national
AGED CARE alliance

June 2014

NACA RESPONSE TO THE KEY DIRECTIONS FOR THE COMMONWEALTH HOME SUPPORT PROGRAMME DISCUSSION PAPER

Background

The National Aged Care Alliance (the Alliance) welcomes the opportunity to respond to the Department of Social Services (the Department) Discussion Paper *'Key directions for the Commonwealth Home Support Programme Basic support for older people living at home'*. This short response builds on the Alliance's advice of September 2013 *'Commonwealth Home Support Programme Design Paper'*.[1]

The Alliance commends the Department on the comprehensive discussion paper and believes it has adopted many elements of the Alliance's advice. We reiterate our view that in the long term there should be a single, integrated community care programme, combining the current Home Care Packages Programme and the Commonwealth Home Support Programme (CHSP), funded via a mix of individualised funding and block funding.

We have cast this response around the questions in the Department's discussion paper.

Question 1: Are there any other key directions that you consider should be pursued in the development of the Commonwealth Home Support Programme from July 2015?

The Alliance supports the broad direction of the CHSP Vision (page 8). The Alliance warmly welcomes the inclusion of carers within the vision for the programme. We note however that the use of the term 'basic' in the same sentence as 'underpinned by a strong emphasis on wellness and reablement' could be seen as contradictory. Reablement services may require intensive service delivery over a short and targeted period. This may result in discharge, or it may result in an ongoing service, or it may lead to an intensive restorative burst, which in turn may lead to discharge or ongoing services.

The Alliance notes that some clients currently receiving services over basic levels by the Commonwealth Home and Community Care (HACC) programme may need to be transitioned by their current providers into alternative programmes, such as Home Care Packages or Residential Care, in order to access appropriate service levels to their needs. While ongoing services at a basic level may support independence within the community, it may be preferable to remove the statement of wellness and reablement to a separate sentence within the vision statement for the programme to overcome any future confusion.

Support for episodic needs must explicitly form part of the CHSP, as is the case of the example outlined in the discussion paper (page24). These intensive reablement services should form a part of the key features of the programme (page18) in addition to the underpinning of reablement and wellness mentioned.

1 Available from www.naca.asn.au

While the inclusion of reablement and wellness may be intended to be covered under the term 'short term restorative care' in the future system diagram (page20), the Alliance feels the CHSP would benefit from a more prominent featuring beyond the short term restorative care box. A new key direction should be included along the lines of the CHSP 'will be underpinned by a wellness and reablement philosophy, including short term restorative services'. Additionally the discussion paper provides no specific mention of 'early intervention/response' as a strategy to avoid future (and often more serious/costly) crises from occurring. In addition the Alliance believes that the principle of 'equity of access' should be formalised within the CHSP guidelines.

The success of the CHSP into the future will in part be based upon the robust evidence base and planning framework put in place to support the programme's development in coming years. The Alliance notes that this is most likely to be dealt with in the Programme Guidelines and Programme Manual stages of the design process.

The Alliance notes that from 1 July 2015 Home and Community Care services in Victoria will form part of the Commonwealth Home Support Programme. The Department has confirmed during roadshows that existing Victorian HACC services will receive a three year continuation of contract and funding arrangements. This is in line with what other states were provided upon their commencement in the Commonwealth HACC Programme in 2012. While HACC services in Western Australia have not yet been agreed to form part of the Commonwealth Home Support Programme, we note Western Australian services from the Day Therapy Centres Programme and National Respite for Carers Programme will commence within the CHSP on 1 July 2015.

Future iterations of CHSP documentation will need to discuss the relationship of the CHSP with the concept of consumer directed care (CDC) to clearly articulate expectations in this regard, recognising the limitations of CDC outside of individualised funding. The Alliance notes however that touch points along the CHSP journey will involve consumer choice and control and that these aspects should be promoted and encouraged throughout the sector. Particular choice and control occurs during the assessment process in identifying consumers care plan goals; in the selection of preferred supplier for referrals from My Aged Care and in the direction from consumers of the particular tasks needed to be completed during a visit from CHSP funded staff (e.g. could you change my bed rather than do my dishes today?).

While recognising this is not the fully aspired to CDC that occurs within the Home Care Packages Programme, promotion of the principles of consumer direction should be included within the CHSP. Importantly, the Alliance notes the distinction between person centred care and consumer directed care. The Alliance encourages the Department to distinguish between these concepts and supports both a person centred approach and the improved choice and control of consumers over the care services they receive. The Alliance is concerned however that the key directions of the CHSP do not sufficiently indicate the role of CHSP for people who acquire a disability over the age of 65. We believe it is necessary and important for the Department to articulate its vision for how the Commonwealth will service people over the age of 65 (over 50 years for indigenous Australians) with a disability. The National Health and Hospitals Reform Agreement, along with the design of the National Disability Insurance Scheme (NDIS) and the CHSP, has left concern within the sector that there is a group of people who may not be serviced by any program. Clients who are ineligible for CHSP may continue to need disability services that due to their age they will not be able to access from the NDIS. Similarly, a person over 65 may have higher needs than can be provided through a Home Care Package. With the design of these aged care reforms it remains a concern to the Alliance that there will be no support for people with a disability who fall outside these aged care programs.

Question 2: How should restorative care be implemented in the new Programme?

The Alliance supports the inclusion of wellness and reablement as a principle across the Commonwealth Home Support Programme (CHSP). The Alliance believes that the restorative care principles of reablement and wellness embedded in the programme will be of enormous assistance to delivering improved quality outcomes for clients of the CHSP. We particularly welcome this change in consumer expectations from the current 'doing for' approach to an approach of 'doing with' and hope to see this message embedded within the Government's communications. We note our previous comments to question one in relation to episodic intensive services and early intervention.

The Alliance notes the experiences of Western Australia and Victoria in embedding a reablement and wellness approach within their HACC services. A key success of these experiences has been the comprehensive training and education for HACC workers in the principles and practices of reablement. While noting the brief mention in the discussion paper (page26), the Alliance believes that a workforce development strategy must be articulated to support the roll out of wellness, reablement and restorative care across the sector. Such a strategy should include training in cross cultural competencies and the use of interpreters.

The Alliance believes that investment in up skilling knowledge of reablement and wellness skills among the CHSP workforce will be a key component of success for the programme. The Alliance considers the Department could examine funding the Community Services and Health Industry Skill Council to develop a nationally recognised skill set (to sit above Certificate III level) on wellness and reablement to address the competence gap for the vocationally trained workforce. Reablement and wellness should also be reviewed within existing certificates to ensure a basic level of understanding of these philosophies, along with training in cross cultural competencies and the use of interpreters. These should be included as mandatory components of all certificate and diplomas. Such qualifications should also be supported by coaching and mentoring 'on the job' to maximise reablement outcomes.

Consideration should be given to the funding of multicultural, ethno-specific and specialist providers of care to Aboriginal communities to deliver wellness and reablement allied health and nursing services. Such an approach may lead to improved client outcomes by removing the cultural barriers experienced by some mainstream agencies. Where mainstream agencies are seeking further support and assistance from multicultural or Aboriginal community controlled agencies, funding should be allocated to cover consultancy costs.

Due to lack of or limited English language skills, and low levels of education and literacy amongst older Australians of CALD background, additional funding should also be allocated to multicultural and ethno-specific organisations for community education programmes and information provision to CALD communities, particularly in relation to the principles of CDC and changes to the aged care system. There is concern amongst service providers that CALD consumers will be unable to access aged care services under the new CDC model and more burden will be placed on their children as carers, and that carers may miss out on support services due to not being fully aware of what is available. Intake and assessment procedures need to be adapted for CALD consumers to help overcome language and cultural barriers.

In addition, the Alliance notes that allied health and day therapy centres are likely to be strained in the initial implementation of a restorative care programme. The Alliance believes there will be a need for increased allied health positions to support the wellness and reablement objectives of the programme. There will be particular and unique challenges to achieving adequate allied health services in regional or remote locations due to the lack of available workforce. This may be alleviated through the appropriate use of allied health assistants in some situations (with defined scope of practice) or through the use of telehealth services. The Department should also look to target increases in funded services as part of growth rounds to allied health services that support the reablement approach. This may include support for occupational yherapy required to undertake an assessment of goods and equipment or home modifications, or the contribution of dietitians in improving health outcomes.

The Alliance notes that the use of the term 'network' of restorative services (page25) may lead to confusion with other similar networks (primary healthcare networks, hospital networks etc.). A greater explanation of what constitutes a network of services will be required. The Department needs to be clear about the role of services under increased independence for the purpose of the network and how resources should be allocated/prioritised. The Alliance notes that some organisations provide crucial restorative services to older Australians who are not funded under CHSP allied health or Day Therapy Centres. Consideration should be given as to how these networks will work with such specialist organisations.

The Alliance welcomes the opportunity to further discuss the implementation of the Government's wellness and reablement approach as part of the National Assessment and Screening Framework, the priorities of the CHSP and the review of the CHSP Manual. The Alliance notes there may be benefit in the Department investigating and promoting the successful models of wellness and reablement utilised today. This may include promoting some of the existing approaches used today in the Transitional Care Programme, as well as use of innovative delivery models for delivery within regional and rural areas, such as telehealth.

Given the sheer range and diversity of disability conditions, it is highly unlikely that disability assessors specialised in the specific disability would be able to be employed by Regional Assessment Teams. However, the Alliance believes that My Aged Care staff and assessors should have some knowledge and skills to identify older people with a disability. Assessments should include consideration of safety, independence and wellbeing issues and where a disability is identified the assessment should refer the client for specialised disability assessments and service delivery by service providers including those outside of the aged care system or funded uniquely from within the aged care system.

Question 3: Are these proposed client eligibility criteria appropriate? Should the eligibility criteria specify the level of functional limitation?

The Alliance is concerned about the lack of consistent understanding within the Commonwealth HACC Programme in relation to eligibility of carers within the Commonwealth HACC Programme. The Alliance recommends that the CHSP eligibility criteria should seek to redress this by making carer eligibility clear in the following ways:

- amend 'aims' to recognise a carer as a client in their own right (page27);
- amend 'target group' eligibility of carers, to clarify that carers do not need to be above the age

of 65 in order to access the CHSP by inserting the words 'of any age'. The eligibility bullet point would then read 'a carer of any age of above target group (e.g. a 45 year old carer of a 70 years old person should be eligible to receive services under the CHSP in order to support the 70 year old remaining in the community) (page27); and

- affirm in eligibility or programme manual that a carer may be eligible for CHSP even where the eligible person they care for is not receiving a service themselves.

The eligibility requirement that clients 'have needs that do not exceed a basic support programme' requires more specific explanation before the Alliance could comment (page27). Is the intention to set a limit in terms of dollars or hours? How will this be managed and monitored? At the roadshows, Departmental officials explained that CHSP is intended to provide small amounts of service to a broad target population ('a little to a lot'). Thus the focus is intended to be on the low level of service, not drawing distinctions between types of service which may traditionally be thought of as 'simple' (such as domestic assistance or social support) or 'complex' (such as allied health). The Alliance proposes a definition of 'basic support means:

- providing small amounts of a single or a few services when this is sufficient to maintain independent community living and wellbeing; or
- a higher intensity of episodic or short term services where improvements in function or capacity can be made, or further deterioration avoided.'

The Alliance believes Level 1 Home Care Packages should be disbanded and notes its previous advice that any 'capping' of services in the CHSP should be at service levels equivalent to a Home Care Level 2. If however Level 1 packages are continued, the overlap between levels of service between CHSP and the Home Care Packages Programme must be kept to a minimum. While the Alliance supports the broad principle of a basic support programme, until such time as a single community care programme may be developed, we remain concerned that the undefined inclusion of this statement in the eligibility requirement could confuse matters. In particular we are concerned about how the interface between the Home Care Programme and the CHSP will ensure that unique and complex clients previously serviced by the Commonwealth HACC programme are serviced by providers in the future. CHSP is rightly designed as a basic support programme. Where no Home Care Packages are available the CHSP should not be utilised to fill the gaps of Home Care package deficiencies. The Alliance supports greater explanation and elaboration of scenarios in the programme manual to ensure the Government's policy intent is clearly understood. One such scenario is the issue of ongoing management of wound care under nursing services. The Alliance would encourage the Department to clearly spell out the common scenarios provided for under the existing programmes that are not basic support and indicate the Department's preferred pathway for transition of such clients, either to remain within eligibility of the CHSP or transitioned to another programme.

The Alliance believes the CHSP should continue its commitment to financially disadvantaged clients (formerly a HACC target group) beyond those who are homeless or at risk of homelessness as outlined in the Aged Care Act.

The Alliance welcomes the inclusion of all Special Needs Groups under the Aged Care Act into the Commonwealth Home Support Programme (page28) and notes the value of keeping the definitions consistent in the future. We note however that any consideration of special needs groups in the CHSP should include people with mental health issues; cognitive impairment, including dementia; and sensory impairments such as vision impairment.

The Alliance remains concerned about the lack of clear interfaces between services within the disability sector (either state programmes or National Disability Insurance Scheme (NDIS)) and the aged care CHSP. This is particularly acute in the area of people under the age of 65, with low level needs relating to early onset of ageing. The programme structure requires them to receive services from the NDIS or state disability services. However where funding for such services is no longer being continued, or where the eligibility criteria is not met for basic needs, the CHSP is likely to be inundated with unmet demand of clients upon turning 65 years old. Transition arrangements will need to be considered where people under 65 years old acquire ageing related diseases (e.g. dementia) to ensure that the most appropriately skilled services are enabled to assist those clients.

The Alliance is also concerned about the future of services available to people over the age of 65 provided by State and Territory governments that may not exist from 1 July 2015 or 2016 as the programme funds may be transferred towards the state's contribution towards the NDIS. A particular area of concern is the current aids, goods, equipment and assistive technologies programmes run by the state governments for all people regardless of age. The Alliance notes the announcement by some State governments[2] and the impression given to Alliance members by State representatives that these programmes will either be discontinued, significantly reduced or potentially restricted to people eligible under the NDIS (thus under 65 years old). Should these programmes be discontinued for people over the age of 65, the Commonwealth will need to consider how to respond to this policy and programme gap. Clear interfaces with the disability sector will be required to ensure this group of people receive appropriate support services in the CHSP.

The Alliance strongly urges the Department to work with State and Territory Governments and the National Disability Insurance Agency (NDIA) to ensure the interface is clearly articulated and gaps between the programmes identified and outcomes actioned, before locking down the eligibility criteria of the CHSP. The Alliance's Ageing and Disability Interface Working Group stands ready to assist the Department in these discussions where necessary. Should these discussions conclude that people with a disability over the age of 65 years old will need to access services via the CHSP, it may be necessary to reconsider the eligibility criteria to ensure its appropriateness. The inclusion of people over 65 years old with a disability within the CHSP system would necessitate increased referrals from the My Aged Care Gateway to a range of specialist services such as vision impairment, orientation and mobility specialists, and other allied health professionals not traditionally associated with the current CHSP workforce. Finally, should people who are otherwise active people over the age of 65 years old with a disability become part of the CHSP, it may be necessary to ensure that clients from the My Aged Care Gateway are appropriately referred to disability specific services rather than generic aged care providers in a similar fashion to other special needs groups following their holistic assessment by My Aged Care.

In relation to the second question 'Should the eligibility criteria specify the level of functional limitation?' The Alliance believes that stipulating a functional limitation is an unnecessary burden to be included in the eligibility criteria. Given that an independent assessment will occur by the Regional Assessment Teams, publicly available guidance to assessment teams on the types of scenarios that constitute functional limitations would be an appropriate balance to address this issue. Such guidelines, including the assessment tool used, should identify if the client is malnourished or at risk of malnutrition as part of the client needs assessment.

2 See for example the Queensland Government statement that "Once the NDIS is fully implemented, the Department will no longer directly deliver disability services." (Department of Communities, Child Safety and Disability Services 2014 'Investing in Queenslanders: social and human services blueprint', Queensland Government Brisbane, p17. Available from http://www.communities.qld.gov.au/gateway/reform-and-renewal/social-investment/social-and-human-services-investment-blueprint/investing-in-queenslanders-social-and-human-services-blueprint)

Question 4: Are the circumstances for direct referral from screening to service provision appropriate?

The Alliance supports circumstances where direct referral from screening may occur as discussed in the Alliance's advice paper *Assessment and the Aged Care System ('Direct Referral to a Service'*, page9). As the National Assessment and Screening process has not yet been made public, our answer below assumes that the screening process will include eligibility assessment. Should an assessment of eligibility not form part of the screening process, the Alliance caveats the below response with such eligibility assessment questions being asked prior to any referral occurring.

As outlined in our previous advice, the reason why a referral is sought is a key determinant of whether an assessment is needed. Examples of appropriate direct referral include:

- emergency or urgent service delivery needs (e.g. hospital admission of carer or hospital discharge); and
- specific service requested for reasons unrelated to the consumer's health or wellbeing (e.g. meals due to carer holiday, transport due to lack of public transport).

Referrals direct from screening do not necessarily negate the need for an assessment. Such situations may simply indicate that the timeframe for needing service commencement is shorter than the timeframe in which an assessment may occur (for whatever reason). In cases where a direct referral from screening occurs, a scheduled assessment should occur as soon as possible (either by phone or by the usual regional assessment face to face). In most cases where an assessment was deemed necessary this should occur within 1-2 weeks. Where an assessment was deemed not necessary initially (perhaps because only a single service was required due to a particular occurrence) and the service continues longer than 12 weeks an assessment must occur no later than 12 weeks after the original service commenced. Even in situations where a single service is requested there may be benefits to a holistic assessment of the client (e.g. a client requesting meals who may be found to have a range of other concerns following a nutritional assessment being completed).

The Alliance (and its Gateway Advisory Group) would welcome the opportunity to provide advice on the specific business rules about when an assessment would be triggered.

In the current system today, various providers receive direct calls from clients seeking their services. It is unlikely in the early years of the My Aged Care Gateway that this direct to service provider request for service will change, especially for some special needs groups such as ethnic and Aboriginal communities with a strong relationship to ethno-specific services. As a starting point the Alliance notes that it may be appropriate for some service providers to commence service, while at the same time 'registering' the client with the My Aged Care Gateway and the My Aged Care Gateway initiating an outbound screening and assessment process. It may also be appropriate where 'urgent' services are required. Accordingly, clear business rules outlined in the programme manual and/or within a service provider's contract must be included outlining how service providers should handle direct requests for service. Referrals to My Aged Care Gateway should facilitate the receipt of the basic level of client information from the service provider via a range of options (online portal, fax, telephone). Providing clear rules around direct service requests from clients (with their consent) will enable service providers to pass on the minimum information to the My Aged Care Gateway as part of the transition period and will ensure that the 'no wrong door' principle will be implemented.

There are concerns that due to language and cultural barriers, CALD clients and their carers may struggle to access aged care services at the point of entry (i.e. the My Aged Care telephone call or website). This may result in some clients not even reaching the initial screening stage. The Alliance recognises that in such cases, ongoing support to register with My Aged Care Gateway will be needed beyond the transition period. This may include both interpreter or translator services for direct calls to My Aged Care as well as funded support positions with CALD organisations to support clients to communicate with My Aged Care.

Question 5: Are there particular service types that it would be appropriate to access without face to face assessment?

The Alliance believes there is great value in an independent assessment of the holistic needs of clients and carers. We note there were concerns in Western Australia, when centralised assessment was introduced, about delays to the system; eighteen months later, such concerns have proved largely unfounded. Nevertheless there is a need to ensure transitional arrangements support service providers from old approaches to the new approaches, particularly where new approaches require technological skills beyond the provider's capabilities.

The research on the trial assessment tool highlighted the limitations of a deficit telephone based assessment model. Accordingly, while the Alliance recognises that a telephone assessment may occur from time to time for basic assessments, the Alliance cannot identify specific service types where a non face to face assessment would always be appropriate. It is important to note that it is the client's individual needs and history that is the major determination of whether an assessment is required and not a particular service type. In many instances clients of single services (e.g. transport or meals) may still benefit from a holistic assessment of their needs. The Alliance notes that screening questions regarding sensory impairments (e.g. hearing loss, vision loss) will be needed and should automatically trigger a face to face assessment. Documentation from My Aged Care should also accommodate large, clear appropriate print format or in an accessible format such as e text, audio or Braille upon request.

An exception to this may be the provision of respite where the client is not receiving any other service than the respite for their carer. In this situation a telephone based assessment may be appropriate.

Question 6: Are there any other specific triggers that would mean an older person would require a face to face assessment?

Clients who identify with special needs (as defined in the Aged Care Act); including clients of CALD background facing language and cultural barriers; older people with mental health issues; cognitive impairments including dementia; and sensory impairments, such as vision impairment; should automatically trigger a mandated face to face assessment. It will be necessary for the screening process to identify such cases to ensure appropriate referrals. Where available, such face to face assessment should be conducted by an assessment service with skills in the issues/needs of the client, or involve a consumer advocate with such skills.

We note the discussion paper's reference to a 'two way' conversation between assessor and the client (page32). While the Alliance firmly supports consumer directed care and the centrality of the client in these processes, we also note that in some situations it may be necessary for this two way conversation to become a three way conversation involving the person's carer.

Further information about the assessment workforce including skills sets and the structure of the workforce will need to be known before additional comments on face to face assessment can be made. In particular, attention should be given to the balance between in house skills to address special needs concerns, versus independent or external organisations supporting clients with special needs through the assessment process. For example, accurate assessment of individuals with specific cultural needs, including Aboriginal and CALD clients, will require appropriate skills and experience (including skills in LOTE, use of interpreters and cross-cultural knowledge).

Cross-cultural resources and training have been provided to ACATs in the past to increase their skills and knowledge in working with CALD communities. This will need to be revisited for both ACATs and Regional Assessment Centres. Regional Assessment Centres will likely rely on the National Translating and Interpreting Service (TIS) for interpreting services. In contrast with Health Care interpreters (that are used by ACATs), TIS interpreters have no training in aged care services or related conditions and therefore may need training to increase their skills and knowledge.

The Alliance is concerned about the process of assessment and defining assessment efficiency. A wellness and reablement programme is best delivered in the context of early intervention and timely response. The starting assumption should be that there may be different approaches which support most people to gain greater independence. Mapping clients' needs against service scenarios will allow further exploration of the opportunities to assist 'people to be all they can be'. The Alliance recommends that with the disbanding of the Assessment Sub Group the HSP and Gateway advisory groups work together to advise the Department on streamlining assessment in this context and in defining benchmarks which adequately manage demand and optimise service availability and capacity. The CHSP network of service providers will require dynamic referral processes in order to maximise the intended wellness and reablement outcomes.

Question 7: Are there better ways to group outcomes?

The Alliance is pleased to see much of the original service grouping proposal outlined in our design paper has been adopted in this discussion paper. The Alliance welcomes the opportunity to trial individualised funding in the future as an alternative approach to contestability.

The Alliance is supportive of the general direction of the service grouping outcomes with the following comments for consideration:

- The Alliance recognises the primary reason most clients receive a meals service is to provide a nutritional meal which in turn improves the health and wellbeing of the client. The Alliance recognises that some believe this may be best achieved as a stand alone outcome group; however the Alliance strongly believes that 'nutrition' should be moved to become a service type within the 'Increased Independence' outcome group. This is the appropriate place to recognise the primary service being delivered is the improvement of health and wellbeing, along with other such services. The Alliance recognises that a large number of 'embedded' meals will continue to be delivered as part of programmes under Social Participation. All meals funded under CHSP should have a consistent approach to nutrition and improved reporting activities should ensure that embedded meals are recorded. The Alliance notes its comments in question 13 urging an expedited timeline for the introduction of voluntary national nutritional guidelines.

- Other Food Services (OFS) formerly of Service Group One should be altered to 'Assistance with Home Skills' in recognition that the services delivered under OFS are reskilling older people with meal preparation. A number of other HACC programmes provide restorative skills/programmes that could be included within this broader definition and should be encouraged in future growth rounds. An example of such programmes may include retraining older people to drive as an alternative to being delivered a transportation service.
- The Alliance supports the broad direction of Service Group 2's transition from Commonwealth HACC. However due to the complexity of individual services funded under this service group the Alliance is not confident that all information services currently funded and delivered within the community can be accommodated by the My Aged Care Gateway. It may be necessary therefore for the 'Sector Development and Support' outcome to include elements of professional development/education and for regional assessment teams to include information about local services within their service remit. Sufficient support should be given to remunerate organisations supporting clients through the My Aged Care Gateway assessment process. Special needs organisations (including organisations with specialist cultural skills) should not be expected to provide this service without remuneration.
- The Alliance is concerned that the defunding of Service Group 2 will remove some valuable support and education services of clients within the CHSP that may not neatly fit within future Workforce Development or Sector Development funding arrangements. In particular for special needs groups, special needs organisations need to be funded in order for older Australians from those groups to have equitable access to the programme.
- In addition, the Alliance is aware of the inconsistency of funding approaches to similar innovative services, some of which may fall under Service Group 2. For example the provision of a monitoring health alarm and daily phone call in one state may be seen as goods and equipment and social support respectively, while in another state has been funded under Service Group 2 information advocacy and referral. In these unique cases where the funding purpose of individual contracts clearly fall under an alternative service type the Alliance recommends the Department facilitate transfer of that service contract to the appropriate service outcome/service type, rather than automatically discontinue the service because of its incorrect funding location.
- The Alliance notes some concerns around the care relationships grouping which are further discussed at question 9.
- The Alliance believes that the Department should rename the service type 'Goods and Equipment' to 'Assistive Technologies', or at a minimum include assistive technologies within the title programme in recognition of the broader types of products now available to support basic level needs that should fall within this category.
- The Alliance is concerned that for some equipment currently hired under the programme a $500 per annum cap is too restrictive, but recognises for the vast majority of consumers currently accessing this programme the $500 cap is appropriate. Some assistive technology costs are significant but provide significant long term benefits to the individual (e.g. a person with vision impairment may use a myriad of aids and technology to achieve independence). The Alliance recommends that this cap be placed at $1,000 to enable the purchase of a range of technologies including low vision aids such as binoculars, electronic magnifiers and magnifying/reading software.

- Given our former comments in relation to the concern over discontinuation of State and Territory goods and equipment programmes, the Alliance believes that the Government in partnership with State and Territory governments should develop a stand alone goods, equipment and assistive technologies programme in order to service these higher needs over 65 year olds. Without some technology, people are likely to lose their independence and will create a greater demand either for residential care or higher levels of packaged care resulting in overall higher costs to the Commonwealth.
- The Alliance supports in principle a one stop shop for aged care sector individual advocacy, such as could be achieved by the inclusion of HACC advocacy for individuals within the National Aged Care Advocacy Programme (the NACAP). However, HACC advocacy also provides a significant amount of systemic advocacy that may not be provided for under the NACAP. NACAP also does not accommodate the policy advocacy that has stemmed from HACC programmes to ensure the best outcomes for HACC clients. The Alliance recommends that either a review of the NACAP and broader advocacy services be brought forward for completion by 1 July 2015, in line with the commencement of CHSP, or that transitional arrangements for systemic and policy advocacy be included (potentially via sector support and development) until such time as a single advocacy programme may be developed following the review.
- The Alliance notes the Department's proposal that transport remains a stand alone outcome stream and appreciates the Departments position that there is much work to do around transport following the service type review report. In our September 2013 Discussion Paper, we recommended that transport be included in the 'Social Participation' stream, in line with its key outcome for consumers. We therefore recommend the viability of this as a stand alone stream should be considered as part of the five year aged care review, once more data becomes available on the operation of transport providers and the changes resulting from the initial review are bedded down over the next three years old. The Alliance further notes that a range of transport services will continue to be delivered under alternative outcome streams as embedded transport to that service. The Alliance would support an increased awareness of non-transport funded transport services in order to build a holistic picture of the transport footprint across the programme.
- The Alliance notes its support for programmes under the social participation programme that utilise telephony or other technologies to connect consumers. This is particularly important for people with sensory impairments or in geographically isolated areas.

The Alliance reaffirms its understanding that the Sector will receive approximately nine months notification of the structural design of the CHSP to enable it to adjust its policies, procedures and processes and to retrain staff on the new programme design. Should this timeframe diminish for any reason, additional transition issues may need to be considered.

Question 8: Are there specific transition issues to consider?

The Alliance reaffirms its view that a clear transition plan should be issued on the creation of CHSP to help the sector prepare for the steps involved. A number of transition issues are discussed throughout this response, in addition to specific transition issues identified here. These include:

- Some clients currently in the HACC programme will no longer be eligible under the CHSP, particularly where service levels are above the benchmark of basic services. The proposed solution to accommodate this situation is to transfer clients onto the appropriate Home Care

package or through eligibility into residential care. However such transition pathways assume the necessary Home Care Package or residential place will be available. This may not be the case on 1 July 2015. The Alliance notes that this will also apply to some carers with services funded under NRCP. While the Alliance appreciates that new clients will not have these issues and where possible service providers will transition clients in advance of 1 July 2015, there will nevertheless be some high need clients within the CHSP on 1 July 2015. The Alliance believes that the Department should closely examine the data to determine the scale and location of high use needs. Based on this understanding of who they are, how much they are using and what types of services are involved (especially the overlap with case management including Community Options Programme (COPs) and Linkages) the Department should then consider (in consultation with the HSP Advisory Group) a range of transition options which could include (1) grandparent services for remaining clients until they exit or transition; or (2) transfer a proportion of the base of the HACC programme to create additional Home Care Packages (recognising that HACC has always provided a proportion of its services to high needs clients and carers) and transfer existing clients to the new packages.

- There will be some case management clients (especially those assisted by Community Options or Linkages services) who will require transition to an alternative ongoing case management service. This group may overlap with the high needs clients, but there are also some clients who receive lower levels of regular HACC services but need regular access to a case manager. The ACHA homeless client group may also overlap with this group of clients. It is important the design of CHSP, Home Care Packages and My Aged Care Gateway are not too inflexible to meet the needs of these clients.
- Information should be provided in an equitable and accessible manner about the changes and the new aged care system. This includes large print, audio, Braille, electronic and other accessible formats for people who are blind or have low vision should be available.
- The Alliance is concerned by the issue of contestability and will discuss this in more detail below in question 13.
- The transition plan should include workforce development strategies to ensure staff are up skilled in wellness and reablement approaches (as discussed in response to question 2).
- Should the Department rule that the programme will not provide access to services for people living in a residential care setting; then transitional and grand parenting arrangements should be made for existing clients of the Day Therapy Centre programme.
- During the 2015-2016 period between the discontinuation of Service Group 2 and the design of an improved advocacy programme, some transitional arrangements for existing system and policy advocacy should be maintained.
- Clear transition pathways from HACC for under 65 year olds need to be communicated as part of the CHSP. This is particularly relevant where the person is presenting with ageing related issues that do not entitle them to Level 3 services under the National Disability Insurance Scheme.
- Existing service types need to be translated into new service/outcome streams. Individual providers will need to receive translated information from the current services they provide to the new service/outcome streams. The old to new service types should continue to be identified for the first twelve months of operation. From 1 July 2016 identification of specific service types should cease and providers should be allowed to deliver any service type within the broad

outcome stream for which they are funded and with a view to the local planning framework's identified needs. An increase in the percentage of funds able to be spent on a different outcome stream (beyond the current 5per cent level today) should be trialled from 1 July 2016. Items that cannot be purchased or provided with CHSP funding ('excluded items') should be clearly articulated from 1 July 2015 in the programme manual and should be in line with the exclusions listed in the Home Care Programme. These changes will enable greater flexibility of service provision within the service/outcome streams.

- The accountability requirements, including the minimum data set, will need to be overhauled. This provides an opportunity to reduce unnecessary red tape, report on programme and service outcomes and gather data which can be used to improve service delivery. It will be important to determine data requirements prior to CHSP commencement, to enable systems to be established. Clear online training on the new accountability requirements (including MDS) will be required and should include recording of individual client impact/outcomes.
- Specifications for essential changes to IT systems, along with support to enable such changes, will be required. Consideration of financial implications for providers should be considered in the transition year's growth funding opportunities.
- During the 5 year review, the Alliance feels the issue of lifetime caps should be revisited and consideration should be given to adjustments that include caps for the CHSP. This will be of particular relevance as consumers begin to contribute around the same amount for the same service under CHSP compared with the Home Care packages.

Question 9: How are supports for carers (other than respite services) best offered? For example, should these be separate to or part of the Commonwealth Home Support Programme?

The Productivity Commission Inquiry into *Caring for Older Australians* (2011), made the following points in relation to support for carers:

- '*The Commission supports the development of a National Carer Strategy but also considers there is an immediate need to develop additional supports for carers from the existing base of programmes in the aged care system.*
- *Carers should be better supported in their caring role through a variety of measures:*
    - *The proposed Australian Seniors Gateway Agency would assess the capacity of informal carers to provide ongoing support when assessing an older person's needs; and*
    - *The proposed Carer Support Centres should be developed to undertake assessments of carers needs. Where appropriate, these centres would also deliver specialist carer support services including carer education and training; emergency respite; carer counselling and peer group support; and carer advocacy.*
- *Action in other areas can also improve support for carers, including trials and evaluations of various respite options*[3]*.*'

3 Productivity Commission 2011, Caring for Older Australians, Report No. 53, Final Inquiry Report, Ch. 13 – Key Points, p 325, Canberra.

Additionally the Productivity Commission Inquiry into Disability Care and Support recommended that in order to sustain informal care and support, the NDIS should:

- *'assess carer needs as well as those of people with disabilities and, where needed, use the assessment results to:*
    - *refer people to specialist carer support services including Carer Support Centres … and to the National Carers Counselling Programme; and*
    - *include the capacity for accessing counselling and support services for carers as part of the individual support packages provided to people with a disability.'* [4]

Whilst the two reports differ slightly regarding carer assessment, they are in agreement on the need for carers to have access to a range of carer support services other than respite care in order to sustain their caring role and that these services should be available separately to services for older and younger people with care and support needs.

The Productivity Commission recognised that carers form a key, if unpaid, part of the aged care and disability support workforce and that sustaining informal care is crucial to the sustainability of these formal systems. Of course carers are not only part of the workforce, they are also co clients and people with needs *separate* from their caring roles. The Alliance recommends that any strategies to build the capacity of the aged care workforce should also consider the education and training needs of informal carers, especially in relation to embedding a wellness and reablement approach.

Currently carers cannot access the suite of services under the Commonwealth HACC Programme in their own right without the older person they care for having been assessed as eligible. In some situations where a client does not wish to be assessed, this means carers do not receive services. This includes the proposed Service Outcome 'Care Relationships' in CHSP, specifically respite care. Respite care cannot be provided to a client who is unknown to the 'system', except in an emergency, hence the provision of 'indirect respite' services under NRCP to carers as clients in their own right. In order to provide maximum support for carers it is anticipated that eligibility in their own right will occur under a future design of the remaining elements of Carer Support Services in whatever way they may be designed. Further we anticipate that the future design of the Carers Support Services will enable brokerage of some of the specific services available under the CHSP where required. For the majority of carers however the older person receiving care will allow an assessment of their eligibility to enable direct recognition of the carer as an eligible service recipient under the CHSP, regardless of whether the carer is over or under 65 years of age.

Independent access is an important principle in the design and delivery of carer support services; carers should not require the knowledge, permission or cooperation of the person they care for in order to access peer support or counselling for example.

The Alliance reaffirms its support for the Productivity Commission's recommendation that Carers Advocacy form part of the services of any future Carer Support Centres. Carer Advocacy is essential to assist caring families to transition to new programmes and to navigate the changing landscape of aged care and disability services as the reforms continue to roll out.

The discussion paper prepared by Urbis on developing a model for new carer support centres emphasised the importance of carer support services:

4 Productivity Commission 2011, Disability Care and Support, Report no. 54, Final Inquiry Report, Rec 15.4, p 728, Canberra.

- integrating with other functions and services of the My Aged Care Gateway; and
- complementing other aged care, disability, health and community care systems.

The vision outlined in the Urbis report[5] of carer support services being for 'all carers' regardless of the age of the person receiving care, their condition or their eligibility for formal care and support services is now more important than ever.

The Alliance recommends that the Department expedite internal discussions between the former FAHCSIA and DOHA sections about how to approach caring needs and issues across the lifespan. The Alliance supports the recommendation that the Department convenes a cross sector advisory group to provide expert advice on nationally consistent design and delivery of carer support services.

The Alliance notes it's in principle support for the development of a single programme for carers, regardless of whether their client is part of the disability, mental health or aged care systems. Should the Department proceed with the development of such a carers support services programme, the Alliance notes this would not form part of the CHSP. Once this programme design has been announced by the Department, further discussion about the role of CHSP in servicing carers may need to occur.

Question 10: What capacity building resources are needed to assist with the sector's transition to the Commonwealth Home Support Programme?

There are a range of capacity building resources that the sector would benefit from being provided as part of transition to the Commonwealth Home Support Programme:

- A small capital grants programme to assist current CHSP providers' access technologies to interface with the My Aged Care Gateway. Some providers may not have the necessary technology to provide direct referrals to the My Aged Care Gateway.
- Direct engagement between the Department and the leading technology providers in Australia should be commenced as soon as possible so that design specifications can be produced for future versions of aged care software.
- As discussed before a focus on training and education to accommodate the increased skills around restorative care approaches will be needed. This should include capacity building for consumers, carers and referring health practitioners to ensure they are actively involved in and knowledgeable about the CHSP wellness and reablement philosophies.
- Online training for the equivalent of the Minimum Data Set reporting, with clearer definitions and examples in the data dictionary. It is clear from a number of the HACC reviews that over time different states have reported activities undertaken in different ways. While the Alliance supports an improved mechanism of reporting, any continued use of the MDS process (or equivalent mechanism) should be accompanied by online training to ensure consistent reporting processes.

5 Urbis June 2013 'Developing A Model For New Carer Support Centres – Outcomes From Background Research- Discussion Paper'. Available from: http://www.qld.lasa.asn.au/sites/default/files/final_csc_consultation_discussion_paper_-_24.6.13.pdf

- Grant training for volunteer led organisations is required. Various smaller providers within HACC have reported a lack of skills, within their largely volunteer organisations, to be able to apply successfully for growth grants. Some training and support on the process and the key selection criteria for grants would assist in alleviating these concerns.
- Support for consumers in navigating the Commonwealth Home Support Programme should also be provided. This should include specialised support for special needs groups under the Act who may have specific barriers in navigating or accessing the Programme.
- The Alliance supports the proposed Development Officers however notes the current inconsistency in delivered outcomes and inequitable geographical coverage. Some centralised or supplemental tools, resourcing and training of development officers should be considered as possible ways to smooth out these different experiences, while retaining a local focus. The Development Officers should provide more of a community development focus, supporting mainstream services; the community and aged care service providers; assisting clients with access and 'aged care literacy'; as well as supporting the service planning context. Such programs should ensure equitable access to services by people with special needs, including culturally and linguistically diverse backgrounds. The development officers should not be focused on 'service development' but should facilitate information about workforce development, innovation and best practice research development. Consideration should be given for specific development positions working with special needs populations.
- Specialist services to special needs groups are required to develop approaches that support delivery of specialist disability service to people from diverse backgrounds with varying needs.

The Alliance believes a review of the Home Care Standards may be necessary to ensure that compliance with these standards remains relevant and continues to underpin quality in the new CHSP.

Question 11: How should the current Assistance with Care and Housing for the Aged Programme be positioned into the future?

The Alliance recognises that the Assistance with Care and Housing for the Aged (ACHA) programme is diverse across jurisdictions and does not neatly fit within any aspect of the reformed aged care system. Following consultation with ACHA providers, the Alliance supports the below set of principles that should be maintained within any ACHA programme.

1. The ACHA programme has a unique position in straddling the specialist homelessness and aged care sectors. ACHA's focus is on older people (including people experiencing premature ageing) who are homeless or at risk of becoming homeless to obtain long term affordable housing with appropriate support. It provides a targeted approach that is not available through the specialist homelessness sector. Within the aged care sector the programme coordinates a response that is directed to ensuring appropriate housing is secured for the older person and that their care needs are met so that they can continue to live in the community.
2. The ACHA programme provides a rapid response to older people who are homeless or at risk of homelessness through one on one contact. Staff are empowered to determine the most appropriate options for clients with minimal restrictions. ACHA workers build trust with clients and support clients who have a distrust of Government systems or are unable to access or negotiate these systems. Maintaining this trust and contact is essential to achieving results.

3. ACHA provides a flexible and individualised service delivery approach. This is essential to keeping people housed or getting them rehoused due to the variety of circumstances that are involved in older people's housing insecurity and their care needs. The flexibility and tailoring of services to the people ACHA works with must be retained so that the programme is well positioned to continue to achieve meaningful outcomes. Innovative and localised responses to an individuals needs must be fostered through the ACHA workers continuing to:

    3.1 undertake outreach services (both passive and assertive);

    3.2 maintain trust and direct contact with clients (integral to achieving results);

    3.3 provide case management and face to face assessment that has an uncapped time period for interventions; and

    3.4 offer holistic support and a wide range of activities based on the clients individual needs including but not limited to advocacy, assistance with packing when moving and addressing squalor or hoarding issues.

4. The ACHA programme interacts and works with multiple services across a range of sectors including health, community care, mental health, housing sector, financial services, welfare and social services, Guardianship tribunals, Public Trustees, refuges, legal and tenants advocacy groups. This flexibility to move between programmes must continue in order to make the ACHA programme responsive to client needs.

5. The ACHA programme must have strong links with the community, housing services and all aspects of the aged care sector. ACHA services should be included in the My Aged Care website and promoted to Consumers and other aged care providers to ensure appropriate referrals are made between ACHA and the broader aged care sector.

6. Client eligibility must continue to be broad and include clients who are over 65 (and over 50 for Aboriginal and Torres Strait Islander people) as well as provide services for people aged 50 years old who are prematurely aged (and 45 years old for Aboriginal and Torres Strait Islander people). It is noted that ACHA clients are often those that fall through the gaps of a range of service types (including specialist homeless services, mental health services and aged care services). ACHA provides a cost effective means of preventing older people becoming homeless and/or the loss of their capability to live independently in the community. As such it is a component in supporting the wellness of older people.

7. Case management is a crucial component of the ACHA programme. Stabilising housing or finding alternate housing can be a complex task and while pathways to accessing care can be more straight forward, the case management relationship is important in determining the full range and nuance of needs that a person has as well as the strengths they are able to mobilise. Coordination and linking of services along with service level advocacy in a goal focussed case management relationship are necessary within ACHA.

8. My Aged Care is currently being developed and rolled out. When My Aged Care is fully operational it is recognised that this will be the point of entry and referral for all aged care programmes and this may include a record of clients accessing the ACHA programme. However the specific needs of ACHA clients will require a specialised approach which fully understands the complex needs of these clients. ACHA needs to be the point of entry and assessment for the bulk of ACHA clients. This requires further discussion and a comprehensive understanding of the role of Regional Assessment Services and its 'linking service'. ACHA services will continue to be

the entry and assessment point for all ACHA clients until this is resolved. For this reason until My Aged Care is fully implemented and the capability to undertake such assessment is firmly embedded within My Aged Care the ACHA programme should continue to receive referrals directly. It may be necessary following these conversations for ACHA to continue being an ongoing entry point for clients who are homeless or at risk of homelessness

9. The ACHA programme is currently very limited in its distribution of sites and there are already significant gaps in service. The ageing of the population, changing demographics, an increase in the number of older people likely to be living alone and the lack of affordable housing options will all significantly increase demand pressures. ACHA should be expanded so that it is provided in all aged care regions within Australia. To achieve this growth, funding beyond indexation increases must be planned for.

10. ACHA services support mainstream community and residential aged care programmes with their most complex cases. It provides a unique opportunity for all associated services and programmes to work cooperatively to meet the essential housing, health and community care needs of extremely vulnerable and disadvantaged members of the community.

11. Service agreements should be for a five year period in line with other Department grants (and the Alliance's proposal for grants within the Commonwealth Home Support Programme). A minimum of six months notice should be given for any discontinued funding in order for a business to transition staff from the programme appropriately.

12. Brokerage is a necessity within the ACHA programme that requires a funding commitment. The capacity to prevent people becoming homeless or requiring residential aged care because they could not be supported to live independently are expensive in contrast to the provision of some limited funds to broker necessary goods and services or secure accommodation, where there is no other funds available (such as removalists, assistance with packing, fumigation, clean outs and to provide small whitegoods). Currently brokerage within the ACHA programme is extremely limited and heavily relies on donations and support from the community. The ACHA programme should have brokerage funds available to facilitate the achievement of goals and make a difference to the sustainability of the outcomes achieved for vulnerable people. Increased availability of brokerage should be considered a priority of growth funding.

13. The ACHA programme must have access to interpreter services via the Commonwealth funded Telephone Interpreter Services, rather than use of core service funding.

The Alliance recognises there is a range of views amongst current ACHA providers as to whether these principles would best be delivered upon as a stand alone programme, or whether it would be better delivered as an outcome stream within the CHSP. The Alliance sees value in both solutions, but favours the programme becoming an outcome stream of 'Housing Security' within the CHSP.

Question 12: Are there any other issues that need to be considered in transitioning functions from the current HACC Service Group Two to My Aged Care?

The Alliance supports the broad direction of moving Information to the My Aged Care Gateway. However the diverse nature of services delivered under the umbrella of HACC Service Group 2 means some may not continue to be delivered by the My Aged Care Gateway. In particular local information services about non-HACC and indeed non-government funded aged care and related

services have provided unique sources of information for the whole sector.

It will be important for the Department to evaluate how this knowledge information may transition from the current intellectual property owners and be retained into the future. This may be via incorporation into an expanded set of local information within the My Aged Care Gateway or via transfer of information to be housed and managed as part of the Regional Assessment Services. Some local volunteer based information services may warrant ongoing funding, separate from My Aged Care, at least for a period of time.

Current assessment processes in some states have a commitment to regular reviews that has not been articulated in the discussion paper. The Alliance believes regular reviews will be necessary. The Alliance reaffirms its discussion in question 8 in relation to the importance of the ongoing role of special needs providers and peaks in supporting clients with special needs in accessing the system.

Question 13: Is there anything else you want to raise to help with the development of the Commonwealth Home Support Programme?

Planning Processes

A clear planning process for each region is needed to both monitor existing service impact and to identify gaps in service delivery and future growth needs. The planning process should occur through a dual approach (information up and information down) process.

On one level analytical data should be provided by the Department (e.g aged care current service levels on a region versus national average, My Aged Care waitlist times, ABS projected needs). On another level, regional recommendations should be included in planning processes to maximise efficiencies from knowledge at the regional level based on on the ground experiences from client facing personnel. Information should, at a minimum, be provided at a Local Government Area level and where possible should be integrated with general local planning processes.

The Victorian HACC Growth Funding Allocation process may provide a starting point for such a planning framework to be developed, and models in other States should also be examined. The role of HACC Development Officers, as a conduit in local planning, should be considered.

Planning information should be transparent and available to the sector as a whole.

Contestability/Competitive Tendering

There is a range of views amongst Alliance members regarding the selection of service providers section of the discussion paper (page42). Accordingly, the Alliance has agreed upon the following principles for the Department to consider when addressing competitive tendering:

1. Contestability should not be applied across the whole CHSP all at once, either in the lead up to July 2015 or in the future. A clear plan for contestability should be included in the proposed transition plan, so that providers have a clear understanding of the timeline and processes involved.

2. Contestability should only occur following publication of a cost of care study that outlines the unit measurements and range of costs for each service type across the country.Contestability should only occur once clear units of measurements have been confirmed for specific service types (e.g. transport).

3. Any decision to proceed with contestability should consider not only the financial benefits to the Department, but also the improvement of quality services to clients and safe and satisfying workplaces.

4. The Department's approach to contestability and the process utilised should be in line with the recommendations of the Productivity Commission's *'Contribution of the Not for Profit Sector'* report. In particular recommendations 12.1, 12.2 and 12.3.

5. Consideration should be given to capital investments for particular services before contestability is determined and, where deemed appropriate, recontestability for existing services dependent on high capital contributions by the provider should not occur (e.g. Day Therapy Centres, centre based day care or specialist dementia day care centres). The CHSP should be supported by a capital grants programme.

6. Growth funds should be targetted to areas of need, identified through the planning process discussed above. Selection criteria should include an assessment of the applicant's local knowledge and experience.

7. The Department must support organisations in understanding the grant round process and up skilling providers in effective grant writing processes. Simplification of grant application processes should occur where possible. Consideration of the value that localised small community controlled organisations provide to the CHSP service footprint should also recognise the challenges such organisations may have when engaging in grant based processes.

8. Transitional arrangements should consider use of a closed grant round, to ensure existing providers of all sizes in a particular region are aware of the contestability process, before introducing open rounds.

9. Open grant rounds may not be the most effective source of securing optimal outcomes where there is no identifable or profitable market (e.g. remote services, some ATSI or CALD services). In these cases, where only small growth amounts may be available, an open grant round may not be the most appropriate approach.

10. Consistency should be considered with other aged care programmes where initial allocation is contestable but not recontestable after initial allocation (e.g. Home Care Packages, residential care places).

11. Where contestability does occur it should be consistent with other the Department grant processes, allowing for five year contracts, rather than the proposed three year contracts. Notice of non-renewal of contract or renewal of contract, should occur with a minimum six month notification period in order for businesses to transition staffing arrangements appropriately and in accordance with relevant workplace laws.

12. Services utilising high levels of volunteers should be subject to the same considerations for contestability as other services. Before tendering, consideration should be given to the distruption and during transition diminishing of volunteer services that could occur due to potential changes of service providers. Decisions on contestability should not assume however that high volunteer services automatically provide a lower unit cost than high staff services, as this is not always the case.

13. A clear decision from Government about the timeline for contestability, including specific statements where contestability will not occur (including for a period) is needed. The Alliance notes reports from HACC, DTC and NRCP providers that the uncertainity of this decision has increased the risk to the provider of whether it can be seen as an ongoing concern particularly in relation to the 2015/16 period and in securing operational and capital finances.

Nutritional Guidelines

The Alliance is supportive of the development of voluntary National Nutritional Guidelines for all types of meals funded through the CHSP, regardless of their funding source or service type. The Alliance is concerned the Department has not committed to these guidelines by 1 July 2015 and urges the Department to introduce the guidelines on or as close to the commencement of the CHSP.

Alignment/Interface with NDIS

The Alliance believes that as far as practicable, there should be alignment between CHSP (and aged care more generally) and the NDIS to minimise the need for separate systems and processes, reduce red tape, and improve workforce transferability between the systems. The pricing of specialist services (e.g. disability services) must considered in the development of the CHSP fee policy. The Alliance encourages the Department and NDIA to actively engage each other and include within their respective consultations discussions with the sector to effect greatest possible alignment between the two systems where possible.

Embedding the principles of the National Strategies within CHSP

It is important that the principles embodied in both the Commonwealth National Ageing and Aged Care Strategy for People of Culturally and Linguistically Diverse (CALD) Backgrounds and the National Ageing and Aged Care Strategy for Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) People be incorporated into the design of the CHSP. New and emerging communities require particular attention, as do smaller CALD communities in regional and remote areas.

CALD clients and carers with limited or no English language skills require the assistance of interpreters and bi-lingual workers (where available) and access to information professionally translated into their preferred language. This requires the allocation of funds for these services to ensure access and equity.

The National Aged Care Alliance is the representative body of peak national organisations in aged care including consumer groups, providers, unions and professionals.