ICSS model that doesn’t include strong connection to community through local service delivery would impact negatively on the health of Carers. In times of hardship, such as those often experienced by Carers, being able to be supported by the surrounding community and surrounding community services, that know you, is invaluable in making positive recovery as evidenced in research done with the Canberra community after the bush fires of 2003 (Winkworth et al, 2009).

A large percentage of carers are older, and it is known that these older members of the community don’t seek supports that they perceive to be too complicated, superficial, or disconnected to their life experience or community knowledge (Gallagher et al, 2004). This will have implications for large RDP’s and consortiums if they cannot create or maintain community connection that older carers are familiar with.

How to ensure the breadth and reach of services provided under the proposed service area models, including the incorporation of local service providers.

The experience of the Network of Carers Associations has demonstrated the ability to deliver services across broad and vast regions with each Association providing counselling and carer information and advice across their respective state or territory. However, it should be noted that the majority of counselling is provided through brokered local service providers at a higher cost than in-house counselling and that the information and advice service is a phone-based service.

Carers ACT's experience of delivering two CRCCs (one in the ACT and one in Southern NSW) has demonstrated the challenges inherent with running in-person supports across a large geographical area and in maintaining relationships with local service providers. Whilst we have demonstrated our ability to do this well it does require specific resourcing to cover the region effectively and ensure high quality service delivery. The engagement of local service delivery partners requires relationship development and maintenance to ensure quality, service outcomes, client satisfaction and consistent service delivery. This cannot be achieved simply through service level agreements or sub-contracting arrangements. It requires specific staffing investments and can be particularly challenging in more regional and rural areas where internet connections are limited, service providers are limited, and ease of access is difficult.

Ensuring depth and reach of services can be overcome through business operational procedures (monitoring data etc) however management of a consistent approach is more difficult. Despite the use of manuals, guidelines, procedures, CRM's etc, staff and service providers who are left unmonitored and unsupervised tend to start delivering in ways that suit them and consistency is lost.

Our experience would indicate that resourcing needs to be allocated to developing and maintaining a network of quality and model consistent local service partners and staff located in regional/local areas. In addition, there needs to be demonstratable business processes in place that will help to ensure depth and spread are met. This includes, at a minimum, quality assurance processes, outreach frameworks, service partner management frameworks, service level agreements, volunteer management frameworks, CRMs with data analysis capacity and processes to ensure local input into service development/quality assurance.

Are there any alternative RDP service area models that you think the Department should consider? If so, on what basis?

The Regional Delivery Partner Model discussion paper identifies that one of the reasons for changing the existing CRCC regions relates to the identification that these regions are no longer recognised or maintained by Government, resulting in a lack of demographic data necessary for service planning. The discussion paper proposes the development of RDP regions based on the ABS Statistical Area Level 4. According to the ABS, Statistical Area 4 is based on divisions of labour markets:

Labour markets were a key consideration in the design of SA4s. The reason for this is that Labour force data has two geographic components to it - the labour supply (where people live) and demand (where people work). For statistical purposes, it is ideal to maximise the extent to which the region being analysed contains both sets of geographic locations. Labour markets are geographic regions, which reflect the highest degree of interconnectivity between the labour supply and demand. By reflecting labour markets, the output data is relevant to both labour supply and demand.

It is agreed that the regions for the RDPs should reflect other defined government regions to build on and lever existing data sources. Given the biggest impact to carers from their caring role is the effect on their health and wellbeing, it may be more relevant to ensure the RDP regions map to regions responsible for collecting and analysing data on health. In addition, the proposed RDP regions do not map to any existing service delivery regions.

As the role of the RDPs include local service mapping and gap identification, the ability to utilise existing service maps and needs analysis would prove to be efficient and effective. Mapping the RDP regions to the Primary Health Network regions would enable cross use of data, needs analysis and service mapping.

On 1 July 2015, 31 Primary Health Networks (PHNs) were established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time (PHN Website, Department of Health).

According to the Programme Guidelines, key tasks of the PHNs include:

- understanding the health care needs of their PHN communities through analysis and planning. They will know what services are available and help to identify and address service gaps where needed, including in rural and remote areas, while getting value for money;
- working with other funders of services and purchasing or commissioning health and medical/clinical services for local groups most in need, including, for example, patients with complex chronic conditions or mental illness.

PHNs have a key role in undertaking systematic needs assessment processes that identify and analyse the health and service needs within their regions and prioritise activity to address those needs. The Department of Health has established consistency for the PHN needs assessments through a programme guide which outlines the steps involved in conducting health needs analysis and service needs analysis, synthesising the evidence and determining priorities.

These needs assessments are conducted in conjunction with regional partners to coordinate service planning and include a mix of statistical data and qualitative information. The purpose of the needs assessment is to identify key issues and primary health care priorities in the region. The needs assessments include demographic and health information about specific vulnerable groups within the community. They include service mapping and gap analysis and are the base of workplans focused on improving health outcomes. Carers can be incorporated as a vulnerable group within these needs assessments. As an example, the Capital Health Network has already worked with Carers ACT to incorporate carers as a group within their needs assessment. A specific chapter on the needs, issues and profile of carers in the ACT can be found in the PHN's needs assessment. This is used to track impact and outcomes through the implementation of targeted initiatives.

Aligning to ABS labour regions gives the impression that the focus of the ICSS is to maintain carers in their unpaid caring role, or to return them to the workforce, or both. The model should focus on Carer health and wellbeing as this is the focus of Carers – it's what they say is important to their roles as Carers, and this should be the focus of services that seek to support them.

The discussion point asks for alternate models and it is suggested that existing CRCC and/or PHN regions are already supported by research and supported by other agencies with an interest in supporting Carers in the region. Carers value relationships. Carers know Carers ACT, trust Carers ACT, and know that we will support them. The reality is the bigger the RDP the less connection Carers will have, the less input they will have, and potentially the less effective the RDP will be.

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