**LIVEBETTER COMMUNITY SERVICES SUBMISSION TO THE DRAFT MODEL FOR INTEGRATED CARER SUPPORT SERVICE: REGIONAL DELIVERY PARTNERS**

**INTRODUCTION**

As an auspice for Commonwealth Carer Respite Centres (CCRC) for over 20 years, LiveBetter Services Limited (previously CareWest Limited) welcomes this opportunity to respond to the Department’s *Integrated Carer Support Service: Regional Delivery Partners* discussion paper.

Our response is informed by our learning and expertise in supporting carers in regional NSW, a priority strategy for achieving our long-standing corporate purpose of “Enabling regional Australians to live their best lives.”

Over our 20 years of involvement in delivering the CCRC and a range of other respite services we have built the capacity, partnerships and infrastructure to provide carers located across the challenging geography of regional NSW and (now) Queensland with a wide range of supports including: ‘accidental’ counselling, coaching, direct provision of respite care and timely and responsive support in emergencies.

Key to our track-record of success in engaging with our highly diverse and widely dispersed participant cohort has been our local presence in communities across out extensive geographic footprint in rural and regional Australia with 43 service outlets in NSW, Victoria and Queensland, including: Albury/Wodonga, the NSW Regions of: Murrumbidgee, Central West, Orana Far West, Hunter/New England, Far North Coast; and, Central Queensland Region. Over the past 8 years our growth strategies have included amalgamations with a number of like-minded organisations providing a depth of resources, infrastructure and expertise that enable us to offer a diverse portfolio of face to face and digital services across the disability, mental health, child and family, and aged care sectors. We have a track record of success in facilitating positive participant outcomes through our proven remote monitoring services offered via our expanding Telehealth program. This allows carers (and a range of other participant cohorts) in any location, to access reliable, preventative health and well-being oversight.

We have also established a network of partner service providers with whom we collaborate to deliver local, face-to-face carer supports (and supports for all other participant cohorts), including the direct provision of respite care. These collaborative networks, which include health professionals: GPs, practice nurses, allied health clinicians and, community nursing services; are an invaluable source of both well-targeted referrals and of timely and cost-effective supports for carers. Local collaborations are resourced by LiveBetter’s highly motivated, trained and dedicated local staff teams which can be mobilised across multiple regions and who are well placed to identify carers and direct them into the ICSS at one or more of the three proposed service delivery levels. This includes our in-house clinicians and therapists – an expert team we are continuing to develop in order to improve access to primary health services in regional areas.

LiveBetter welcomes the shift from reactive, crisis-driven support to an early intervention, preventative approach to sustaining the caring relationship which the ICSS represents; and, supports the introduction of platforms where carers can access timely, objective and reliable information to support their day to day caring decisions; enhance their confidence; and, allow carers to pursue avenues to improve their own physical and mental health, as well as reducing social isolation.

**RESPONSE TO DISCUSSION POINTS**

1. ***Key issues with the approach to structuring the service areas.***

In our view, in determining how best to structure service areas consideration should be given not only to economies of scale, but to:

**Effective service delivery to all communities and population cohorts throughout service areas**.

Over the past 12 months as we have delivered NDIS services we have identified, through participant, family and partner feedback, an emerging trend that, as new providers establish operations in regional areas about which they have little knowledge, participants, while they are offered increased choice, report that their expectations are not being met; and that, service delivery is often confined to large regional centres because providers are not equipped or prepared for the challenges of service delivery in rural and remote communities. Issues and access barriers facing the regions’ highly dispersed Aboriginal and Torres Strait Islander and CALD communities are reported to be particularly acute.

**Recommendation**: While a consortium approach may alleviate these issues to a certain extent, we believe there is justification for identifying and ensuring the retention of acquired local and specialist knowledge and expertise in vulnerable communities to ensure a smooth transition to new delivery models and reduce the risk that service responsiveness, quality and accessibility will be reduced while new entrants become familiar with the unique operational environments these communities present.

**The capacity of all RDPs to provide, throughout their service area, the person-centred, highly responsive and locally relevant services carers have come to expect and rely upon.**

Carers, over many years, have reported that one of the most valuable services they currently receive is access to a local person who understands the context of the challenges they face. The highest levels of satisfaction reported by carers contacting the CCRC, are in respect of the person centred, thorough and knowledgeable support they receive, which in many cases is delivered over a series of interactions with the CCRC. In transitioning to smaller numbers of service areas each with a higher volume of traffic, LiveBetter would use existing expertise and invest in workforce training to ensure that this personalised service can continue to be provided.

We note that for many regional communities, particularly Aboriginal and Torres Strait Islander communities, the long history of services being unilaterally discontinued or changed is experienced as a breach of trust that prompts alienation from the formal service system and significant disincentives to engage with new providers.

**Recommendation**: That RDPs are resourced to undertake thorough, localised and well-targeted community engagement and a careful transition process to ensure local communities are aware of, and involved in the change process, and that their planned services are continued throughout the transition period.

**Clarification of the role and function of RDPs and the impact on carers of the ICSS approach.**

Having studied all available information about the ICSS the following questions have arisen.

**RDP role**

CCRCs currently provide a Residential Respite Booking Service to assist carers and aged care facilities to plan and manage respite bed bookings.

*Q. 1 Will this service now be provided through the Carer Gateway or My Aged Care, or will this sit with the RDPs?*

CCRCs currently provide a high level of advocacy and assistance to carers and recipients accessing My Aged Care and the NDIS. This may extend to guided referral for those carers/recipients unable to fully participate in the process, and in some instances, may necessitate access to brokered case management to achieve a successful outcome.

*Q. 2 Will there be scope for RDPs to provide brokered access to specialised advocacy/case management for those carers/recipients who are unable to successfully engage with the service system?*

***Impact on Carers***

We note that Carer Directed Packages are included in the service mix under the ICSS at the value of $3000 per recipient per annum. In administering the CCRC programs over the past 20 years it is apparent that whilst this will assist carers to access basic levels of respite and other supports, the amount is patently inadequate in providing support to all carers over a full year. Leaving aside the possibility that the carer may need to access services in their own right from time to time, the main issue for carers is access to respite care when they need it.

In our experience with CCRC, short term planned respite care is usually requested as in-home support, ranging from an hour or two on a weekday, to evening care, overnight care and weekend care. The concern is that there may need to be flexibility in the budget to allow for higher costs associated with more complex care needs, geographic isolation and employing staff with higher qualifications While the care recipient may be able to access flexible daytime activities and support in some areas, these services are not available in many rural and remote locations. It is also often the carer’s preference that the care recipient be cared for in their home environment.

*Q. 1 Is there scope for flexibility in the package budget to allow for higher costs as detailed above?*

CCRCs currently operate on the basis that carers may access short-term episodic respite on multiple occasions, depending on change in circumstances, e.g.: when a carer needs to attend an appointment, needs a piece of equipment for a 6-week recuperation period, needs study time to complete a training program etc. These types of unplanned events occur in isolation and may necessitate the provision of assistance to the carer on more than one occasion in a 12-month period. This episodic support may particularly apply to those carers who support a person with mental illness or dementia, and those carers supporting a person with a degenerative disease where care needs regularly change.

*Q.2 What, if any, budget Is attached to ‘one-off practical support’?*

As above provision needs to be made for higher costs associated with delivering emergency care in the rural and remote context.

*Is there an upper limit attached to the budget for instances of emergency respite care?*

There is no provision for palliative care. Carers providing 24-hour end of life care to a loved one will need considerable support, possibly including overnight relief. In-home respite care for a person who has complex clinical needs, including medication administration, will not be covered by a $3000 package.

*Q. 3 Is it intended that specific funding will be included in the ICSS for palliative care carer respite?*

**Equitable access throughout all service areas to, and capacity of all carers to use, self-service and/or guided technology-based services, without necessarily having to engage directly with an RDP or service provider**.

Across our extensive footprint a high proportion of our participant cohort is: older, does not have access to (or can’t afford) reliable internet or communication technology; does not wish to access technology, and/or does not have family members available to assist them to engage with technology. Often these carers are among the most vulnerable and most likely to be impacted by lack of access to timely, responsive support. In our view they will require pro-active and more labour and resource intensive engagement with RDPs and local service providers, possibly resulting in the need for a higher ‘on the ground’ staffing ratio in some RDP regions.

**Recommendation**: That RDPs covering regional areas experiencing rapid population aging, high levels of poverty, low levels of health and technological infrastructure and/or literacy, should be allocated funding levels that include a loading to enable them to establish sufficient local services and/or staffing levels (perhaps including volunteers) to ameliorate such local access barriers.

**Capacity of the proposed ICSS model to deliver a seamless integrated support service**

In implementing the ICSS model, it is anticipated that the services delivered at each of the three service delivery levels (national, regional and local) would form a seamless support system within which carers could navigate to the supports needed at any stage within the carer lifecycle, without being impeded by layers of administration. While a ‘no wrong door’ approach allows carers to initiate contact at the most local level, there needs to be provision for that access point to facilitate direct and easy entry into the ICSS. Over the years, numerous carers have reported to CCRCs, that they have been directed by local health and social care providers to call multiple numbers before finally reaching the CCRC where their needs can actually be met. This causes carers additional stress, frustration and erodes their confidence in the effectiveness of the support system.

**Recommendation**: That a comprehensive education program and community collateral is rolled out to key local stakeholders and “first to know” agencies such as GPs, pharmacists, teachers (particularly concerning young carers’ needs) practice nurses, allied health clinicians, community nursing providers and so on, to increase their capacity to identify and engage with carers and to make effective referrals.

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

LiveBetter is well placed to form and lead consortia to provide effective coverage across service areas in regional NSW, central Queensland; and, increasingly, in Northern Victoria. We offer the scale, experience, operational management and governance resources and infrastructure necessary to effectively mobilise, support and manage multiple consortium partners to deliver the planned ICSS regional and local service approaches, systems and resources.

We have an established presence throughout the regional communities to be included in either the Option A or B service area designs in NSW and Central Queensland. Our physical infrastructure includes office facilities, ICT infrastructure and vehicle fleets in 43 regional towns/cities. Members of our more than 1500 staff are located in more than 60 regional communities, many co-located with partner agencies which will be key stakeholders and/or valued members of RDP consortia.

Across our geographic footprint we also offer established and functional cross-sector partnerships and collaborations that already support “no wrong door” referral networks in the aged care, disability, health and mental health sectors; providing local communities with clearly articulated pathways that enable easy navigation through the fragmented and complex health and human services systems that confront them.

The CCRCs have been centrally involved in establishing these collaborative networks and practices and have in particular, established a network of service providers with capacity to support carers, including through the provision of direct respite care. These collaborative networks are invaluable in delivering timely and cost-effective respite for carers.

Under both Option A and B service area concepts there is a focus on RDPs covering rural,

remote and metro areas. If this is the final model, LiveBetter would look at consortia

arrangements with organisations with proven track record, expertise and resources dedicated to

delivering high quality services to metropolitan carers. However, there may also be a case for

looking at service areas based on the specialisation of organisations. LiveBetter has an identified

presence in rural areas, operating under its ethos of ‘enabling people in regional Australia to live

their best lives’. LiveBetter’s knowledge base, resources and proven success is in working to

support country people in their own communities from the Victorian border to Central

Queensland. LiveBetter’s strategic approach to amalgamation with like organisations has resulted

in a broad rural network with satellite offices specialising in the issues facing their own regions, a

structure well placed to support the operation of an RDP.

**Area Planning**

In our experience, broad brush needs-based or population planning approaches are often not sensitive enough to be effective in regional areas that include multiple small, isolated, remote and disadvantaged communities. This approach may lead to development decisions that undermine duplicate or replace well-functioning local support systems, many of which are informal and structured to address unique local issues. Such results reduce the resilience and capacity of affected small communities and reduce their liveability.

We have a history of undertaking planning in regional areas based on thorough and detailed mapping of local and regional service systems and an expert understanding of the unique and challenging business environments presented by the rural, regional and remote communities in which we work. Detailed and accurate local knowledge is central to ensuring efficient and effective allocation of scarce resources in a way the builds on local strengths and capacities. In particular, effective planning in rural and remote areas requires:

* Testing common planning assumptions against the realities of local communities;
* Comprehensive mapping of both formal and informal locally available support resources;
* Establishing an accurate understanding of the connections that have formed over the years between small localities and the wider service system, regardless of formal boundaries; and,
* A detailed understanding of the basic infrastructure issues each community faces and the options available to respond to these (e.g. outside large regional towns/cities, many communities in Western NSW have no or little access to public transport and, where incomes are low, private vehicles able to cope safely with local driving conditions are unaffordable.)

**Recommendation:** That, to ensure the retention of current networks and expertise in working with carers throughout the planned service areas; and, to retain key planning expertise, the foreshadowed RDP tender process include a requirement that consortia must demonstrate established presence in, and expert knowledge of, all of the communities in the service areas in which they propose to establish an RDP.

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

LiveBetter supports the establishment of a recognisable, easy to use and credible support network for carers, eliminating as far as possible the fragmentation and confusion of the existing system. In our view, ensuring sufficient breadth and reach of services to achieve these objectives within service areas based on either Option A or B depends in large part on:

1. A well- trained, informed and supportive local workforce to provide a visible presence in the community, engage with carers and provide the planned face-to-face services to assist carers to achieve their goals; and,
2. Accurate and timely referrals to the RDP from the Carer Gateway.

*Workforce*

We believe that the key test of whether or not RDPs deliver a system with the necessary breadth and reach should be success in identifying and engaging ‘hidden carers’ – those who delay seeking support and those who are hard to reach for a range of reasons, including: distrust of, and alienation from, formal service systems; lack of knowledge that support is available or of how and from whom to seek support; and, physical or technological isolation from support gateways.

To develop and mobilise appropriately trained and skilled local staff as cost-effectively as possible in widely dispersed regional and rural communities, the key challenges to overcome are:

* Difficulties in sourcing skilled workers locally;
* Servicing small populations which means that employee time may not be efficiently utilised; and,
* The travel costs of moving staff between widely separated locations.

We have found that the most effective strategies in responding to these challenges are:

* Offering sub-contracts or fee-for-service arrangements to local service providers with appropriately skilled staff;
* Actively engaging in inter-agency groups and networks;
* Establishing collaborative arrangements with local services that are designed to deliver an inter-agency approach to service provision;
* Resourcing or taking responsibility for, the development of necessary protocols and processes to underpin collaborative service delivery; and,
* Resourcing and delivering joint staff training and development opportunities (offered either face-to-face or through ICT-based strategies) to build local skills and capacities.

Inter-agency collaboration is also a very effective framework for developing a local “no wrong door” approach and ensuring that all service providers have the information and capability to identify eligible carers and refer them to the service. Including “first to know” providers in inter-agency arrangements (e.g. GPs, community health services, teachers (an especially effective way of identifying young carers in need of support), neighbourhood services, child care services etc.) is particularly effective.

*Connections with the Carer Gateway*

In our view ensuring that the Carer Gateway protocols and practices facilitate accurate and timely referrals of carers to the appropriate RDP will be vital to ensuring RDP services both reach all eligible participants and deliver an appropriately broad range of services using strategies that are effective over the large distances they will manage. We raise this issue as a result of our experience of the Gateway to date.

Since the launch of the Gateway in December 2015, there have been very few referrals from the Gateway to the CCRC for carer support and respite care. While the Gateway’s original brief was the provision of carer-focused information only, it was reasonable to expect that CCRCs (as the national carer support network) would experience an increase in carer contacts resulting from carer interaction with the Contact Centre. In the Central and Far West CCRC regions this did not occur. Anecdotal evidence, gathered through consultation between NSW State CCRCs, would indicate that this has been a common experience.

As a pivotal ICSS entry point for carers, and with the foreshadowed expansion of the Carer Gateway’s role in October 2018 to include provision of digital/on-line services and resources for carers, prompt, accurate outward referrals of carers requiring access to respite care and face-to-face support will be crucial to establishing RDP operations and the bona fides of the ICSS as a well-integrated, seamless and responsive support system.

**Recommendation:** That nationally consistent training modules (such as those developed in the implementation phase of the Regional Assessment Service) be developed for ICSS staff and are made accessible to the staff of partner agencies, ensuring that organisations are assisted to embed carer awareness within their own operations and training programs.

1. ***Are there any alternate RDP service area models that you think the Department should consider? If so, on what basis? Your statistical analysis and / or evidence base should be provided to support this****.*

LiveBetter does not propose any alternate RDP service area models, believing that, so long as the issues we have raised are resolved, either of the options proposed will likely be effective.

**LIVEBETTER COMMUNITY SERVICES**

**1800 580 580**