SUBMISSION TO
SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE
INQUIRY INTO AGED CARE

Inner West 5 Home and Community Care Forum

CONTENTS

Introduction

This document has been compiled and submitted to the Inquiry on behalf of the Inner West 5 Home and Community Care (HACC) Forum. The HACC Forum represents over 60 government and non government organisations that provide a range of services to aged people, people with disabilities and their carers in the Leichhardt, Ashfield, Strathfield, Burwood and Canada Bay Local Government Areas in the Sydney Metropolitan Area.

Because the primary focus of this group is community care, i.e., care provided in a person's home or in a community setting, this submission will address the terms of reference as they relate to community care only, and will not address Part (b) relating to the Aged Care Standards and Accreditation Agency.

Where a considerable body of evidence already exists to support a position taken in this submission, reference will be made to that work, in the form of footnotes and, where possible, relevant documents will be included as attachments

(a) the adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training

It is widely acknowledged that there is a crisis in the recruitment and retention of a skilled workforce in both residential and community aged care. The Australian Government has responded with a National Taskforce looking at residential aged care. Strategies have included funding for an advertising program for nurses, and the HECS supplement for nursing education. These strategies will not necessarily address the shortage of nurses in aged care, until aged care nurses can be guaranteed the same pay, conditions and status as their counterparts in the acute setting.

This has serious implications for the funding of aged care facilities, given the Hogan Review[1] finding that "Labour costs and associated on-costs on average make up around 66 per cent of the total expenses of aged care services."[2]

The Hogan review also notes that

> *The share of direct care provided by registered and enrolled nurses has declined……The use of personal care assistants, by contrast has significantly increased…..With this greater reliance on personal care assistants comes a need to improve the skills of these workers.*[3]

Similar issues confront the community care workforce. The environment in which community care services are delivered has become increasingly complex in recent years. Service providers are faced with the continuing challenge of providing the highest possible service quality in an environment of increasing legislative obligations, fiscal

[1] Commonwealth of Australia *Review of Pricing Arrangements in Residential Aged Care Summary of the Report,* 2004.
[2] Ibid, p5.
[3] Ibid, p41

responsibility, accountability requirements, higher service user needs and high staff turnover.

The community care sector, in which HACC remains the largest funding program, is facing a workforce crisis in the following key areas:

- An Ageing Workforce
- Image/Status crisis
- Gender equity issues
- Qualifications and training
- Part time and casual workforce
- Low levels of pay
- Recruitment difficulties
- Lack of identified career paths within community care
- Retention

These issues also relate to residential care and are well documented and acknowledged. However little has been done in the Community Care Sector regarding workforce issues and industry development, yet one of the most significant policy developments in Australia over the past decade has been the shift in the balance away from residential care towards home –based care.[45] The figures quoted in the Hogan Review are instructive:

In 2002-03 184,095 people received permanent residential care, 34, 025 people received residential respite care, 31,186 received care through a Community Aged Care Package and an estimated 700,000 received services through the Home and Community Care (HACC) program.[6]

In recognition of this policy shift and the stated preferences of aged people and people with disabilities, a coalition of professional bodies, consumer groups and aged, disability and carer groups[7] has developed a Vision Document for Community Care[8]. The Coalition makes the following recommendations about staffing in community care:

- Staff are valued and supported to provide optimal care
- Competency based training at all levels of care
- A minimum standard of training required for all care workers
- A best practice employment culture, including education and continuous professional development, that attracts and retains care workers and professionals
- Care workers trained to observe and report signs that indicate need for assessment
- Appropriate support for workers, particularly in extreme situations (e.g., abuse)

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[4] Austrralian Institute of Health & Welfare, 1999, Sheet 17 quoted in Angley, P *The Recruitment and Retention of Community Care Workers*. Brotherhood of St Laurence. Dec 2002. www.bsl.org.au

[5] *A Vision for Community Care Discussion Paper* , www.agedcare.org.au June 2003, p4.

[6] *Review of Pricing Arrangements in Residential Aged Care*, ibid p 6.

[7] The Coalition includes ACROD Ltd, Aged & Community Services Australia, Alzheimer's Association, Australian Association of Gerontology, Australian Council of Community Nursing, Australian Division of General practice, the AMA, Australian Society for Geriatric Medicine, Carers Australia,COTA National Seniors and the Mental health Council of Australia.

[8] *A Vision for Community Care Discussion Paper* op. cit.

- Wages and conditions comparable with other care systems.[9]

A copy of this Discussion Paper is provided as an attachment to this submission.

The Community Aged Care Industry Policy Committee has developed a Policy Position Paper on Workforce Issues. The Committee estimates that 20,000 people work in community care in NSW and the ACT.[10] The key strategies identified by the Committee are

1. Improved remuneration levels
2. Development of identifiable community care career paths
3. Engagement by community care providers with government and employment agencies
4. Development of approaches to risk management, occupational health & safety and duty of care which improve the quality of the workplace for staff.

A full copy of this Position Paper is provided as an attachment to this submission.

(c) the appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs such as dementia……are met under current funding arrangements

With regard to younger people with disabilities, we refer the Committee to two documents which address this issue.[11][12] The first is included as attachments to this submission, however the second paper is still in Draft form.

The number of younger people with disabilities in residential aged care facilities has been increasing since 1990[13] , largely because there are no reliable and appropriate alternative service options. The position taken by the majority of the aged, community care and disability services industry is that this is an unacceptable situation.

Entry to residential aged care is determined by ACAT Teams whose major focus and skill base is around aged people. The *Younger People with Disability Out of Nursing Homes* paper notes:

…due to the high levels of unmet need in disability support and accommodation services and the number of people in "crisis" seeking assessments by ACATs, there is significant

[9] Op Cit , p 8.
[10] Community Aged Care Industry Policy Committee *Workforce Issues* September 2003.
[11] *Younger People with Disability out of Nursing Homes A Discussion Paper,* Brain Injury Association of NSW Inc, MS Society, Multicultural Disability Advocacy Association of NSW, The NSW Council for Intellectual Disability, New South Wales Council for Social services (NCOSS) People with Disabilities, and Physical Disability Council of NSW, September 2002.
[12] NSW Industry Group on People Ageing with Disability (ACROD NSW, Aged & Community Services Association of NSW & ACT & NCOSS) *Finding Solutions for People with Disability who are Ageing* May 2004. (draft)
[13] *Younger People with Disability out of Nursing Homes A Discussion Paper,* op cit p2-3.

pressure on ACATs to assess a younger person with disability in residential aged care facilities.[14]

ACAT Teams in the Inner West (Central Sydney Area Health Service) have experienced this pressure. They have expressed concerns at how this impacts negatively on their already extensive waiting lists and on the appropriateness of assessing younger people with disability for residential aged care.

It is interesting to note that in NSW the Department of Ageing Disability & Home Care has embarked on a significant Devolution Program to relocate people with disabilities living in large institutions, into community living situations. It has also embarked on a comprehensive program of reform of Boarding Houses which primarily house people with Mental Illness, psychiatric disabilities and addictions. Yet to date no move has been made to relocate the estimated 450 people under 50 years who are resident in aged care facilities in NSW.[15]

While the Inquiry Terms of Reference relate specifically to young people with disability, this issue cannot be considered without reference to people with disability who are ageing. This demographic trend places particular demands on the government and non government providers of accommodation for people with disabilities, e.g., Group Homes whose residents are ageing. Because there are lengthy waiting lists for supported accommodation for people with disabilities, it is likely that, by default, a significant number of people on these waiting lists will end up in residential aged care, which is not designed to meet the needs of people with disability.

The *Finding Solutions* Paper strongly urges the State and Commonwealth governments to work collaboratively to address these issues, so that younger people with disability do not end up in residential aged care, and people ageing with disability in the community and in supported accommodation are able to access appropriate aged care services without discrimination. These issues and the challenges they pose for governments and service providers are explored extensively in this paper.[16]

<u>People with dementia</u>

People with dementia usually require higher staffing levels than many other groups. Funding currently limits the number of staff that is available.[17] The Two Year Review of Aged Care Reforms highlighted a number of areas where further progress needs to be made in meeting the needs of people with dementia and their families. In particular the Review noted that access to care for people with behavioural problems had not improved as some providers were reluctant to admit residents who exhibit difficult behaviours and others were unable to provide secure accommodation.[18] The consultation process which informed the Review outcomes highlighted a lack of specialist and secure

[14] P 8.
[15] ibid, p 3
[16] op cit p 18ff
[17] *Central Sydney Area Dementia Plan 2003-2006,* May 2004*,* p19.
[18] Quoted in *Dementia and Central Sydney Area Health Services- Discussion Paper* CSAHS, July 2003, p 21

accommodation for people with moderate to severe dementia, and insufficient support for providers to provide it.[19] The Review also identified a need for substantially expanded dementia and person-centred education and training, review of current staff to resident ratios and remuneration for nursing and care staff, all of which has cost implications for providers.[20]

The Hogan Review of Pricing Arrangements in Residential Aged Care recommends that the RCS (Resident Classification Scale) be limited to three categories, "supplemented by additional payments for extraordinary care needs which add significantly to the cost of care."[21] Residents exhibiting challenging behaviours were considered in this scenario.

At a local level, residential care providers in Central Sydney identified a number of difficulties in meeting the needs of residents with dementia.[22] These included

- Retention of staff which they attributed to low levels of remuneration
- All residential care facilities consulted identified managing people who had challenging behaviours as a feature of their dementia as a difficulty. Indeed many of these providers reported this as their biggest problem.
- People with dementia and co-existing psychiatric illnesses or intellectual disability require additional support and specialized management which is not always available.
- The residential facilities identified a need for further education and training especially in managing challenging behaviours, but most felt they did not have a training budget which could adequately meet the needs of their staff
- People with dementia who are physically fit often have difficulty finding appropriate placement. Many facilities are not equipped to manage people who are stronger and more agile.
- Residential facilities have great difficulty in accessing specialist advice for residents with dementia and very complex needs. On many occasions residents are sent to emergency departments unnecessarily.
- Facilities identified the need for assistance managing behavious of concern. Medical, behavioural and educational support were identified as needs.
- Providers also identified the need for alternative placement options where facilities cannot manage people.
- Most facilities reported that they were often not given a thorough profile of people on admission, due either to the inappropriateness of the assessment tool or the desperation to place people.

<u>Transport Needs of people in residential aged care</u>

Residential aged care facilities face particular challenges in meeting the transport needs of residents with medical conditions which necessitate frequent trips to medical specialists or hospitals and someone to accompany them on these trips. Recent research

[19] Ibid p22
[20] Ibid p24
[21] Op cit p37
[22] *Central Sydney Area Dementia Plan* , op cit pp 17 -29

by the Council of Social Service of NSW (NCOSS)[23] highlights the huge unmet need for transport for residents of aged care facilities. This need cannot be met within the resources of aged care facilities. NCOSS recommends a Residential Aged Care Transport Supplement which

Funded by the Australian Government…..would mirror the other supplements contained in the Aged Care Act to provide a dedicated funding allocation towards transport support for people receiving residential aged care services.[24]

(d) the adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly

The stated purpose of the Home and Community Care Program is to fund basic maintenance and support services to help frail older people, younger people with disabilities and their carers to continue to live in the community.[25]

Demand for HACC Services has grown since its inception in 1985, and State and Federal Governments have in most years since then allocated growth to the program. There are currently 17 different community care programs funded by the Australian Government[26], of which HACC is the largest program. Demand for HACC services has been growing in accordance with demographic changes and will continue to increase. Much of the discussion in government publications, e.g., NSW Department of Ageing & Disability *Future Directions Paper*[27] identify the challenges in meeting future increased demand for services, without acknowledging current unmet demand for services.

Growth in the HACC program, while welcome, has been consistently less than what is required to meet existing demand.[2829] The Aged Care Alliance has recommended an

increase in HACC funding by 20% as an initial re-injection to enable a more appropriate level of care to be offered to existing clients to be followed by maintenance of sufficient growth to match future growth in demand.[30]

In an effort to highlight the growing importance of community care and the need for increased funding to this sector, the Myer Foundation has provided funds to Aged and Community Services Australia to run a National Community Care Awareness Campaign.[31] The Coalition has compiled the following data based (refer to table below)

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[23] NCOSS, Council of Social Service of NSW, *On the Road Again The Transport Needs of People in Residential Aged Care,* December 2003.www.ncoss.org.au/bookshelf
[24] Ibid, p 6
[25] Commonwealth of Australia, *Summary of the National Program Guidelines for the Home and Community Care Program* 2002.
[26] Dept of Health & Ageing *A New Strategy for Community Care Consultation Paper* March 2003
[27] Dept of Ageing Disability and Home Care *Future Directions 2004,* February 2004, p2
[28] Council of Social Services for NSW (NCOSS) *Pre- Budget Submission*
[29] NSW Aged Care Alliance *Federal Election 2004 Issues Kit, p.4*
[30] Ibid
[31] see www.agedcare.org.au

on the HACC MDS, which, even taking into account possible underreporting, clearly demonstrates that the HACC program nationally is providing very low levels of service in two key service types, Domestic Assistance and Personal Care.[32]

These levels of care are not adequate to support very frail people to live with dignity in the community, particularly when more than half of HACC clients report not having an unpaid carer. The authors of this submission are aware of reports across the State of HACC services being severely rationed. In particular the Home Care Service of NSW seems particularly stretched. The ACAT team at Concord Hospital have expressed concern that they cannot refer people they have assessed for Domestic Assistance, as the Inner West Branch of the Homecare Service of New South Wales can only accept new referrals as existing clients exit the program. A large non–government provider of HACC funded Domestic Assistance to the Inner West reported a waiting list of 150 people in May 2004.

HACC clients by State/Territory and Average Service for Domestic Assistance and Personal Care Clients (derived from HACC Minimum Data Set 2002-03)

State	Total No. HACC Clients	No. of Domestic Assistance Clients A	Average Service received (minutes per week) B	No.of Personal Care Clients C	Average Service received (minutes per week) D
NSW	170,661	44,538	45	14,670	100
VIC	195,694	70,012	36.6	18,245	58.6
QLD	129,600	41,975	33.7	11,825	31.5
SA	75,000	13,899	31.3	5952	55.8
WA	56,857	17,799	43.4	5018	96
TAS	20,059	7149	31.3	1851	75.3
NT	3,746	1381	45.7	457	76.2
ACT	9,375	1993	42	531	119.4

[32] Aged and Community Services Australia, *State Community Care Coalition Action Kit* July 2004, p21

Likewise in May this year the Department of Ageing Disability and Home Care in the Hunter Region of NSW reported that the Homecare Service in that region is not taking on any new referrals even when existing clients exit the program, because of a budget overrun. It is clear that not only is there unmet demand for services, those that are receiving services are receiving quite low levels of service.

The 2004-05 Budget for the New South Wales Department of Ageing Disability and Home Care (DADHC) predicts a small increase of 1.2% for the Home Care Service of NSW, but with a reported reduction of 293,000 hours from last year. This is accounted for by the late roll out of the 02/03 HACC State Plan. Home Care was given extra hours to make up the shortfall and then exceeded its hours in relation to resources in the 2002-03 financial year.[33] As the largest provider of HACC services in NSW, the demand for its services are an indicator of general demand across the State for HACC services.

As well as supply and demand and funding issues, there are other factors which negatively affect the capacity of the HACC Program to meet the current and future needs of the elderly:

- The myriad of community care programs for the elderly, e.g., HACC, Community Aged Care Packages, Commonwealth Respite for Carers, Veterans Home Care, Extended Aged Care at Home, Assistance with Care and Housing for the Aged to name but a few of the 17 community aged care programs funded by the Australian Government. The confusion that this can cause to people trying to access services is well documented.[34] This has serious implications for access and equity issues, particularly for people from Culturally and Linguistically Diverse Backgrounds.[35] The Australian Government is urged to continue the process of reform towards a simpler system, in collaboration with service provider and consumer stakeholders.
- Within this complex community care system, the fragmentation of the HACC program itself can mitigate against its effectiveness and can cause anxiety to service users and their families. For example, a HACC client who receives Meals on Wheels, attends Centre Based Respite and received Domestic Assistance has to deal with three different HACC agencies and may have to undergo three separate service level assessments. Reforms in the HACC Program in recent years, such as the introduction of the Client Information and Referral Record (CIARR) and Comprehensive Assessment have gone some way towards addressing these issues. However the issue of multiple entry points to the HACC Program still needs to be addressed.
- Commonwealth State Relations can impede the effectiveness of the HACC Program. HACC funding in NSW is often delayed because of delays in the sign off of the HACC State Plan. This significantly delays the release of growth funds

[33] Information provided by the Director General DADHC at Budget Briefing, Parliament House, June 22, 2004

[34] *A Vision for Community Care Discussion Paper,* op cit; Dept of Health & Ageing *A New Strategy for Community Care Discussion Paper,* op cit; Aged & Community Services Australia *State Community Care Coalition Kit,* op cit; NSW Aged Care Coalition *Federal Election 2004 Issues Kit*, op cit.

[35] *The State Community Care Coalition Kit* op cit contains case studies which demonstrate the effects of this complexity for clients and their families/carers.

to the sector and causes uncertainty for service providers in terms of forward planning and efficient allocation of resources. The inordinate delay in the sign off of the NSW 02-03 HACC State Plan caused significant anxiety and confusion in the sector, as well as delaying the release of much needed growth funds.

(e) the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community

As the *Vision for Community Care* paper[36] states

There is increasing recognition that community care programs can no longer be considered separately from the myriad of intersecting service sectors, including residential aged care, disability services and primary and acute health services. Changes in any one of these systems inevitably affect others, as has been the case with the reduction of length of stay in hospitals increasing the care needs of some community care clients after discharge home.

Issues around early discharge planning and post-acute care have an enormous impact on the community care system. There has long been dissatisfaction in the community care sector over discharge planning practices, where elderly people are discharged from an acute care setting back into the community, without appropriate supports, or where community service providers are not given sufficient notice to resume services to the person being discharged.

This has implications for the HACC program in terms of cost shifting from the health sector to an already stretched and under resourced community care sector, and it places unrealistic demands on the HACC program which was never intended to provide immediate response to need.

In NSW there has been considerable policy work undertaken by the NSW Department of Health, through the Models of Implementation Working Group, on development of a Discharge Planning Framework. There are a number of transitional care projects in NSW that assist community care clients with the transition from hospital to home. These projects have been very successful in meeting the needs of older people being discharged from hospital.

The COMPACK Pilot, in which the Department of Health provided case management and brokerage funds to selected HACC funded Community Options Projects for patients being discharged from hospital, has been highly successful and the Pilots have been given ongoing funding. The COMPACK projects are currently limited to the catchments areas of the major teaching hospitals. They are an excellent example of cross sector collaboration between the Department of Health and the HACC program in NSW.[37]

[36] Op cit, p4

[37] For further detail on COMPACK contact Executive Officer at NSW Community Options Project nswcops@ozemail.com.au

There have been a number of other initiatives across NSW which address the issue of discharge planning for elderly patients. For example in the Macarthur Area of NSW HACC has funded *Carrington Temporary Aged Care.* In this model the hospital discharge planner and HACC services work closely together to provide a quick response to older people who have been discharged from hospital. The service is provided for a maximum of 8 weeks post discharge. The service is withdrawn either once the patient is well and can manage the tasks of daily living without assistance, or after they have been referred to other community care services for their ongoing needs.[38]

Other programs such as the Innovative Care and Rehabilitation Service, which is a joint program of Uniting Care and Central Sydney Area Health Service, provides up to 12 weeks rehabilitation post hospital discharge.

Baptist Community Services NSW & ACT has also piloted a successful transitional care model, which has been successful in significantly reducing the numbers of older people requiring residential aged care.

These various pilot programs demonstrate the need for and the efficacy of funding targeted specifically for post discharge. The outcomes of these projects demonstrate that it is possible to provide a smooth transition from an acute setting to the community. However success beyond the immediate post discharge period of 8-12 weeks relies on the availability of ongoing services, whether they be HACC services or Community Aged Care Packages. Funding for transitional programs, must be in addition to funding for HACC and similar programs and should not involve cost shifting to the community sector and they should be available in all areas not just in those where there are large teaching hospitals. A comprehensive and coordinated approach to transitional care is required. The successful pilots in NSW prove that this is achievable.

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[38] For a full report of this initiative see www.nswhaccdos.org.au/innovations