9th May 2018

Feedback on: Integrated Carer Support Service (ICSS): Regional Delivery Partners -

A Draft on the regional delivery model

Merri Health welcomes the opportunity to provide feedback on the Department of Social Services (DSS) draft delivery model for ICSS Regional Delivery Partners (RDP's). As one of Victoria's largest community health providers and with a long-standing role in delivering services to support carers for more than 20 years, Merri Health has a strong understanding of the context surrounding carer reforms. As such, we are committed to supporting the Australian Government's Integrated Plan for Carer Support Services (the Plan), developed to reflect the Australian Government's priorities for carers and to outline the actions to improve access to information and services specifically for carers. In response to the development of the new ICSS Concept, Merri Health proactively began in 2015 the process of structuring our existing carer services to align with the draft Concept and further improve outcomes for the carers we support. We welcome the opportunity to provide input into this next stage of the reform process, and acknowledge that the structure and role of the RDP's will be critical in the successful implementation and sustainability of the new ICSS model. Please find below a summary of Merri's feedback to the proposed regional delivery model:

General Feedback

- Merri Health commends DSS for establishing an ICSS specifically for carers and for seeking to achieve better outcomes through the implementation of a more consolidated model. We forsee and support the many benefits the new model will bring, however, we have some concerns in relation to the proposed timelines for implementation and operation. Appropriate resources and well planned timelines are critical in the successful implementation of the new model, and with some ambitious timelines currently in place for implementation and delivery, we suggest a comprehensive mitigation strategy is developed and put in place to address potential time blow outs and the impact these might have on any interdependencies, as well as the potential of impairing the effectiveness of the ICSS implementation. We also advocate to ensure there is a whole of government understanding of the impact the carer reforms will have and the interdependencies on other government funded services, many of which are also under ongoing reforms. It will be critical to have a whole of carer/client viewpoint given many carers do not just receive existing services from the current carer respite service centres, but also are reliant upon other government funded services.

- We propose further information and guidelines are included around quality and safety. CRCC's are currently measured against Home Care Standards to ensure a consistent

approach is applied, however the discussion paper does not identify which measures or standards will be applied to RDP's, as well as for subcontractors and service outlets.

- It is noted that the target audience will be carers of individuals who have a disability, medical condition, mental illness or are frail and aged. There are currently significant concurrent reforms related to these proposed target audiences taking place, yet the report makes no mention of these or the possible implications for the operations of the ICSS. The release of the ICSS model provides Government with an opportunity to align these policy directions and articulate how integration will be facilitated via these reforms. Merri Health recommends that the roll out of the ICSS model should be more explicitly interlinked with relevant reforms taking place in disability, mental health, and the aged care sector, to reduce further duplication across various government systems and support a more streamlined approach to an already fragmented and disjointed health reform process. In addition to this, the model should also articulate the connectivity and linkages with other service systems such as aged care, disability, mental health and chronic care etc.

- In our experience working with carers, we have found that they require support in navigating the service system on behalf of their loved ones, and this has become exacerbated and more evident with the recent implementation of NDIS and aged care reforms. Although it is still unclear what role the ICSS will have in an already ever changing and complex service system, we foresee additional challenges for carers in navigating yet another new service system, that could potentially have a negative impact on accessibility to services and in the longer term, health and wellbeing outcomes for carers. In order to mitigate this, we recommend that the structure of the RDP model takes into account ease of accessibility and navigation from a carer perspective, which will be critical in the ultimate success and sustainability of the new model.

- The development of this model does not take into account some of the unique and specific needs relevant to young carers. Merri Health has a history of working closely with young carers and tailoring our services to address their specific needs. Through our advocacy work in recent years we have found that young carers highly value indirect respite support services such as recreational groups and activities, which have been critical in providing practical peer support and reducing isolation, however there is no mention whether there will be scope for this in the new model.

- The Carer Gateway has been identified as a critical component of the new ICSS model, we therefore recommend this platform is fully operational and effective before the establishment and roll out of the RDP's. To date the Gateway has not been effectively utilised and Commonwealth Carelink Respite Centres (CRCC 's) are still directing many queries which should be channelled to the Gateway. In order for the new model to be effective, The Gateway will need to be fully functioning to ensure RDP's are not fielding additional queries from the Gateway.

Key Issues with the approach to structuring the service areas

Of the two options proposed, Merri Health strongly supports the adoption of Option A (20 service areas nationally with 20 RDP's) for the following reasons:

- Option B proposes 11 service areas nationally with 11 RDP's, for most states, this will result in a singular statewide RDP, and for the rest, a maximum of 2 RDP's in each state. This is a significant change and reduction to the current model, which has approximately 54 CRCC's across the country with several in each state, and could significantly compromise effectiveness and accessibility of services for carers.
- Although the ICSS discussion paper lists the larger sized areas as beneficial for providing a good mix of metropolitan, regional and rural regions, it doesn't acknowledge the challenges this would present in having so few RDP's servicing such a broad catchment. The RDP's would have more limited capacity to be responsive to local community need, as they are servicing such a large and diverse catchment. It would be difficult to respond adequately to the unique challenges and needs of specific communities and demographics within this model, risking potential disengagement from carers in the new ICSS.
- Although the discussion paper highlights one of the benefits of Option B as greater funding made available for the direct provision of carer services, it fails to acknowledge the additional resourcing that would need to be allocated for the fewer RDP's to have to manage and subcontract to a greater amount of services with more providers across such an extensive region. Having oversight of such a broad region and needing to subcontract and partner with such a large number of organisations across a far-reaching geographic catchment could also inevitably lead to reduced consistency of service delivery, compromised quality, and a higher number of contracts and transactions to manage requiring additional resourcing and cost implications. Merri Health strongly believes that quality and consistency of service delivery should be first and foremost in the ICSS model, and Option B could potentially hinder this. Although Option A still more than halves the number of national providers for CRCC services from approximately 54 to 20, from Merri's perspective, this option poses much less risk than Option B, and is more conducive to better outcomes and more effective delivery of services for carers. Having a larger number of RDP's will also minimize the amount of outsourcing and subcontracting required, which will allow for better oversight, and enable RDP's to implement higher standards for quality and consistency.
- The discussion paper indicates that RDP's will be required to undertake service planning and mapping, as well as create and maintain a network of professionals and service providers. This would also be much more difficult to facilitate adequately across such a large region. Option A will also enable RDP's to provide a more tailored and responsive approach for carers within their catchment, as well undertake more meaningful service area planning and more effective co-ordination of networks and partnerships with providers in their catchment.

Although Merri Health supports Option A and the notion of 20 RDP's nationally, we have apprehensions around the proposed boundaries of the RDP's and how the catchments have been determined:

- The proposed RDP regions do not align with any existing Commonwealth boundaries or regions such as Primary Health Networks, NDIS regions or Local Government Areas. The creation of new regions that don't align with existing ones poses added complexity and reduced efficiency for funders, RDP's and consumers and carers alike. Merri Health strongly recommends the RDP boundaries are aligned with existing boundaries to minimize confusion, duplication, and reduce inconsistency across government reforms. Although the discussion paper refers to the 52 Aged Care HACC planning regions as no longer being utilised by Government, and the lack of demographic data available as a result, this contradicts other information being released. The Department of Health (Commonwealth) as part of the current aged care reforms have utilized these existing regional boundaries, and it would appear opportune for the RDP's to align with these.
- It is noted that the proposed 20 and 11 service areas nationally are based on SLA's (Statistical Local Areas) as utilized by the Australian Bureau of Statistics, rather than local government authority boundaries. This poses significant concern and potential confusion as SLA's are not utilized as boundaries for service delivery, and from an evidence informed social planning perspective, LGA boundaries should form the building blocks in constructing these service areas.
- The utilization of SLA's leads to the splitting of local government areas across RDP's. For instance if we take the City of Moreland in Victoria, the proposed split of Moreland North from Coburg and Brunswick would disrupt the current patterns of service partnerships and communities of interest that have been established over a long period of time. Alignment of geographic boundaries is important to minimise duplication of effort in establishing partnerships, seeking demographic and population health information, and in synergising communities of interest.
- The splitting of LGA's across RDP's will also pose significant confusion from a carer and consumer perspective. Consumers currently are accustomed to service delivery boundaries by LGA, and having consumers from the same LGA (and in some instances, the same suburb) informed they are serviced by different RDP's could inevitably create added confusion and inconsistency.

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

- We propose that Option A would allow for capacity and capability of organisations to manage a regional presence and undertake service area planning, however Option B would not allow for this, purely because of the size of the RDP regions. Additionally, a consortia led model could be feasibly managed within Option A, but would be more challenging to manage under Option B.
- In considering a consortia led model within Option A, we propose the Commonwealth provide structure and guidelines to RDP's around subcontracting arrangements to ensure quality and consistency of services to carers, and also to minimize disparity and fragmentation between regions. If no guidelines are provided, there is a risk RDP's will seek to hold as much funding as they can internally, for their own financial benefit, rather than ensuring the best provider is engaged to deliver the best service for carers.

Guidelines for RDP's should ensure existing carer expertise and skills across the region are utilized and maximized, rather than lost within the new model.

- We propose that clear measures and guidelines are put in place to articulate how hard to reach populations will be engaged in the new model – for example, how an access and equity and diversity lens will be effectively applied across such a large, regional and geographic area.

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

- Although the consultation paper refers to a number of service outlets delivering face to face provision across the RDP's, there was very little information provided on the number of outlets which may be required, how these will be managed, and whether there may be financial and resource implications for the RDP's. Merri Health strongly supports the utilization of existing service providers and leveraging from well established relationships between providers and consumers, however clear principles and expectations should be identified, for example:
    - How will the service outlets be identified and who will manage them ie. will RDP's act as commissioning bodies seeking expressions of interest, or will they appoint service outlets / providers?
    - What process will be applied to ensure fairness and equity in a highly competitive environment ie. that the best service provider is appointed?
    - How will service outlets be funded and managed, via the RDP's? If so, will this be a permanent / ongoing or contractual arrangement?
    - What oversight will be provided to service outlets to ensure consistency of quality and delivery across such a broad region?

We appreciate the opportunity to provide input into this consultation and welcome any queries or further discussion on the contact details provided below:

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